NHS Greater Glasgow & Clyde

NHS BOARD MEETING

Medical Director **21 February 2017** **Paper No: 17/07**

Prison Healthcare Services

Recommendation:-

The Board is asked to note the report.

Purpose of Paper:-

The purpose of this paper is to provide the Board with an update on Prison Healthcare.

Key Issues to be considered:-

The Service Developments, on-going challenges, Governance, Suicide Risk Management and Her Majesty's Inspector of Prisons Report on HMP Barlinnie.

Any Patient Safety /Patient Experience Issues:-

The report highlights issues in relation to Suicide Risk Management.

Any Financial Implications from this Paper:-

None

Any Staffing Implications from this Paper:-

None

Any Equality Implications from this Paper:-

None

Any Health Inequalities Implications from this Paper:-

The report highlights a number of challenges in delivering healthcare within the prison environment.

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome:-

None

Highlight the Corporate Plan priorities to which your paper relates:-

Early Intervention and Preventing Ill-health

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Tel No 0141 427 8304
Date 7 February 2017

NHS Greater Glasgow and Clyde

NHS Board Meeting

Medical Director **21 February 2017** **Paper 17/07**

Prison Healthcare Services

1. Background

In November 2011, the responsibility for delivering healthcare to prisoners transferred from the SPS (Scottish Prison Service) to the NHS.

At that time, all staff transferred under TUPE and NHS GG&C took over responsibility for HMP Greenock and HMP Barlinnie. In early 2012, HMP Low Moss opened and NHS GG&C assumed responsibility for healthcare at that point.

HMP Barlinnie and HMP Low Moss are all male prisons; however HMP Greenock has around 50 women, currently housed in a male prison with no purpose built female cells.

2. Service Developments

Since 2011, NHS GG&C has continued to develop healthcare provision and implemented a range of developments and initiatives, briefly described below:

- Introduction of a Service Manager role across all 3 prisons.
- Developed and implemented a new policy for Drug, Alcohol and Tobacco services to bring them into line with the wider NHS GG&C services. This includes the integration of the former Phoenix Futures staff who are employed to deliver enhanced addiction casework services.
- Work is currently underway to review the Mental Health services, again to bring them into line with GG&C community provision, where appropriate.
- Developed, in conjunction with SPS, Joint Health Improvement Plans for all 3 prisons.
- Introduced a nursing team leader role to HMP Barlinnie, for primary care and mental health.
- Increased administration support to all 3 prisons with the introduction of an Admin Team Leader.
- Introduced a Clinical Pharmacist (Band 8a Full Time)
- Introduced a Consultant Clinical Psychologist – full time.
- Introduced a GP Clinical Lead – full time.

- Increased the number of dental sessions from 8 to 10 to cope with the very high demand for dental services within the prisons.

- Introduced a podiatry service to all 3 prisons.

- Consolidated screening services which are now offered to all prisoners bringing equity with community primary care services.

- Introduced Blood Born Virus (BBV) testing for all prisoners on admission, and a comprehensive treatment programme for prisoners testing positive.

- Introduced, with funding from the Alcohol and Drug Partnerships (ADPs), an alcohol liaison nurse.

- All prison healthcare staff now participate in all NHS GG&C mandatory training, and have received additional training in Mental Health First Aid, Personality Disorder Awareness. NHS staff also undergo mandatory SPS training in personal protection, key handling, fire safety, health and safety.

3. Challenges/Barriers to delivering healthcare

- Delivering safe and effective healthcare in a locked environment
- Working within the confines of the prison security regime, for example, gaining access to patients during "lock down" periods, relying on Prison Officers or G4S staff to escort prisoners to appointments
- Access to prisoners for clinical interventions as we rely on SPS to escort prisoners to both internal and external appointments.
- Delivering healthcare to a deprived population who often suffer inequalities and do not engage with health services in the community
- Overcoming cultural differences between the 2 organisations
- Delivering appropriate healthcare to female prisoners housed in a male prison.
- Lack of fit for purpose IT system (National issue).

4. Governance

Prison healthcare is currently a hosted service within the Glasgow City HSCP. There is a Clinical Governance Committee which is chaired by the Clinical Director, a Health and Safety Committee, chaired by the Service Manager, a Workforce Planning Group, chaired by the Service Manager, an Operational Group, Chaired by the Head of Adult Services, South Glasgow.

In addition, there are regular liaison meetings within each prison between healthcare managers and local SPS managers, and a tri-annual meeting between the 3 Prison Governors, and the Senior Management Team from Glasgow City HSCP (Clinical Director, Lead GP, Service Manager and Head of Adult Services (South)). The meeting with the Governors is a "joint governance" meeting whereby service developments/improvements, performance reports and any other issues pertaining to the service are discussed.

5. Suicide Risk Management

In December 2016, a new process for suicide risk management was introduced by the SPS – "Talk to Me" which replaced the previous system "Act2Care". In 2016, there were 3 suicides in Glasgow prisons.

A paper outlining this process is attached at **Appendix 1**.

Briefly, the previous process dictated that every new admission to prison should be seen by a doctor (GP) within 24 hours of admission. This has now been replaced with "Healthcare Professional". Work is currently

ongoing to develop the role and determine the skill set for an “Admission Nurse” which will allow GPs to focus more on patients requiring their particular skills.

6. Her Majesty’s Inspectorate for Prisons (HMIP) Report on HMP Barlinnie 2016.

All prisons are subject to a routine inspection from HMIP; however, in 2016, a new template for inspecting health aspects was introduced.

The report for HMP Barlinnie was positive as can be seen by the section pertaining to health (Section 4 Health and Well Being) at **Appendix 2**.

Following publication of the report, an Action Plan with links to the governance arrangements was developed to address those issues pertaining to healthcare.

The Inspectorate also introduced the role of Prison Monitor which replaced the Visiting Committees. These monitors report to the inspectorate instead of SPS and NHSGG&C has engaged with the local manager to explore ways in which we can work together to respond to the feedback from prisoners.

7. National Prisoner Healthcare Network

The NPHN was set up at the point of transfer to allow all Boards to come together with representatives from SPS, Trade Unions and the Voluntary Sector to share good practice, ensure consistency across the prison estate and to set up a range of workstreams looking at various topics. Whilst the network cannot mandate Boards to deliver on the recommendations from the workstreams, it does aim to set out important principles in the delivery of healthcare to prisoners.

Examples of some of this work are:

Expert Advisory Group for Medicines – this group is currently chaired by the Lead GP for Prison Healthcare in NHSGG&C and has developed a number of good practice guidelines around prescribing, specifically for pain relief.
Other reports have been completed on Mental Health, Throughcare, and Substance Misuse.

There is also a Health Board Leads and a Healthcare Managers group who meet regularly to discuss a range of topics.

8. Recommendation

The Board is asked to note this report.

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Date 7 February 2017

Appendix 1

Review Processes in Place within Prison Health Care (GG&C)

Prisons are a microcosm of society therefore suicides also occur amongst our patient group whilst they are in prison. Generally the contributory factors are similar to those found within the community.

Scottish Government is committed to reducing the incidence of suicide and of self harm and targets were set in 2002 in the Choose Life strategy and action plan to reduce rates of suicide by 20% by 2013. The suicide rate in Scotland was reduced by 18% in the period 200 – 02 to 2010 -12.

In 2014 696 people died by suicide in Scotland, in the same year only 8 people died by suicide in Prison, this reduced to 7 in the year April 2015 – March 2016. 71% of suicides in the community were men, similarly 80% of suicides in prison were also men. The average age range of men in community and prison taking their own lives has risen and is now 45 – 54. The main prisoner population within GG&C is male with an average daily population of 2240 with a very small number of women within that group (58 currently located within HMP Greenock)

When a suicide takes place we need to understand what happened and learn from any lessons identified. Lessons learned are important to improve services and help staff recognise where risk exists.

All deaths in prison custody are subject to a Fatal Accident Inquiry (FAI) under the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976.

Prior to the transfer of responsibility for Health Care from Scottish Prison Service to NHS on 1st November 2011 the SIDCAAR (Self Inflicted Death In Custody: Audit, Analysis & Review) was introduced to assist the Scottish Prison Service (SPS) as an organisation to adopt a standardised approach to review of suicide.

It is vital to remember at this point that this process applied to a 'one organisation approach' who had a single governance structure and considered how an individual was being managed in prison. The process also considered how the suicide impacted on staff involved in the incident, the person's family, management processes and practise and the Establishment as a whole. The principles of this are based in critical appraisal and required the willingness to engage in open and honest dialogue. Where an apparent suicide occurs, 2 representatives of National Suicide Risk

Management Group (Health & Care Directorate Mental Health & Suicide Risk Management Coordinator plus one other) conducted a file review of an individual's Health Care Information and wider prison information which informed the Review process. This review is organised locally by the Establishment Act 2 Care Coordinator (SPS Suicide Risk Management policy & Process) and is chaired the Governor or Deputy Governor of the Establishment. ACT 2 Care is currently the process employed by all staff working within Scottish Prisons to keep people safe and manage the risk they may present. A SIDCAAR report is completed and submitted to the National Review Group (SPS National Suicide Risk Management Group) with an Action Plan based on any relevant learning for the establishment going forward. This report is not confidential and can be entered into evidence as part of the FAI process.

Following transfer of responsibility for Health Care to NHS Boards and the relevant change in legislation associated with Prison Rules in 2011 there was an identified need to review all processes associated with Suicide Prevention within Prisons. This has resulted in the development of 'The Prevention of Suicide in Prisons Strategy (PSiPS)' which will 'go live' on 5th December 2016. The 'Talk To Me' process will replace ACT 2 Care, however it retains the principles of partnership working to prevent the incidence of suicide in prison. There is a change in emphasis from the management of risk to that of prevention. This Strategy and training has taken cognisance that this is no longer a 'One Organisation' approach and has engaged with Health Boards and Scottish Government to develop training packages to support suicide prevention within Scottish Prisons in line with those in place within communities in Scotland. A result of this has been the development of a DIPLAR(Death in Prison Learning, Audit and Review).

The DIPLAR adopts a similar approach to the SIDCAAR relating to both Purpose and Scope and the Underlying principles. However, the main differences identified in this review are:-

- This process allows for the review not only of people who take their own lives but also considers people who die in custody of natural causes (these remain subject to FAI)
- This is no longer a 'One organisation' approach – the main participants in this process (NHS & SPS) have very distinct and separate governance structures.
- This process is now 'Co Chaired' by NHS & SPS
- Not all NHS staff who may be in contact with an individual in the run up to suicide or death by natural causes are direct employees of Prison Health Care

Services – whilst the DIPLAR approach suggests this should be the only review of the significant event, it may be appropriate to carry out a Significant Clinical Incident Review separately to consider the input of other NHS staff who would not normally attend the proposed review.

- The process has 3 distinct areas which are Operational response and offender management section which is entirely the responsibility of the SPS, an NHS Suicide Learning and Review report, and a joint NHS/SPS learning plan.

Appendix 2

STANDARD 4 – HEALTH AND WELLBEING

The prison takes all reasonable steps to ensure the health and wellbeing of all prisoners.

Commentary

All prisoners receive care and treatment which takes account of all relevant NHS standards, guidelines and evidence-based treatments. Healthcare professionals play an effective role in preventing harm associated with prison life and in promoting the health and wellbeing of all prisoners.

Inspection findings

Overall rating: Satisfactory performance

There was an overarching culture of professionalism within the healthcare team who demonstrated a strong sense of commitment to their patients. Effective leadership and governance within the team was evident. This was underpinned by clear links and support from the wider organisation of NHS Greater Glasgow and Clyde.

An Extensive range of condition specific clinics and specialist services were being provided within the prison. However, waiting times for services were variable. Access to dental services did not meet the Scottish Government's recommended 10 week access to services for routine appointments, but did meet the 12 week waiting time set by NHS Greater Glasgow and Clyde.

Health promotion and prevention activities were a priority and significant investment and resources had been provided to promote and improve the health and wellbeing of prisoners.

The process for patients ordering and receiving medication was paper-based which resulted in there being a lack of auditable trail and prisoners frequently raised complaints that they had not received their medication on time. This would be largely resolved if an electronic prescribing system was introduced.

The age and layout of the building meant that there was limited space to see patients and deliver treatment. Much of the accommodation within the health centre was not fit-for-purpose, especially for prisoners with disabilities.

We saw examples where access to healthcare interventions were compromised. A specific example of this was operational staff not adequately securing prisoner attendance at or access to health appointments. This was contributing to an increase in waiting times for some clinics. It was the opinion of the inspection team that this was a cultural issue and that a review of this required to be undertaken, as a matter of urgency, recognising the impact of these attitudes and the requirement for prisoners to access healthcare services consistently and appropriate to their needs.

Quality indicators

4.1 There is an appropriate level of healthcare staffing in a range of specialisms relevant to the health care need of the prisoner population.

Rating: Good Performance

Primary care nursing staff were based within the Halls during the week and the service also provided a primary care nurse at weekends and nights.

The mental health team comprised three registered nurses which was relatively small given the population of HMP Barlinnie, however, the service worked well with no waiting lists. This was due to the effective and competent management of the team who were not expected to perform task outwith their remit of providing expertise in mental health.

There was an on-site pharmacy and there was additional support from a professional nurse advisor and a pharmacy advisor supplementing the healthcare team.

The addiction team had a good skill mix of staff and had close links with the mental health team and worked in collaboration to manage patients who were identified as having addictions as well as well as mental health issues. This constitutes **practice worthy of sharing.**

NHS Greater Glasgow and Clyde had recently secured funding for two consultant clinical psychologists, one permanent and one fixed term, to develop and deliver a programme of psychological interventions across the three prisons within the NHS board area.

Although there was access to a dentist and dental nurse, there was no provision of a dental hygienist. A Dental hygienist pilot project was currently underway in another prison within the NHS board area. Healthcare managers hoped this service, once reviewed, would be extended to HMP Barlinnie.

Psychiatry and Blood Bourne Virus (BBV) consultants held clinics within the prison and worked closely with the healthcare team, however, these clinics often ran inefficiently due to the operational issues highlighted in the introduction to this section.

4.2 Prisoners have direct confidential access to a healthcare professional.

Rating: Generally acceptable performance

Self-referral forms and envelopes were readily available with locked post boxes in Halls for patients to put them in. It was noted that some forms were placed in the box without an envelope by SPS staff therefore could have been read by these staff. The SRU did not have a locked post box and we witnessed referral forms being handed to nursing staff by prison officers without envelopes.

In some Halls old forms were still being issued by officers. There was a need to remind officers of the need to use the current forms.

The referral forms had pictures of services on the form for ease of use by the prisoners and to enable them to easily identify the service they required. This constitutes **practice worthy**

of sharing. We saw instanced of vulnerable prisoners being assisted and supported to fill out forms by officers in a sensitive and supportive way.

There were significant levels of"did not attend" appointments, with prisoners not being brought to appointments by officers. This had contributed to an increase in waiting times for certain clinics. The healthcare manager had raised the matter, to no avail, with SPS. NHS Greater Glasgow and Clyde had also introduced on occasion additional clinics at weekends in an attempt to reduce waiting lists. Despite the healthcare manager's efforts to highlight this issue, "did not attend" rates continued to be significant. **This was a concern**.

4.3 Appropriate confidentiality of healthcare consultations and records is maintained in the prison.

Rating: Satisfactory performance

Confidentiality was maintained in both clinics and consultations. The prisoner's electronic health record (Vision) was updated at the time of consultation. Care entries recorded on Vision had a clear chronology of events. The psychiatrists also recorded their consultations onto Vision which enabled healthcare staff to easily review and note any changes to medication or care planning. **This constitutes practice worthy of sharing.**

Appointment slips, results and any written information from healthcare staff were issued in sealed envelopes to the patient marked confidential.

Where information needed to shared with prison staff such as medical markers or alerts, this was via the PR2 system. The medical markers contained sufficient information for the management of risk but did not include unrelated information.

The treatment/ consulting rooms within the Halls had large whiteboards which showed some patients names, number, location and planned treatment. This information was visible to anyone using the room and as such did not maintain confidentiality.

4.4 Healthcare provided in the prison meets accepted professional standards.

Rating: Good performance

Robust governance structures were in place with clear links to and support for the healthcare team from NHS Greater Glasgow and Clyde. This structure included support and management from a clinical service manager, and access to the professional nurse advisor and pharmacy advisor.

Strong leadership was evident, with the healthcare manager being supported by three clinical managers to deliver services. The clinical nursing team had regular access to clinical supervision and line management supervision. This constitutes **practice worthy of sharing.**

There were clear systems in place for checking Nursing and Midwifery Council registrations and supporting revalidation for nursing staff. Staff stated they felt supported with revalidation and that reflective discussion was embedded into practice.

The induction process for new staff was comprehensive and detailed. This was confirmed by staff who stated that they valued the induction process.

All mandatory training was up-to-date for staff, and access to training was viewed as being goof by healthcare staff. Training needs were identified through the NHS knowledge and skills framework with staff having an up-to-date plan and scheduled review date.

During the inspection, we noted that one member of the primary care team was studying to complete a nurse prescriber course. The strategic view was that further nursing staff would complete this and HMP Barlinnie would eventually progress to having advanced nurse practitioners. This constitutes **practice worthy of sharing**.

The administration of controlled drugs and the stock checking of controlled drugs was in line with the Nursing and Midwifery Council guidelines and NHS Greater Glasgow and Clyde's policy.

Overall, there was a culture of professionalism within the healthcare team who demonstrated a strong sense of commitment to their patients.

4.5 Where the healthcare professional identifies a need, prisoners are able to access specialist healthcare services either inside the prison or in the community.

Rating: Satisfactory performance

In the self-assessment information submitted by the healthcare team, waiting list information was provided for all clinics and specialist services within the prison. Waiting times were acceptable and met NHS Greater Glasgow and Clyde's target for access to clinical services. The longest waits for appointments were routine dental appointments. As noted previously a dental hygienist would help reduce the number of patients waiting for appointments. Currently the dentist would see all routine patients.

At the point of admission, if a prisoner had on-going investigations or treatment in secondary services they would be supported for this to continue.

There were no waiting lists for assessment and support from the mental health team and there was a clear triage process to screen referrals and urgency of need.

A range of individual interventions were offered with all mental health nurses trained in Structured Psychosocial Interventions in Teams known as SPIRIT. Two primary care nursing staff also has learning disability nurse training.

Where admission to a psychiatric unit was indicated, arrangements were made to transfer prisoners required assessment or in-patient treatment. This could be to a low secure environment (intensive psychiatric care unit), medium or high secure environment, determined by the level of illness and offence. There could be delays in accessing medium secure beds due to limited national provision.

As noted in 4.1, the addiction team and the mental health team worked closely together.

4.6 Prisoners indentified as having been victims of physical, mental or sexual abuse are supported and offered appropriate treatment. The relevant agencies are notified.

Rating: Satisfactory performance

Prisoners who suffered injury within the prison were seen immediately by the healthcare team and if the injury was serious would attend the local accident and emergency department.

No written procedures were in place for the notification of abuse occurring within the prison. This information would be given to staff verbally at their induction. Prisoners were able to access a weekly sexual health clinic. Open Secret, a Third Sector organisation, provided support to prisoners who were victims of abuse. However, communication between this service and healthcare staff was poor. Prisoners could make a confidential referral to the mental health team. Within the prison, Lifelink[2]counselling services was available to prisoners. Lifelink also facilitated transfer to local counsellors if indicated for patients on liberation. This constitutes **practice worthy of sharing.**

4.7 Care is taken during the period immediately following the admission of a prisoner to ensure their health and wellbeing.

Rating: Generally acceptable performance

For admissions, there was one practitioner nurse and one healthcare assistant. However, nursing staff breaks were staggered to allow two practitioner nurses and one healthcare assistant to be deployed to admissions when it was busy, and, where possible, clinical manager s would deploy a further two nurses to the admission desk near the end of the shift when all their other duties were completed, should they be required. Nursing staff told us that they felt pressured to quickly complete the health admission assessment by prison officers to ensure prisoners were processed without delay. **This was a concern**.

A registered mental health nurse did not routinely carry out the admission assessment. Although all registered general nurses had undergone mandatory ACT2Care training the number of nurses who had completed further mental health risk assessment training such as SPIRIT and mental health first aid varied. The NHS board should ensure that all registered general nurses who admit prisoners are skilled and competent enough to identify and manage the risk of self-harm. Further training in mental risk assessment should be make available to all registered nurses.

Prisoners were screened for alcohol and drugs and had the opportunity to discuss issues in relation to problematic drug and alcohol use.

New admissions were seen by the GP the day after admission. Transfers were seen within 72 hours. Consent to share patient details was obtained on admission and patients were given information on how to access services and information on the ordering of medication

[2] Lifelink is a charity and social enterprise offering one-to-one counselling, stress management and group work across Scotland.

Staff would arrange and interpreter for the patient's GP appointment if required and could access language line for interpreter services during the admission process.

4.8 Care plans are implemented for prisoners whose physical or psychological health or capability leave them at risk of harm from other.

Rating: Satisfactory performance

Patients had outcome-focused care plans personalised to their individual needs. Primary care plans were based on activities of daily living and had weekly review timescales with the patient being reviewed daily if clinically indicated. This was recorded onto Vision.

Complex care plans were available for prisoners with mental health needs. When a prisoner was considered at risk of self-harm, the plan of care was jointly agreed through ACT2Care process. As noted in 4.3 the psychiatrist recorded interventions onto Vision ensuring clear communication and chronology of events.

Low level psychotherapeutic interventions were provided by the mental health team however, there was a recognised need to accurately record these interventions appropriately to reflect the interventions and measure progress of patients.

The cells available for prisoners who had disabilities were a concern. The cell doors were not wide enough to allow prisoners who were wheelchair users access. The size of the cells also meant that if a patient required specialistequipment such as hoists and slings this would not be able to be accommodated. **This was a concern**.

We were informed that if a prisoner had high care needs, SPS would endeavour to transfer them to HMP Low Moss which had specialist facilities to support the patients' health needs.

4.9 Healthcare staff offer a range of clinics relevant to the prisoner population.

Rating: Good Performance

There was an impressive and comprehensive range of clinics available to prisoners provided in the Halls and health centre. We observed that staff providing the nurse-led clinics were competent in their delivery of these clinics and worked within their scope of practice.

The Wellman Clinic was an area that constitutes**practice worthy of sharingwith** patients receiving a comprehensive assessment and being signposted for follow-up to other services, if clinically indicated. As previously discussed in 4.1, visiting consultants attended the prison to provide specialist care. As noted in 4.1 and 4.5, a dental hygienist service would be of value within the prison.

4.10 Preventive healthcare practices are implemented effectively in relation to transmissible diseases.

Rating: Satisfactory performance

Staff were aware of infection prevention and control procedures. A test for BBV was offered on admission. If a patient was exposed to Hepatitis C, follow-up tests and treatment were offered. A Hepatitis B vaccination was also offered if Hepatitis B Virus negative. Human Immunodeficiency Virus positive (HIV+) prisoners were given single cells.

Some injecting paraphernalia such as filters, swabs and spoons were available on request; however there was very limited uptake. Condoms were available. Cleaning equipment, such as bleach tablets for injecting equipment, was not easily accessible. Prisoners and staff that the uptake was low as this would be supplied by the SPS and prisoners were fearful of

reprisal, such as frequent cell searches. Harm reduction education was available if prisoners took part in the addiction programme.

4.11 Preventive healthcare practices are implemented effectively in relation to the maintenance of hygiene and infection control standards

Rating: Satisfactory performance

The physical infrastructure of many of the areas where healthcare was delivered was not fit-for-purpose. However healthcare staff were doing the best they could to achieve the quality indicators. There was a need for a more modern and clinically appropriate environment. Some clinics were held in the Halls in an unused cell which had an examination bed, desk, chair and sink. These rooms were small with limited access to the sink. The examination bed was beside the clinical waste bin and the sharps box was stored underneath desk.

We witnessed good hygiene and use of personal protective equipment. Cleaning schedules were in place and completed. Sharps bins were appropriately assembled and labelled, and bins were available for pharmaceutical waste. The health centre staff told us they frequently communicated with the infection prevention and control team at NHS Greater Glasgow and Clyde.

4.12 Preventive healthcare practices are implemented effectively in relation to the assessment, care and treatment of those at risk to self harm or suicide.

Rating: Satisfactory performance

On admission, ACT2Care documentation was completed for all prisoners.
Documentation for those placed on ACT2Care was completed in conjunction with healthcare staff. Multi-disciplinary care conferences were then convened with an agreed action plan implemented. A number of “safer cells” had been refurbished to provide specialist furnishing and a television.

The prison was visited by two psychiatrists twice per week and accepted referrals from the prison GPs, mental health and addiction nurses. As noted in 4.5, delays in accessing medium secure beds were experienced as a result of a shortage in national provision.

4.13 Preventive healthcare practices are implanted effectively in relation to the care and treatment of those exhibiting self-harming and addictive behaviours.

Rating: Generally acceptable performance

The addiction service staff demonstrated a good understanding of the requirements of their patients and were observed to carry out assessments and interviews in a professional and empathic manner.

Staff training plans and mandatory training were up-to-date and access to training was perceived by the addiction team to be good. The addiction team had received Naloxone training. Access to general dried blood spot testing training was viewed by staff to be beneficial if available. Addiction staff could access smoking cessation training.

There was uncertainty over methadone prescribing and opioid detoxification as complaints by prisoners had been made over lack of access to Opioid Replacement Therapy (ORT) and other medications when admitted to prison. During the inspection ORT initiation appeared to be available if a prisoner was high risk, such as HIV+, but did not appear to be as readily available as in the community to opiate dependent prisoners.

Records sent to the prison from community prescribers were highly variable in quality from minimal to excellent.

Investment had been provided for a full-time nurse who specialised in supporting prisoners with alcohol addiction. **This constitutes practice worthy of sharing.**

Joint working with the mental health team was evident with case management being shared with patients who had addiction and mental health needs. The addiction team had regular one-to-one supervision and line management supervision, however, there was no multi-disciplinary team meeting to discuss cases. **This was a concern.**

The addiction service across the three prisons in NHS Greater Glasgow and Clyde's area was undergoing a service review during the time of the inspection.

4.14 Health education activities for both prisoners and staff implemented throughout the prison.

Rating: Good performance

An impressive and wide range of health education and health improvement opportunities were available for both prisoners and staff. A health improvement lead was in post for the three prisons across NHS Greater Glasgow and Clyde. There was a clear understanding of the value of implementing health education practices and health improvement within the prison. There were strong examples of collaborative working with the NHS and SPS in the pursuit of improving health education activities.
An oral health assessment programme was to be rolled out across the prison to ensure that every prisoner had an oral health assessment and visits had received a "breast feeders welcome award" with prison officers receiving training by NHS staff.

There were health improvement events held twice a year for both staff and prisoners and the healthcare team had retained the health working lives gold award.

Self-assessment evidence submitted by the healthcare team showed that SPS staff and health staff had received joint training, including: personality disorder training, learning disability training and mental health awareness.

4.15 Healthcare professionals working in the prison are able to demonstrate an understanding of the particular ethical and procedural responsibilities that attach to practice in a prison and to evidence that they apply these in their work.

Rating: Satisfactory performance

Staff were able to explain the boundaries between professional and ethical issues.
Healthcare staff were aware of the demand of delivering healthcare within the prison setting and the requirement for security. Regular meetings were held with prison management to discuss any issues, review incidents and to improve practice.

4.16 Every prisoner on admission is given a health assessment, supplemented, where available, by the health record maintained by their community record.
Care plans are instituted and implemented timeously.

Rating: Satisfactory performance

As discussed in 4.7, patients were initially assessed by a primary care nurse. With new prisoners being then seen by a GP the day after admission. Prisoners transferred from other prisons were seen within a 72 hours period. Prison GPs had access to the assessment information on vision, and if the patient originated from within NHS Greater Glasgow and Clyde area, the GP could access clinical portal[3].

As noted in 4.8, care plans were initiated for prisoners with specific care needs and patients were offered referral to the Wellman Clinic where a range of health checks were carried out and could then be referred to appropriate clinic or specialist service.

4.17 Healthcare record are held for all prisoners. There are effective procedures to ensure that healthcare records accompany all prisoners who are transferred in or out of the prison.

Rating: Good performance

There was good administrative support within the health centre for the management of records. Paper records were appropriately filed and stored in a secure room. Old notes not in use were archived and destroyed in line with NHS Greater Glasgow and Clyde records management policy. Notes for transfer in or out of the prison were transported in secure bags and a track of their location was kept on a database.

The health records for patients were mainly stored electronically using Vision. Health staff could access NHS Greater Glasgow and Clyde records via clinical portal.
Referrals for treatment within NHS Greater Glasgow and Clyde were via the electronic system with out of area ones by letter. Patient GP notes were obtained where the patient was de-registered from their community GP and then sent back to practitioner services division when no longer required.

Clinical portal is a combination of computer systems and paper records that records information about patients and their care

4.18 Healthcare professionals exercise all the statutory duties placed on them to advise the governor or director of any situations in which conditions of detention and decisions about any prisoner could result in physical or psychological harm.

Rating: Satisfactory performance

Systems and processes were in place to ensure healthcare staff made appropriate notifications in cases where there could possibly by physical or psychological harm to prisoners. These include notification of when a prisoner was not fit to work or when they required access to treatment in the community. Staff were aware of this procedure and were comfortable that it did not conflict with their professional expectations.

Notifications about prisoner health concerns were made by healthcare staff to SPS in relation to restraint and confinement concerns. Staff were clear in their duty to pass on any intelligence that may compromise the health and well being of the prisoner or the safe running of the prison.

4.19 Healthcare professionals fully undertake their responsibilities as described in the law and professional guidance to assess, record and report any medical evidence of mistreatment and to offer prisoners treatment needed as a consequence.

Rating: Satisfactory performance

Healthcare staff had a clear understanding of their duty of care, escalating concerns through the intelligence reporting system. Regular communication between the healthcare and SPS management teams ensured concerns were discussed.

Prisoners who complained of mistreatment would be medically assessed and supported. Information affecting the welfare of prisoners would be passed on to the appropriate SPS manager who would then initiate an investigation and involve the Police if necessary. Prisoners would be offered counselling and appropriate protective measures of required. Incident reporting would also be recorded by health staff on DATIX.

4.20 Effective measures that ensure the timeous attendance of appropriate healthcare staff in the event of a medical emergency are in place and are practiced as necessary.

Rating:Satisfactory performance

In line with other SPS prisons, HMP Barlinnie had an emergency coding system: blue and red. In case of an emergency staff had access to two NHS defibrillators kept in the health centre. A third defibrillator belonging to SPS was kept in Letham Hall but as there was no guarantee that this would be working order, staff were advised to only take defibrillators from the health centre. Emergency bags were also kept in these areas. AS nursing staff were based in the Halls there was a fast response time to emergencies.

4.21 Appropriate steps are taken prior to release to assess a prisoner's needs for on-going care and to assist them in securing continuity of care from community health services.

Rating: Satisfactory performance

Health care administrative staff were notified of all liberations and ensured that a discharge summary was completed by the GP and nursing staff. This was then attached to the GP notes to ensure relevant information was readily available for the new registering GP.

The mental health team linked with the throughcare team prior to the planned release of a prisoner. Staff described good links with community mental health teams. The majority of these teams were within NHS Greater Glasgow and Clyde. Where prisoners were due to be released to another NHS board area, the appropriate team was contacted and medication on release along with a copy of the discharge prescription.

Throughcare available for more chaotic addiction prisoners was limited to linking into community addiction services. For some opioid dependent prisoners not commenced on ORT there was limited motivation to link with addiction services on liberation, this needs to be addressed as a matter of urgency.