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To meet the changing demands of the health care needs of the Scottish prison population, and to ensure that the SPS provides a modern, cost effective, proactive and appropriate service now and in the future, a major Nursing Review was commenced in August 2002. The Review has been the most significant work of its kind in the last 10 years.

The Review took a broad overview of the changes in health care needs, the role of the nursing profession generally, which has undergone significant change in recent times, and the current means of service delivery. In addition, the Review took account of the advances in modern health care delivery, changes in nursing philosophy and broader societal changes which have impacted on attitudes to health in the wider community. The need to maintain and improve standards of nursing care was fundamental.

The SPS is a unique and challenging environment within which nurses work. The NMC Code of Conduct in relation to practice and behaviour is particularly important.

By commissioning this Nursing Review, the SPS has demonstrated its commitment to continue to provide a professional nursing service which is research and evidenced-based and within a framework of Clinical Governance. We in the Scottish Executive and the broader nursing community fully endorse this aim.

I believe that the Review and the subsequent recommendations detailed in this comprehensive report are an excellent basis for the development of the health care service in meeting its future demands. Partnership with the NHS and others will be key to the delivery of high quality healthcare within prisons.

In my role as Chief Nursing Officer for Scotland, I would like to commend this Report to you and to wish the SPS Health Care and Nursing Service every success in its implementation.

ANNE JARVIE CBE
Chief Nursing Officer for Scotland
## 1.1 Summary of Recommendations

The Project Board’s key recommendations from the Nursing Services Review are as follows:

### Summary of recommendations:

<table>
<thead>
<tr>
<th>No</th>
<th>Recommendation</th>
<th>Reference point</th>
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<tr>
<td>1</td>
<td>The SPS primary care nursing service should continue to be provided on an <strong>in-house basis</strong>.</td>
<td><em>Service Provider Option Appraisal</em>. Page 11. Section 4 Conclusions. 4.3 Recommendations 4.3.3</td>
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<td>2</td>
<td>The SPS should pursue <strong>greater integration with NHS Scotland</strong>, incorporated into a formal partnership agreement.</td>
<td><em>Service Provider Option Appraisal</em>. Page 11. Section 4 Conclusions. 4.3 Recommendations 4.3.5</td>
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<td>3</td>
<td>Primary care nursing staff should be <strong>released from as many non-nursing duties as possible</strong>, thus enabling them to better meet prisoners, healthcare needs.</td>
<td><em>A service framework and development plan for primary care Nursing 2003 – 2010</em>. Page 13. The SPS Health Care Service is Changing 4.2.9 - 4.2.11. Page 15. 4.4 Developing the Nurse Staffing structure 4.4.4. Assessment of current services. Page 4 Section 4 Self-care and informal care.</td>
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<td>4</td>
<td>A model of <strong>self-care by prisoners</strong> should be implemented across the service.</td>
<td><em>Assessment of current services</em>. Page 4 Section 4 Self-care and informal care.</td>
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<td>5</td>
<td>The <strong>self-referral triage</strong> model should be applied across all Scottish prisons.</td>
<td><em>Assessment of current services</em>. Page 6. Primary Care 5.1.2 – 5.1.5</td>
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<td>6</td>
<td>The SPS should continue to <strong>monitor the healthcare needs of prisoners</strong> to ensure that the primary care nursing service maintains the appropriate focus.</td>
<td><em>A service framework and development plan for primary care Nursing 2003 – 2010</em>. Page 5 Healthcare needs assessment 2.3.10.</td>
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<td>7</td>
<td>In-patient beds should be provided in one <strong>unit</strong>, designed specifically for that purpose and located in a central area – the unit should contain fewer beds than are currently provided.</td>
<td><em>A service framework and development plan for primary care Nursing 2003 – 2010</em>. Page 6/7 In-Patient Facilities.</td>
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<td>8</td>
<td>There should be <strong>no night-duty for nursing services</strong>, other than at the in-patient unit.</td>
<td><em>A service framework and development plan for primary care Nursing 2003 – 2010</em>. Page 9 The scope of the service 3.2.1 &amp; 3.3.5</td>
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<td>9</td>
<td>A new <strong>Nursing Service Model</strong> should be implemented adopting the concept of specialist teams for primary care, mental health and addictions.</td>
<td><em>A service framework and development plan for primary care Nursing 2003 – 2010</em>. Page 10 3.3 The Primary Care Nursing Service Model. 3.3.1 – 3.3.6. Page 14 Changing roles within nursing.</td>
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<td>10</td>
<td>The <strong>nursing structure should be reviewed and revised to reflect the new service model</strong>.</td>
<td><em>A service framework and development plan for primary care Nursing 2003 – 2010</em>. Page 14 Changing roles within nursing. Page 15 Developing the nurse staffing structure.</td>
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<tr>
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<td>11</td>
<td>An improved framework for Clinical Governance should be developed and implemented.</td>
<td>A service framework and development plan for primary care Nursing 2003 – 2010. Page 18 Section 5 Professional Development / Clinical Governance Framework</td>
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<td>12</td>
<td>The draft Training and Learning Strategy should be agreed and implemented.</td>
<td>A service framework and development plan for primary care Nursing 2003 – 2010. Page 20 Section 5.4 Training Strategy</td>
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<td>14</td>
<td>A robust Performance Management Framework should be developed and implemented to monitor service provision and the extent to which it meets prisoners’ healthcare needs.</td>
<td>A service framework and development plan for primary care Nursing 2003 – 2010. Page 24 Section 8 Performance Management.</td>
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<td>15</td>
<td>The impact of the proposed changes to the primary care nursing services should be reviewed on a regular basis, to ensure that the anticipated benefits have been realised.</td>
<td>A service framework and development plan for primary care Nursing 2003 – 2010. Page 26 Section 9 Implementation</td>
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<td>16</td>
<td>The cultural changes proposed in recommendations 3-5 and the service changes proposed in recommendations 7 and 8 should generate both increases in outputs/efficiency and reductions in costs. Taken together with meeting identified healthcare needs of prisoners and the proposed changes to the nursing structure and healthcare model of the overall package should be cost neutral.</td>
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<td>17</td>
<td>The implementation of the Nursing Review and this Service Framework should be advanced by the secondment of a dedicated part time Project Co-ordinator who will drive the implementation of the Action Plans and ensure the benefits are fully realised.</td>
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1.2 Introduction

1.2.1 The Scottish Prison Service (SPS) Nursing Services Review Project Board was set up to identify the current and future requirements for nursing staff, based on the healthcare needs of the prison population, and to examine how the nursing service might best be provided, taking account of all relevant clinical, personnel and managerial issues.

1.2.2 The purpose of the Nursing Services Review was as follows:

“To provide strategic and operationally achievable options together with clear recommendations as to how SPS Nursing Services might be organised to best meet the nursing needs of the prisoner population, while ensuring value for money.”

1.2.3 The focus of the review is thus illustrated in the following diagram:

SPS Nursing Services Review

Role of Secta Consultancy

1.2.4 The SPS engaged Secta Consulting Ltd to provide support with the Nursing Services Review, in order to:

- carry out a validation exercise as to how primary care nursing services are currently provided;
- prepare an Options Appraisal for how primary care nursing services might best be provided in a cost-effective manner in the immediate future and the longer term; and
- preparation of a stage report for consideration by the Project Board.
1.2 Introduction

Terms of Reference

1.2.5 The specific terms of reference for the Nursing Services Review Project Board, as defined in the Scope of Services, were as follows:

- identify current and probable future appropriate nursing needs of the prisoner population in relation to promoting prisoners’ health, meeting prisoners’ physical and mental health care needs, to include the issuing of medication to prisoners, bearing in mind existing provision;

- identify ways in which prisoners’ nursing needs might best be met, examining the current model of service delivery within SPS and alternative methods. The analysis shall consider the SPS stated vision of providing the appropriate standards of service delivery comparable to those available in the community, whilst continuing to demonstrate value for money for the taxpayer;

- make recommendations with costs, benefits and potential operational or strategic risks of each of the options identified above;

- recommend how Clinical Supervision might best be delivered within SPS;

- propose measurement methodology and standards against which the effectiveness of nursing provision can be evaluated, both for existing arrangements and for a re-designed service;

- examine staffing and human resource issues, including how the Continuing Professional Development/PREP needs of nursing staff might best be assured;

- consider ways of developing and fostering multi-disciplinary and multi-agency partnerships, while reviewing the nature of SPS links with the NHS; and

- examine the role and competencies of Health Centre Managers, Clinical Managers-in-Charge and Clinical Managers, while considering how best the management of health care services might best be delivered within SPS.

Structure of the Report

1.2.6 The outputs from the Nursing Services Review are presented in four separate but inter-linked sections:

- Healthcare Needs Assessment
- Service Provider Option Appraisal
- Assessment of Current Services
- Service Framework & Development Plan

1.2.7 This Executive Summary document presents the key findings from the review, along with recommendations and a draft action plan.
1.3 Healthcare Needs Assessment

1.3.1 A key feature of the Primary Care Nursing Service Framework is that it is needs led, i.e. the services provided are directly and proportionately focussed on the most prevalent and significant health problems.

1.3.2 The main findings of the healthcare needs assessment are as follows:

- Minor illnesses account for the bulk of consultations with nursing and medical staff in the prison population.

- In general the physical health of prisoners is worse than that of the people of equivalent age in the general population.

- Around a quarter of adult prisoners engage in activities likely to put them at risk of infection with HIV, Hepatitis B or Hepatitis C.

- There are a number of health problems and needs that are specific to women in prison. These include maternity care, gynaecology and care of babies in prison, as well as a range of health education services such as family planning.

- Estimates indicate that the rate of psychological disturbance and personality disorder is twice as high as in the general population.

- Prisoners tend to suffer from more than one mental health problem. Those with more serious neurotic disorders are more likely to suffer from functional psychosis and personality disorders. Alcohol and drug misuse also tends to be associated with personality disorders.

- Prisoners tend to have below average levels of intellectual functioning.

- Suicide rates are generally higher in prisons than in the community.

- Many young offenders have temperamental, emotional and behavioural problems that manifest as self-harm and suicidal behaviour.

1.3.3 The healthcare needs assessment exercise has formed the basis from which the new service model for primary care nursing has been developed. The SPS will continue to monitor the healthcare needs of prisoners to ensure that the primary care nursing service maintains the appropriate focus.
1.4 Assessment of Current Services

1.4.1 This report considers the extent to which the existing SPS healthcare services meet the identified needs of prisoners and how effectively the nursing resource is utilised and deployed. It forms the basis from which the Primary Care Nursing Service Framework has been developed.

Self Care

- If minor illnesses continue to account for the bulk of health care consultations within prisons, how is the Service going to meet the prisoner’s real health needs? The model of care needs to change significantly.
- Ways to increase the availability of health promotion and self-care information must be found.
- What models of care can be introduced to reduce the nursing time on semi-informal care? Enhanced primary care skill mix requires to be introduced e.g. pharmacy services and Health Care Assistants.
- Developing a self-care model across the Service would free up a significant scale of nursing resource.

Primary Care

- It is recommended that the self-referral triage model should be applied across all Scottish prisons.
- The self-referral triage system must be confidential and meet the needs of prisoners with learning difficulties.

Secondary Care

- Health Care staff and Governors should actively develop links with the secondary care providers.
- The future SPS Bed Model should be reviewed and changed to ensure effective and safe care.
- In order to enhance physical access to secondary services new Escort workforce plans should be agreed and implemented.

Health Screening

- The health screening process is often rushed and incomplete due to time constraints and the volume of prisoners.
- The volume of prisoners requiring health screening will continue to rise.
- The screening process requires to be reviewed and re-designed by all those involved.

Mental Health

- Not all prisons have dedicated mental health teams to manage the specialist mental health care needs of prisoners.
- The education and supervision of mental health nurses varies across the Scottish Prison Service.
- Evidence based Mental Health guidelines are not being consistently applied across the SPS and there is limited evidence of a multi-professional approach to Mental Health care.
- Prisoners have limited access to secondary care services, particularly, in-patient services and there is limited evidence of jointly working with the NHS.
- The need to improve mental health services in prisons is one of the top priorities to emerge from this Needs Assessment and was a key consideration in developing a specification for the SPS primary care nursing service (Stage 3 of the Review).
1.5 Service Provider Option Appraisal

1.5.1 Within Stage 3 of the Review, Secta was commissioned to carry out a high level assessment of the potential providers of primary care nursing services within the SPS.

1.5.2 Three options for the provision of primary care nursing service in the SPS were identified in Stage 2 of the Review, they are as follows:

- SPS continuing to engage nursing staff on a contract of employment basis;
- NHS Scotland assuming responsibility for provision of primary care nursing services in Scottish prisons; and
- establishing a service contract between SPS and private providers of primary care nursing services.

1.5.3 The main components of the methodology for this exercise were as follows:

- Desktop review of documents relating to the recent transfer of primary care nursing services from the Prison Service in England to the NHS in England and Wales.
- Research into the number and type of private sector providers of primary care nursing services in Scotland.
- Research into the number and type of private sector providers of specialist services (i.e. Mental Health services and Addiction specialist services).
- Structured telephone interviews with four large private sector nursing agencies to establish whether they would be interested and able to provide permanent primary care nursing staff on a service contract basis and/or provide Mental Health services and Addiction specialists on a permanent basis to the SPS.
- Structured telephone interviews with two private sector providers of Mental Health Services based in Scotland to establish whether they would be interested and able to provide specialist services i.e. Mental Health and Addictions.
- In addition, the NHS Nurse representative on the SPS Nursing Services Review Group met with Directors of Nursing Services (DNS) within NHS Scotland, and the SPS Nursing Services Manager met with the Chief Nursing Officer (CNO)/ Director of Nursing at the Scottish Executive Health Department to discuss the options for future service delivery.

Summary of Key Findings

1.5.4 The recent decision to postpone the transfer of responsibility for prison health to the NHS in England as a result of the huge agenda facing PCT’s has meant that it is too early to fully evaluate the experience in England.

1.5.5 The partnership between the Prison Service and the NHS to modernise prison health services has delivered many tangible benefits for prison health in England (refer to figure 2-3).

1.5.6 Given the proposed reforms and changes outlined in ‘Partnership for Care’, the new Scottish Health White Paper, and the feedback from DNS colleagues in NHS Scotland, there is no compelling reason to consider transferring the full responsibility for prison nursing from the Scottish Prison Service to NHS Scotland, at the present time.
1.5 Service Provider Option Appraisal

1.5.7 Although 3 of the 6 private sector providers contacted expressed an interest in providing primary care and specialist nursing services to the SPS, none of the providers were able to demonstrate any evidence of delivering either primary care or specialist nursing services on a permanent basis to any organisations within Scotland. There is therefore no precedent which the SPS could use to assess whether or not contracting out the primary care service to the private sector would deliver clinical/operational benefits and or better value for money.

Recommendation

1.5.8 Given that the primary care nursing service and specialist nursing services are currently provided in-house, any change in service provision should be based on the expectation of significant benefits including:

- Improved availability of appropriately skilled nursing staff.
- Improved clinical quality of service.
- Reduced costs and/or greater value for money.

1.5.9 In addition the long-term security of the provider model must also be assessed, [i.e. the extent to which continuous service delivery to the required standards can be guaranteed].

1.5.10 From the research undertaken, there is no evidence that a change in the responsibility and arrangements for the provision of primary care nursing services within the NHS would yield greater benefits than continuing to provide the service in-house.

1.5.11 Since private sector agencies in Scotland have no experience of supplying permanent staff to health care providers, and there is no evidence that the transfer of services to NHS Scotland is a viable option, it is recommended that the SPS retain the provision of primary care nursing services in-house.

1.5.12 It is also recommended that SPS pursues the development of a formal partnership arrangement with NHS Scotland, as this is likely to deliver significant benefits for both patients and staff.
1.6 Service Framework & Development Plan

1.6.1 The Project Board has drawn up a Service Framework & Development Plan that sets out the long-term strategic direction for the SPS primary care nursing service. The Service Framework provides a policy context within which decisions concerning the shape of the service at a local level can be made. It also sets out the Scottish Prison Service's proposed strategy for addressing the key professional nursing issues.

1.6.2 The Service Framework has been written as a stand-alone section that forms the principal output from the Nursing Services Review. In addition to providing core background and contextual information, it covers the following main topics:

- New Primary Care Nursing service model
- Future shape of in-patient facilities
- Developing the nursing workforce
- Clinical Governance
- Continuing Professional Development
- Nursing Leadership
- Integration with NHS Scotland
- Performance Management

Nursing Service Model

1.6.3 The Service Framework is based on a new nursing service model for primary care, which relates the provision of nursing services to the healthcare needs of the prisoners and facilities the flexibility required to ensure that the necessary nursing skills are effectively applied.

1.6.4 The model is based on the concept of specialist teams, working within prison Health Centres and across the Estate as a whole. The model is designed to:

- Provide a Service focussed on the most significant healthcare needs.
- Ensure equity of access to services across SPS.
- Deliver improved clinical outcomes.
- Utilise nurses’ specialist skills more effectively.
- Provide opportunities for shared learning and peer review.
- Enhance Recruitment and Retention.
- Facilitate integration with the relevant NHS Scotland services.
1.6 Service Framework & Development Plan

The model is illustrated in the diagram below.

1.6.6 The teams identified in this model will deliver a range of services, summarised below:

### Primary Care Nursing Services in SPS

- Health assessment on admission to prison or transfer from another prison
- Health promotion
- Health screening and follow-on treatments, such as immunisations
- Co-ordination of the triage system
- Treatment of minor illnesses and injuries
- Drug prescription and administration
- Chronic disease management
- Emergency response
- Dedicated Mental Health Nursing services – primarily offering assessment and 8-10 week programmes of care
- Dedicated Addictions Nursing services – co-ordinating the clinical aspects of the Addictions service
- Liaison with NHS clinical staff to support the delivery of secondary care services in the Health Centres

1.6.7 A high-level assessment of the potential financial impact of moving to a new service model indicates that the implementation of specialist roles and teams can be achieved within the current budget for primary care nursing.
1.7 Implementation

1.7.1 The SPS has set out a significant development agenda, which is designed to meet the challenges ahead. This section sets out the processes by which the new Service Model and Framework will be implemented across SPS. It includes key tasks and timescales.

1.7.2 It is anticipated that the Service Framework will be implemented over a two-year period commencing September 2003, with the main changes and benefits being realised in the financial year 2004/05. The action highlighted in the text serves as signposts for planning, and as milestones by which to monitor progress.

Draft Action Plan

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<thead>
<tr>
<th>Issue</th>
<th>Action</th>
<th>Date</th>
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<tr>
<td><strong>Service Model</strong></td>
<td>• Review nursing structure</td>
<td>November 2003</td>
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<td></td>
<td>• Confirm proposals for in-patient facilities</td>
<td>November 2003</td>
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<td></td>
<td>• Review and propose new nursing structure</td>
<td>December 2003</td>
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<td></td>
<td>• Agree 2004/05 complements</td>
<td>March 2004</td>
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<td></td>
<td>• Develop plan for achieving required skill-mix</td>
<td>April 2004</td>
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<td><strong>Pay Modernisation</strong></td>
<td>• Agree one year settlement</td>
<td>October 2003</td>
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<td></td>
<td>• Agree principles for future modernisation</td>
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<tr>
<td><strong>Improving Working Lives</strong></td>
<td>• Implement review recommendations e.g. cease nursing nightshifts</td>
<td>April 2004</td>
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<tr>
<td><strong>Clinical Governance</strong></td>
<td>• Complete risk analysis</td>
<td>March 2004</td>
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<td></td>
<td>• Develop new framework</td>
<td>March 2004</td>
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<td></td>
<td>• Agree resource to support new framework</td>
<td>April 2004</td>
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<td><strong>Professional Development</strong></td>
<td>• Produce draft Training and Learning Strategy</td>
<td>September 2003</td>
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<td>• Implement Training and Learning Strategy</td>
<td>July 2004</td>
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<tr>
<td><strong>Nursing Leadership</strong></td>
<td>• Develop outline programme</td>
<td>December 2003</td>
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<td></td>
<td>• Commence programme implementation</td>
<td>April 2004</td>
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<tr>
<td><strong>Partnership &amp; Integration</strong></td>
<td>• Put in place mechanisms for agreeing NHS and geographical network arrangements</td>
<td>December 2003</td>
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1.7.3 Fundamental to the success of the implementation of the Nursing Review and this Service Framework, is the secondment of a dedicated part-time Project Co-ordinator who will drive the implementation of the Action Plans and ensure the benefits are fully realised.
2.1 Introduction

2.1.1 This paper details the key health needs of Scottish prisoners, and gives details of the prevalence of these needs in relation to the general population.

2.1.2 The aims of this healthcare needs assessment exercise were to describe a comprehensive picture of current prisoners’ health and nursing needs, in order to identify priorities for further detailed work, to explore identified priorities, to inform the planning of future service provision and to encourage an evidence based approach and provide effective needs-led nursing care.

2.1.3 Health care needs assessment is not an end in itself. It is simply a means of using information to help plan the future. As patterns of health care needs change over time, there requires to be a continual process of action to address the needs and evaluation as to how well the needs have been met.

Needs Assessment Model

2.1.4 Figure 1-1 below details the SPS Nursing Review needs assessment model.
2.1 Introduction

2.1.5 The model is aimed at ensuring a comprehensive strategic and operational approach to the needs assessment. The methodology included:

- A desk-top review of SPS policy documents, annual reports, clinical guidelines and standards;
- Interviews with staff based at SPS headquarters;
- A literature search;
- A review of ISD information;
- A site visit to all prisons within Scotland;
- Interviews with health care staff in all prisons and also a number of other prison staff including prison governors and officers;
- A review of prisoners’ complaints regarding the health care service within the prisons;
- Desktop review of health centre data and patients records.

Needs Assessment Subcategories

2.1.6 There is a number of ways in which the health care needs of the prison population could be sub-categorised. For the purposes of this report subcategories based on the type of health problem, and where necessary within these categories the type of prisoner, will be used throughout. The categories are described in figure 1-2.

Figure 1-2: Sub-categories of Health Care Needs

<table>
<thead>
<tr>
<th>Main sub-categories</th>
<th>Secondary sub-categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor and self-limiting illnesses</td>
<td>Age</td>
</tr>
<tr>
<td>Physical health problems</td>
<td>Sex</td>
</tr>
<tr>
<td>Pregnancy and maternal health</td>
<td>Remand or sentence</td>
</tr>
<tr>
<td>Mental health disorders</td>
<td></td>
</tr>
<tr>
<td>Substance misuse</td>
<td></td>
</tr>
<tr>
<td>Health promotion</td>
<td></td>
</tr>
</tbody>
</table>
2 Healthcare Needs Assessment

2.1 Introduction

Data Availability

2.1.7 The needs assessment process is naturally dependent upon the ready access to comprehensive data of the care sector being analysed. Although the SPS has plans in place to implement GPASS in 2004, there is currently no systematic collection and analysis of health care needs or activity of prisoners’ health care in Scottish prisons.

2.1.8 The absence of this data has necessitated the need to:

• Undertake a Health Care Record and mental health diagnosis audit;

• Use proxy measures to demonstrate prisoner’s health care needs on a number of occasions, when data were unavailable either from health care audit or local information within the local prisons.

Audit of Health Care Indicators and Mental Health Diagnoses

2.1.9 Figure 1-3 details the health indices that were included within the audit.

Figure 1-3: Health Indices

<table>
<thead>
<tr>
<th>Health Care Indicators</th>
<th>Mental Health Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Epilepsy</td>
<td>• Personality Disorder</td>
</tr>
<tr>
<td>• Asthma</td>
<td>• Functional Psychosis</td>
</tr>
<tr>
<td>• Diabetes</td>
<td>• Neurotic Disorder</td>
</tr>
<tr>
<td>• Ischaemic Heart Disease</td>
<td>• Self-harm</td>
</tr>
<tr>
<td>• Hepatitis B</td>
<td>• Attempted Suicide</td>
</tr>
<tr>
<td>• Hepatitis C</td>
<td></td>
</tr>
<tr>
<td>• HIV/AIDS</td>
<td></td>
</tr>
<tr>
<td>• Tuberculosis</td>
<td></td>
</tr>
</tbody>
</table>

2.1.10 In order to ensure that audits were representative of the individual prison populations, statistically significant samples were identified. The Health Centre Managers coordinated the local audits within each prison, which were completed between 18 and 21 November 2002.

N.B. Dental Health

2.1.11 As a comprehensive dental health audit is currently under way using the UK Adult Dental Health Survey 1998, it is inappropriate to comment on this area of health need in this report.
2.2 Health Promotion

2.2.1 A prevalence analysis would not usually include health promotion, however, as this section is concerned with identifying health needs it has been included.

2.2.2 ‘Towards A Healthier Scotland’ highlighted the importance of the life circumstances in which people find themselves, as well as the lifestyles they adopt, in determining their health in the short, the medium and longer term. This is true for the prison population as well as the population at large, although the former tends to be the more disadvantaged group in our society.

2.2.3 Health promotion is based on an assessment of needs and supported by evidence of effectiveness it can help achieve three objectives. It can build the physical, mental, and social health of prisoners and staff; prevent the deterioration of prisoners’ health during or because of custody; and encourage prisoners to adopt healthy behaviours, which can then be carried back into the community.

2.2.4 Good health care and health promotion in prisons should help enable individuals to function to their maximum potential on release, which may assist in reducing offending. It should also reduce morbidity in a high-risk section of the general population with medium and long-term reduction in demands on the NHS.

Scottish Needs Assessment Programme

2.2.5 Four surveys were carried out under the auspices of the Scottish Needs Assessment Programme in 2000 (focused on health of male prisoners) to explore the range and extent of health promotion activities in Scottish prisons. Detailed below are the key findings of the report.

2.2.6 A survey of the 15 Health Boards showed that the majority of health promotion work which took place with male prisoners was in relation to HIV/AIDS and drug users. A survey of the clinical staff based in prison health centres showed that they were involved in a wider range of health promotion issues including oral/dental health, asthma, dermatology, relationships and hepatitis B and C.

2.2.7 Prisoners’ focus groups were held in more and in less secure prisons and all highlighted the importance of nutrition, exercise and relationships. Some long-term prisoners had a particular interest in diet and many were keen to develop cooking skills and also to change their smoking behaviour.

2.2.8 A number of prisoners said that imprisonment provided an opportunity for improving health and for some, basic provision of food and shelter was a marked improvement in living conditions. The opportunity for detoxification, stress management, and acquiring skills for future employment were reported as having a beneficial effect on health although conversely some felt that the prison environment was not conductive to either physical or mental health. Many highlighted the importance of hygiene, both personally and in their cells, in maintaining self-respect and good mental health.

2.2.9 In seeking to address the wider issues of health promotion, a settings approach has recently been recommended for Scottish Prisons. Perhaps surprisingly, the major finding of the SNAP Report was that HIV/AIDS and drugs were not the over-riding issues for medical officers and prisoners and that basic health issues such as oral/dental health, mental health and relationships were the major concerns.
2.2 Health Promotion

2.2.10 The SNAP report also commented that:

- There is a lack of concerted and coherent action from the services charged with promoting and protecting the public health to work in the prison setting. This is primarily due to limitations on resources, poor communication networks and the different responsibilities/remits for this client group and setting;

- Specific budgets for health promotion were poorly resourced or difficult to identify, with consequent implications for the range and quality of provision;

- There was a significant amount of health promotion activity, though it was often poorly prioritised;

- The concept and practice of promoting health were sometimes poorly understood and evaluation was largely absent;

- Most prisons did not have a written strategy in this area;

- Just a handful of prisons were adopting the Whole Prison Approach to promoting health suggested in this strategy.
2.3 Self-limiting and Minor Illnesses

2.3.1 The term ‘minor illness’ is used to describe self-limiting conditions, including musculo-skeletal problems, upper respiratory-tract infections, gastro-intestinal complaints, allergies and skin conditions.

2.3.2 In the community respiratory conditions, injuries, infectious diseases and skin disorders are the most common reasons for consultations with general practitioners among males aged 16 to 44.

2.3.3 In women of this age, by far the most consultations are for preventative or other health related reasons. This principally means services such as family planning and pregnancy care but also includes routine physical examinations and cervical screening.

2.3.4 For most conditions, women in this age group consult a general practitioner more often than men. This trend is reflected in the higher contact rate of female prisoners with nursing staffing in comparison with the male prisoners.

2.3.5 Prevalence of minor illnesses in the Scottish prison population mirrors the prevalence in the equivalent population in the community. Minor illnesses account for the bulk of consultations in community general practice and also account for the bulk of consultations with nursing and medical staff in the prison population.
2.4 Physical Health Conditions

2.4.1 A number of health indices, described below, indicate that in general the physical health of prisoners is worse than that of the people of equivalent age in the general population.

2.4.2 This has significant implications for health care within SPS. Not only is the physical health of the prisoners worse than that of the general population, the prisoners also have a range of complex and specialist health care requirements.

Adult Male Prisoners

2.4.3 Prisoners, aged 18-49, were more likely than men of equivalent age in the general population to report a long-standing illness or disability. They were also more likely to have consulted a health care professional in the last two weeks and be taking prescribed medicines.

2.4.4 This increased rate of male prisoners' morbidity in comparison to the Scottish general public has been confirmed by reviewing the case notes of prisoners.

Young Prisoners

2.4.5 In a survey of the physical health of young prisoners (aged 16-24), 39% reported long-standing illness or disability, 21% reported respiratory problems and 10% reported musculo-skeletal problems. A review of young offenders case notes confirmed a similar trend within the Scottish young offenders.

Elderly Prisoners

2.4.6 Although the prison population predominately comprises of young adults there is a small cohort of ageing prisoners. These prisoners have specific health needs related to the ageing process, such as coronary heart disease and a higher incidence of cancers.

Women Prisoners

2.4.7 Women prisoners have been found to report higher rates of various physical and psychological problems than women in the general population. These include asthma, epilepsy, high blood pressure, anxiety and depression, stomach complaints, period and menopausal problems, sight and hearing difficulties, and kidney and bladder problems.

2.4.8 Again, a review of women prisoner case notes confirmed a similar trend within the Scottish prison population.

Tuberculosis

2.4.9 Tuberculosis is an important disease for a number of reasons. Firstly, despite being treatable it has a significant mortality. Secondly, untreated cases may spread the illness to others. Thirdly, treatment is complicated by the requirement that patients take medication for many months. Interrupted courses of treatment may lead to the emergence of drug-resistant tuberculosis.

2.4.10 In view of this it seems encouraging that in Scotland the reported prevalence of active tuberculosis in prisons to date remains low.

2.4.11 Tuberculosis is only evident in Aberdeen, Barlinnie, Low Moss and Peterhead with very low prevalence. The highest prevalence is 1.2% in Aberdeen.
2.5 Chronic Disease Prevalence

2.5.1 Detailed below is an analysis of the most common chronic disease needs within the SPS population, i.e. epilepsy, asthma, diabetes and ischaemic heart disease. The prisoners’ main areas of need are similar to those of the general population of Scotland.

2.5.2 Each condition is compared with the Scottish population and within the sub categories of the prisoner groups.

Epilepsy

2.5.3 If the prevalence of epilepsy in the community were similar to that of the prison population, we would expect about 0.4% of the prison population to suffer from epilepsy and 1.3% to become epileptic while in prison².

2.5.4 However, direct estimates of the prevalence of epilepsy among prisoners are somewhat higher. Studies show that the prevalence of epilepsy among male British prison population is almost twice that in the community³.

2.5.5 Figure 5-1 below details the prevalence of epilepsy within the prison population by sex and type of prisoner.

Figure 5-1: Prevalence of Epilepsy within Scottish Prisons

<table>
<thead>
<tr>
<th>Epilepsy Prevalence</th>
<th>Average</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Male</td>
<td>4%</td>
<td>0 (Dumfries)</td>
<td>10% (Aberdeen)</td>
</tr>
<tr>
<td>Male YO</td>
<td>0.9%</td>
<td>0 (Dumfries)</td>
<td>1.6% (Polmont)</td>
</tr>
<tr>
<td>Adult Female</td>
<td>6%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Female YO</td>
<td>7%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
2.5 Chronic Disease Prevalence

Asthma

2.5.6 The available statistics show that the expected prevalence of treated asthma in the general population of Scotland in 1998 was 3.4% for males and 3.9% for females.

2.5.7 Asthma tends to be more common in the young. As the prison population is predominately young, the overall prevalence of asthma is higher than of the general population. The prevalence of asthma among male young offenders is significantly higher than the prevalence of 2.7% in the age range of 16-24 years within the Scottish population.

2.5.8 Figure 5-2 below details the prevalence of asthma within the prison population by sex and type of prisoner.

Figure 5-2: Prevalence of Asthma within Scottish Prisons

2.5.9 Caution should be applied to the interpretation to the above figures. Although the prisoners have either been diagnosed with asthma during imprisonment or had the diagnosis confirmed within prison, it is widely known that prisoners wish to take inhalers to add to the inhalation effect of illegal drugs.

2.5.10 Whilst it is clear that the SPS population has a higher prevalence of asthma than the general population, it may not be quite as high as it first appears. Diagnostic criteria will be discussed later in this document.
2.5 Chronic Disease Prevalence

Diabetes

2.5.11 Diabetes presents a serious challenge for Scotland. There are believed to be 150,000 people in Scotland who have been diagnosed with diabetes and there are almost certainly many thousands more who are, as yet, undiagnosed. The number of people developing diabetes is increasing and may double in the next 10-15 yearsxii.

2.5.12 In 1998 the prevalence of diabetes in Scotland was 1.35% for men and 1.02% for womenxiii. Prevalence was highest amongst people aged 65 and over.

2.5.13 There are few direct estimates of the prevalence of diabetes within Scottish prisons. There are no comprehensive Chronic Disease management registers. One English study observed that diabetes is 2 to 8 times more common in prisoners than in the communityxiv. Because the prison population is predominately young, insulin dependant diabetes is much more likely to be common than non-insulin diabetes.

2.5.14 Figure 4-6 below details the prevalence of diabetes within the prison population by sex and type of prisoner;

**Figure 5-3: Prevalence of Diabetes within Scottish Prisons**

<table>
<thead>
<tr>
<th>Diabetes Prevalence</th>
<th>Average</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Male</td>
<td>1.5%</td>
<td>0 (Castle Huntly [Dumfries])</td>
<td>5%, at Peterhead</td>
</tr>
<tr>
<td>Male YO</td>
<td>0.4%</td>
<td>0 (Dumfries)</td>
<td>1.1% (Glenochil)</td>
</tr>
<tr>
<td>Adult Female</td>
<td>1.8%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Female YO</td>
<td>0%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
2.5 Chronic Disease Prevalence

2.5.15 Prevalence for adult males is broadly similar to the prevalence of 1.3\% within the Scottish population, but is more prevalent among women prisoners than the general female population. The average prevalence of diabetes in male young offenders is broadly similar to the prevalence of 0.3\% within the age range of 16–24 in the Scottish population.

Ischaemic Heart Disease

2.5.16 Patients with pre-existing cardiovascular or cerebrovascular disease are at very high risk of further vascular events. Because of this they are the highest priority in the management of cardiovascular disease and its risk factors.

2.5.17 In Scotland in 1998 prevalence among males was 2.43\% and 1.43\% among females\(^\text{xv}\). The prevalence of ischaemic heart disease is very dependent on the age of the population and was highest for people aged 75 – 84 (10.4\% for males, 6.82\% for females). Heart disease is about half as common again among socio-economic class V as the general population\(^\text{16}\).

Figure 5-4– Prevalence of Ischaemic Heart Disease within Scottish Prisons

<table>
<thead>
<tr>
<th>Ischaemic Heart Disease Prevalence</th>
<th>Average</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Male</td>
<td>4.2%</td>
<td>0 [Dumfries]</td>
<td>17%, at Peterhead</td>
</tr>
<tr>
<td>Male YO</td>
<td>0%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Adult Female</td>
<td>2.4%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Female YO</td>
<td>0%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
2.5 Chronic Disease Prevalence

2.5.18 The average prevalence of ischaemic heart disease for the adult males is higher than the average prevalence of 2.4% in the Scottish population.

2.5.19 None of the male or female young offenders have any prevalence of ischaemic heart disease. This is in line with what is seen in the Scottish population of this age group.

2.5.18 The average prevalence of ischaemic heart disease for the adult males is higher than the average prevalence of 2.4% in the Scottish population.

2.5.19 None of the male or female young offenders have any prevalence of ischaemic heart disease. This is in line with what is seen in the Scottish population of this age group.

Smoking

2.5.20 Smoking is highly prevalent among the English and Welsh prison population. Over three quarters of all prisoners smoke and over half are moderate to heavy smokers17. This trend is reflected within the SPS.

Chronic Disease Prevalence and Co-morbidity

2.5.21 Each prison profile is individual and chronic disease management requires to be geared to the profile of needs within each prison.
2.6 Blood Borne Diseases

2.6.1 Detailed below is an analysis of the blood borne diseases among the SPS population. The prisoners’ main areas of need are in line with those of the general population of Scotland. The blood borne diseases are as follows:

- Hepatitis B;
- Hepatitis C;
- HIV/AIDS.

2.6.2 A survey in 1997 found that about one in four adult prisoners engaged in activities likely to put them at risk of infection with HIV, Hepatitis B or Hepatitis Cxviii.

Figure 6-1 – Prevalence of Blood Borne Diseases within Scottish Prisons

<table>
<thead>
<tr>
<th></th>
<th>Average</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hepatitis B</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Male</td>
<td>1%</td>
<td>0 (5 out of 13</td>
<td>6% (Aberdeen)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>prisons)</td>
<td></td>
</tr>
<tr>
<td>- Male YO</td>
<td>0.22%</td>
<td>0 (Glenochil,</td>
<td>0.65% (Polmont)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dumfries)</td>
<td></td>
</tr>
<tr>
<td>- Female</td>
<td>1.8%</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>- Female YO</td>
<td>0</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>Hepatitis C</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Male</td>
<td>8%</td>
<td>1.7% (Castle</td>
<td>15% (Glenochil)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Huntly)</td>
<td></td>
</tr>
<tr>
<td>- Male YO</td>
<td>3%</td>
<td>0 (Dumfries)</td>
<td>5.6% (Glenochil)</td>
</tr>
<tr>
<td>- Female</td>
<td>14.8%</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>- Female YO</td>
<td>7.4%</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>HIV/AIDS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Male</td>
<td>0.3%</td>
<td>0 (7 out of 13</td>
<td>1.2% (Aberdeen)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>prisons)</td>
<td></td>
</tr>
<tr>
<td>- Male YO</td>
<td>0</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>- Female</td>
<td>0.6%</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>- Female YO</td>
<td>0</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

2.6.3 As with chronic diseases, each prison profile is individual and blood borne disease management requires to be geared to the profile of needs within each prison.
2.6 Blood Borne Diseases

Incidence and Prevalence of Hepatitis C in HMP Shotts

2.6.4 An investigation was undertaken by Dr A Taylor and colleagues to determine the incidence and prevalence of the hepatitis C virus and associated risk factors among prisoners in HMP Shotts.

2.6.5 Results showed the prevalence of hepatitis C in saliva was 16%. Adjusted for test sensitivities this was estimated at 19% seroprevalence. The adjusted prevalence among injector inmates was 53%.

2.6.6 The prevalence of hepatitis C virus salivary antibody positive was significantly related to being older, having been in prison a greater number of times, having injected drugs and having been involved in a bloody fight during the present sentence. Being older and injecting at least weekly during the present sentence were the main predictors of hepatitis C virus positivity in saliva in injecting drug users.

2.6.7 Five incident infections were found. The incident rate for infection with hepatitis C was 3.3 per 100 person years of incarceration risk for all prisoners, 11.9 for those who injected drugs and 9.3 for those who had injected during the current sentence. The only factor found to be associated with Hep. C virus seroconversion was a history of injecting drug use. There are no directly comparable studies of community Hep. C virus incidence; however the rate found in a community study of Glasgow injectors who had been injecting for less than two years was considerably higher than the incidence inside HMP Shotts.

2.6.8 Much has to been done to prevent the transmission of blood borne infection inside Scottish prisons such as HMP Shotts. Measures include the availability of bleach tablets to sterilise injecting equipment, counselling and short detoxification programmes. Nevertheless, as transmission of Hep. C virus has now been proven to occur during incarceration, a strong case can be made for reviewing existing policy.
2.7 Pregnancy and Maternity Care

2.7.1 The maternity services for female prisoners are delivered in close collaboration with the NHS, thus ensuring statutory maternity regulations and clinical governance needs are adhered to.

2.7.2 There will always be a number of pregnant women in custody at any one time. Pregnant prisoners can be a vulnerable group, including adolescent and immature women, and women abusing drugs and alcohol. The need for maternity care varies over time depending on a number of factors. The survey below reflects the current trend in pregnant women within prisons.


2.7.3 In 1999 forty-four women were cared for within the maternity clinic in HMP Cornton Vale. Of those forty-four women the health care team diagnosed 30% (i.e. thirteen) on entry into the prison.

2.7.4 Forty-three of these pregnancies were singleton with one set of twins being diagnosed. Of these pregnancies, four were delivered in Stirling Royal Infirmary with the other deliveries planned for shared care and delivery within their own geographical areas on release from the prison. Six per cent of these pregnancies resulted in termination of pregnancy.

2.7.5 Figure 7-1 details the age range of prisoners receiving maternity care.

Figure 7-1: Age Range of Prisoners Receiving Maternity Care

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20 years</td>
<td>34%</td>
</tr>
<tr>
<td>20-30 years</td>
<td>40%</td>
</tr>
<tr>
<td>30 years and over</td>
<td>9%</td>
</tr>
<tr>
<td>Unknown</td>
<td>17%</td>
</tr>
</tbody>
</table>

Source: HMP Cornton Vale

2.7.6 The need for pregnancy and maternity care may continue to grow, particularly if the number of female prisoners continues to increase.
2.8 Speech, Language and Communication Problems

2.8.1 The ability to communicate is important for three related reasons. Firstly, it is essential for normal social functioning. Secondly, other types of health care are less likely to be effective if communication is impaired. Thirdly, communication problems may be linked to some kinds of offending behaviour.

2.8.2 The most comprehensive prevalence data comes from a survey of twenty years experience in Polmont YOI. The majority of those serving sentences of three months or more underwent a screening assessment by the Speech and Language Therapist using an initial Interview Questionnaire. Between 1973 and 1994, almost half of the 10,000 young offenders were screened, and 11% needed treatment.

2.8.3 Based on these figures, we might expect about one in nine offenders to have a need for speech and language therapy. It is not clear whether a similar figure would apply to adult prisoners. However, adult prisoners are unlikely to have received speech and language therapy and in absence of specific prevalence data it is probably a reasonable estimate for adults.
2.9 Mental Health

Mental Health Illness Prevalence by Prisoners Groups

2.9.1 Detailed below is an analysis of the most common mental health illness needs within the SPS population, as identified by the health care records and mental health diagnosis audit. The prisoners' main areas of need are similar to those of the general population of Scotland. These include functional psychosis, neurotic disorder and personality disorder.

2.9.2 In general terms this section of the audit was completed to a satisfactory level by the SPS nursing staff. However, a small number of anomalies, due to the information available within the case notes, have been identified and discounted from this section.

Figure 9-1: Prevalence of Chronic Mental Health Diseases

<table>
<thead>
<tr>
<th></th>
<th>Average</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional psychosis</td>
<td>Male</td>
<td>3.7%</td>
<td>19% (Aberdeen, Noranside)</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>7.1%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Female YO</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>Neurotic disorder</td>
<td>Male</td>
<td>14%</td>
<td>31% (Inverness)</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>10%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Female YO</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>Male</td>
<td>1.9%</td>
<td>7.6% (Inverness)</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>8.9%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Female YO</td>
<td>0</td>
<td>N/A</td>
</tr>
</tbody>
</table>

A Study of Psychological Disturbance Amongst Prisoners

2.9.3 Detailed below are the findings of the study 'Psychological disturbance in the Scottish Prison System: Prevalence, Precipitants and Policy'.

2.9.4 The overall rate of psychological disturbance in the Scottish prison population is substantially higher than that in the general population. This is confirmed by the findings of the health care records and mental health diagnosis audit. Estimates of prisoners compared with the general population indicate that the rate of psychological disturbance and personality disorder is twice as high as the general population.

2.9.5 Given the high levels of psychological disturbance in the Scottish prison system the important question is why? Epidemiological evidence confirms that those who have a high risk of imprisonment also have a high risk of psychological disorder.
2.9 Mental Health

2.9.6 Not all forms of psychological disturbance are over-represented; particular types predominate. There is little or no evidence of schizophrenia or psychosis; it is likely that prisoners with these conditions are detected and transferred to hospital conditions. This Healthcare Record and mental health diagnosis audit identified that whereas this is generally the case, Aberdeen had a much greater level of functional psychosis.

2.9.7 By way of contrast the rates of depression are particularly high across the board. Over half the female prisoners have experienced major depression at some time in their lives. Male prisoners experienced less depression than females.

2.9.8 The lack of evidence to implicate the regime characteristics in the aetiology of psychological disorder does not mean that the quality of the regime does not intensify or ameliorate the disorders of those imprisoned. The manner in which prisoners are treated by the prison staff appears to be the critical determinant in the maintenance of distress and disorder.

Psychological Co-morbidity

2.9.9 Prisoners tend to suffer from more than one mental health problem. Those with more serious neurotic disorders are more likely to suffer from functional psychosis and personality disorders. Alcohol and drug misuse also tends to be associated with personality disorders - two thirds of female prisoners and over half of male prisoners have psychological co-morbidity of mental health, and drug and alcohol addictions. An estimated 3-11% of prisoners have co-occurring mental health disorders and substance abuse disorders.

2.9.10 Unfortunately, some prisoners are not merely limited to being psychologically disturbed but also have profound social difficulties. The group of prisoners with complex needs present a challenge to the SPS in terms of how these needs are to be met.

Intellectual Function

2.9.11 Prisoners tend to have below average levels of intellectual functioning. Greater proportions of remand than sentence prisoners have very low levels of intellectual functioning. Assessed by the Quick Test (a brief intelligence test of perceptual-verbal performance), one in ten male sentenced, one in twenty male remand and one in ten female prisoners had very low levels of intellectual functioning.

Social Support

2.9.12 Compared to the general population, prisoners have low perceived levels of social support. This is particularly striking among those identified as probably suffering from psychosis, those exhibiting more neurotic symptoms, male prisoners and those with personality disorders (other than anti social personality disorders). These groups of prisoners are also more likely to have a small primary support group (i.e., close friends and relatives).
2.10 Suicide and Self-harm

2.10.1 In the general population, suicides are relatively uncommon. Suicide is more common in men than women and suicide is most common between the ages of 15 and 44. In the community, the great majority of those who commit suicide have a previous history of some form of mental disorder. In the community, persons who self-harm are 100 times more likely to commit suicide than those who do not.

2.10.2 Direct comparisons between suicide rates in the prison population and the community are difficult to make. Even so, the suicide rate is generally much higher in prisons than in the community.

2.10.3 Scotland’s rate is much higher than the rate for the rest of the UK as a whole. Over 600 people commit suicide in Scotland each year. The rate of increase in suicide in Scotland over recent decades is among the highest in Europe (Choose Life: A National Strategy and Action Plan to Prevent Suicide in Scotland, Scottish Executive 2002).

2.10.4 Figure 10-11 shows the number of suicides for the years 2000 to 2002 in the SPS.

**Figure 10-1: Number of Self-inflicted Deaths in SPS**

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Suicides</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>14</td>
</tr>
<tr>
<td>2001</td>
<td>11</td>
</tr>
<tr>
<td>2002</td>
<td>10</td>
</tr>
</tbody>
</table>

**Prevalence of Self-harm and Suicide**

2.10.5 Detailed below is the prevalence of self-harm and suicide as identified by the SPS Suicide & Self-harm Database.

**Fig 10-2: Reported Incidents of Self-harm and Attempted Suicide Within SPS**

[Graph showing reported incidents of self-harm and attempted suicide by facility codes]
2.10 Suicide and Self-harm

2.10.6 Detailed below is the prevalence of self-harm and suicide as identified by the health care record and mental health diagnosis audit. The same audit methodology was applied to collecting these figures. Figure 10-3 details the prevalence of self-harm and suicide in adult male prisoners.

Figure 10-3: The prevalence of self-harm and suicide in adult male prisoners

Adult Males: The prevalence of self-harm and attempted suicide by Establishment

2.10.7 Figure 10-3 identifies that there is a significant variance in the prevalence of self-harm and suicide in adult male prisoners across all Scottish prisons.

2.10.8 Figure 10-4 details the prevalence of self-harm and suicide in young offenders.

Figure 10-4: The prevalence of self-harm and suicide in YOI

YOI’s: Incidence of self-harm and attempted suicide by Establishment
2.10 Suicide and Self-harm

2.10.9 Figure 10-5 details the prevalence of self-harm and suicide in female prisoners.

Figure 10-5: - The prevalence of self-harm and suicide in female prisoners

Women: Incidence of self-harm and attempted suicide by Establishment

2.10.10 The following characteristics in relation to suicide and self-harm can be noted:

- Suicide is about 8 times more common among prisoners than in males of a similar age in the community. Suicide most frequently occurs within the first weeks and months of imprisonment.
- Suicides are consistently higher among remand than among sentenced prisoners.
- The incidence of self-harm is high in the prison population and seems to be higher in prisoners under the age of 30 years of age.
- Self-harm incidents occur with greater frequency among the unsentenced (remand) population than among sentenced prisoners.
- About half of prisoners who commit suicide have self-harmed while in custody. As the frequency of self-harm increases so does the likelihood of suicide.

2.10.11 The Office of National Statistics survey found suicidal thought was more common in female than male prisoners. This also found that about three times as many remand as sentenced prisoners reported suicidal thought in the past week. Research shows more female than male prisoners reported suicide attempts. This is in contrast to the figures of completed suicides.
2.11 Alcohol and Drug Misuse

2.11.1 Over the past few years Scotland has seen a marked rise in drug and alcohol problems. This is reflected in the prison population. On arrival from the community as many as 85% of SPS receptions are assessed as having addictions problems, with many prisoners reporting use of or addiction to cigarette, alcohol, and illicit or prescribed drugs.

2.11.2 An SPS study\textsuperscript{xxviii} found: -

- Almost half of the female prisoners met the clinical criteria for drug dependence and a fifth met clinical criteria for alcohol dependence;

- Male prisoners experienced less drug dependence than female prisoners, however, twice as many – two fifths – meet clinical criteria for alcohol dependence.

2.11.3 The rate of alcohol dependence in the male prisoners is around eight times that of the general population. The rate of alcohol dependency amongst female prisoners is more than thirty times that of the general population.

2.11.4 No general public comparisons are available for drug dependence.
## 2 Healthcare Needs Assessment

### 2.12 Summary of Key Issues

<table>
<thead>
<tr>
<th><strong>Health Status</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Prevalence of minor illnesses in the Scottish prison population mirrors the prevalence in the equivalent population in the community. Minor illnesses account for the bulk of consultations in community general practice and also account for the bulk of consultations with nursing and medical staff in the prison population.</td>
<td></td>
</tr>
<tr>
<td>• In general the physical health of prisoners is worse than that of the people of equivalent age in the general population.</td>
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<table>
<thead>
<tr>
<th><strong>Chronic Diseases</strong></th>
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<tbody>
<tr>
<td>• The prevalence of epilepsy among male prisoners is higher than that of the Scottish population. However, due to the range of prevalence across prisons clinical management requires to be effectively targeted.</td>
<td></td>
</tr>
<tr>
<td>• The greatest chronic disease health need within all male prisoners is that of asthma. The prevalence varies considerably from prison to prison, which has implications for the requirement of a highly specialist workforce and ensuring prisoners gain access to high quality specialist care.</td>
<td></td>
</tr>
<tr>
<td>• As the prevalence of diabetes is similar to that of the Scottish population, and each prison has relatively low numbers of diabetic prisoners, attention must be give as to how the prisoners access the necessary specialist multi professional skills.</td>
<td></td>
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<tr>
<td>• Peterhead has a particular need in relation to ischaemic heart disease due to the older age profile of the prison population.</td>
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<table>
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<tr>
<th><strong>Blood Borne Viruses</strong></th>
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<tr>
<td>• Around a quarter of adult prisoners engage in activities likely to put them at risk of infection with HIV, Hepatitis B or Hepatitis C.</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Women’s Health</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• There is a number of health problems and needs that are specific to women in prison. These include maternity care, gynaecology and care of babies in prison, as well as a range of health education services such as family planning.</td>
<td></td>
</tr>
<tr>
<td>• Primary care consultation rates and admission rates to prison health care centres are high in women prisons compared with other prison types and considerably higher than consultation rates for women in the community.</td>
<td></td>
</tr>
</tbody>
</table>
### Mental Health

- Estimates of prisoners compared with the general population indicate that the rate of psychological disturbance and personality disorder is twice as high as the general population.

- Prisoners tend to suffer from more than one mental health problem. Those with more serious neurotic disorders are more likely to suffer from functional psychosis and personality disorders. Alcohol and drug misuse also tends to be associated with personality disorders.

- Prisoners tend to have below average levels of intellectual functioning – one in ten male sentenced, one in twenty male remand and one in ten female prisoners had very low levels of intellectual functioning.

### Suicide and Self-Harm

- Suicide rates are generally higher in prisons than in the community.

- Many young offenders have temperamental, emotional and behavioural problems that manifest as self-harm and suicidal behaviour.
2 Healthcare Needs Assessment

2.13 Notes

Scottish Needs Assessment Programme: Health Promotion in Prisons. 1999. Glasgow: Office for Public Health in Scotland


Scottish Diabetes Framework. Scottish Executive.

United Kingdom Health Statistics. 2001. London. The stationary Office

Department of Health, Scottish health Survey 1995


United Kingdom Statistic. The Stationary Office. 2001
HM Chief Inspector of Prisons, Suicide is everyone’s concern: thematic review. 1999. London. Home Office
Suicide Risk Management and Custodial Care. An Inter–Agency Approach. SPS
3.1 Introduction

3.1.1 In June 2002, the Scottish Prison Service (SPS) engaged Secta Consulting to provide support with the Nursing Services Review. Stages 1 and 2 of the project were completed in January 2003.

3.1.2 Within stage 3 of the project, a high level assessment of the potential providers of primary care nursing services within the SPS was carried out.

3.1.3 Three options for the provision of primary care nursing service in the SPS were identified in stage 2 of the project, they are as follows:

- SPS continuing to engage nursing staff on a contract of employment basis;
- NHS Scotland assuming responsibility for provision of primary care nursing services in Scottish Prisons;
- Establishing a service contract between SPS and private providers of primary care nursing services.

3.1.4 There is also a potential option of providing core generic primary care nursing services in-house and outsourcing the specialist components of the service, i.e. mental health and addictions. These services could be provided by NHS Scotland or by the private sector. For the purpose of this exercise this option is referred to as the 'Hybrid In-house Model'.

3.1.5 Whilst it appears that the most straight forward option is to continue to engage nursing staff on a contract of employment basis as SPS staff, the SPS Executive Group wish to identify if there are other options available, including how the SPS might link into the NHS, or if there are other potential service providers who could deliver the service on a contractual basis.

Methodology

3.1.6 The main components of the methodology for this exercise were as follows:

- Desktop review of documents relating to the recent transfer of primary care nursing services from the Prison Service in England to the NHS in England and Wales.
- Research into the number and type of private sector providers of primary care nursing services in Scotland.
- Research into the number and type of private sector providers of specialist services (i.e. mental health services and addiction specialist services).
- Structured telephone interviews with four large private sector nursing agencies to establish whether they would be interested and able to provide permanent primary care nursing staff on a service contract basis and or provide mental health nurses and addiction specialists on a permanent basis to the SPS.
- Structured telephone interviews with two private sector providers of Mental Health Services based in Scotland to establish whether they would be interested and able to provide specialist services i.e. mental health and addictions.
3.1 Introduction

3.1.7 In addition, the NHS nurse representative on the SPS Nursing Services Review Group met with Directors of Nursing Services within NHS Scotland and the SPS Nursing Services Manager met with the Chief Nursing Officer (CNO) at the Scottish Executive Health Department to discuss the options for future service delivery. The feedback from these discussions is included in this report.

Structure of the Report

3.1.8 This report provides a high level assessment of the feasibility of the range of options for providing the primary care nursing service in the SPS, identified in stage 2 of the project.

3.1.9 The structure of the report is as follows:

• Section 2 - provides an overview of the proposed transfer of Prison Health Care to the NHS in England and assesses the potential for a similar arrangement in Scotland.

• Section 3 - identifies potential private sector providers of primary care nursing services and also specialist nursing services, i.e. mental health and addictions.

• Section 4 - provides a high-level feasibility assessment of each of the proposed options for primary care nursing, outlining the advantages and disadvantages of each option.
3.2 Potential Transfer of Services to NHS Scotland

Overview

3.2.1 One of the options identified in stage 2 of the project was the possibility of NHS Scotland assuming responsibility for the provision of primary care nursing services in Scottish Prisons. This section considers this option in more detail, and provides a brief overview of the experience in England and Wales where the responsibility for and funding of health care services in prisons transferred from HM Prison Service to the Department of Health on 1 April 2003.

3.2.2 Background to the Review of Prison Healthcare in England & Wales

3.2.3 In 1996, Her Majesty’s Chief Inspector of Prisons for England and Wales produced a discussion paper entitled ‘Patient or Prisoner?’ which highlighted the weaknesses in the current provision of healthcare within prisons. In particular, the paper commented on the quality of care, professional isolation of healthcare staff and poor links with the NHS. The Chief Inspector of Prisons recommended that the NHS should take over the responsibility for providing healthcare to prisoners and outlined several options designed to achieve this. The main reasons and potential benefits for recommending the transfer of responsibility for Prison Health Care Services to the NHS, as set out in the discussion paper, are contained within Appendices A1 and A2.

3.2.4 In 1997, The Health Advisory Committee for the Prison Service published a report on ‘The Provision of Mental Health Care in Prisons’. The report highlighted the uncoordinated way in which mental health care to prisoners was formulated and delivered, and the need for more effective continuity of care following release from prison.

3.2.5 In view of these concerns, in 1999 the Home Secretary and the Secretary of State for Health established a joint Prison Service and NHS Executive Working Group. The group’s remit was to:

- address the issues highlighted in each report;
- develop radical proposals for change that will deliver care for prisoners equivalent to that of the general population;
- take account of the wider prison and NHS agendas and
- take account of the views of key stakeholders.

Options for Change

3.2.6 The Joint Working Group considered three broad options for the future of prison healthcare in England and Wales.
3.2 Potential Transfer of Services to NHS Scotland

Figure 2-1 outlines the three options considered.

Figure 2-1 – Potential Options for Change (from Joint Working Group)

- **Option One – ‘Status Quo Plus’** – add to present policies seeking efficiency and other improvements. Increase the proportion of healthcare provided by contracts with the private or public sector, placing rigorous delivery standards on directly managed services using service level agreements.

- **Option Two – Partnership** – adopt a more collaborative and co-ordinated approach with the NHS supported by a recognised and formal duty of partnership. The prison service and the NHS would jointly set health care and other standards. Services could be jointly commissioned on the basis of assessed need and provided by a combination of directly employed prison healthcare staff, the NHS and others. Resources for primary care would remain within the prison service.

- **Option Three – Full Transfer to the NHS** – the complete integration of prison health care into the NHS, transferring both resources and accountability for prisoners’ health care.

3.2.7 In March 1999, the Joint Working Group published their findings in a report entitled ‘The Future Organisation of Prison Health Care’. The Joint Working Group identified a number of weaknesses in prison healthcare, including:

- professional isolation of staff from the main stream of the NHS;
- difficulties with recruitment and retention of medical and nursing staff;
- variable quality of medical and nursing care not always meeting NHS standards, and poor through care;
- inadequate provision for prisoners with mental health problems, often resulting in delays in transfers to psychiatric hospital;
- some nursing care delivered by non nurse trained staff;
- lack of strategic direction.

3.2.8 The Joint Working Group recommended that the objectives of any new organisational and accountability framework for prison health should be:

- To ensure that health care provided within prisons is appropriate to need and comparable quality to that outside prison.
- To ensure that appropriate health care is not disrupted by entry to prison, by movement between prisons or upon release.
- To reduce re-offending where that is an attribute to health status (e.g. resulting from mental illness or substance abuse) and to use the opportunities presented by time spent in prison to tackle factors that can contribute to social exclusion.
- To have the capability to deal effectively with the problems of the current isolation of prison health, to manage the constraints and take advantage of the opportunities described above.
3.2 Potential Transfer of Services to NHS Scotland

3.2.9 The report considered the costs and benefits of each of the three options identified in Figure 2-1 in detail against the following criteria; delivery of services, needs assessment and commissioning and funding and accountability.

3.2.10 The Joint Working Group did not consider that option one would provide the opportunity or incentive for change within prison health care.

3.2.11 The Joint Working Group also discounted option 3, as it was not considered appropriate in the short term. An analysis of option 3 is provided in Figure 2-2.

Figure 2-2- Analysis of Option 3

- The radical and comprehensive programme of change within the NHS at the time of the study led to concerns about asking the NHS to lead prison healthcare an area which it has been at some distance from and the priority the NHS could therefore in practice give to Prison Health care.

- The risk that the transfer may result in a division within prisons with healthcare staff becoming isolated as a result of differences in philosophy and culture and differing views of regimes was also identified.

- The need for the NHS and the prison service to understand how to work together while minimising disruption to existing services was also highlighted as a concern.

- A move of approximately 2000 health care staff from the prison service to the NHS in the short term would present substantial industrial relations and other difficulties.

- Neither the Prison Service nor the NHS can provide health care for prisoners without the cooperation of the other. Placing all responsibility for what must be a joint service on one agency is likely to result in perverse incentives, as is currently the case.

3.2.12 In order to meet the objectives for the new framework of prison healthcare (outlined in paragraph 2.2.6), it was clear that neither the Prison Service nor the NHS could deliver the necessary change in isolation. The Joint Working Group therefore considered the partnership approach most likely to deliver change in the short to medium term. The question of whether or not the NHS should assume full responsibility for prisoner’s healthcare should be examined again, after their recommendations and actions have been implemented and reviewed. A summary of the recommendations of the Joint Working Group is contained within Appendix A3.

3.2.13 The Government accepted the recommendations of the Working Group and the responsibility for prison healthcare was taken forward on the basis of a formal partnership between the prison service and the NHS.

The Partnership Approach

3.2.14 A Prison Health Policy Unit and Task Force were subsequently set up to assist prisons and Health Authorities to implement the partnership framework. The Policy Unit and Task Force were later merged into one organisation called ‘Prison Health’. 
3.2 Potential Transfer of Services to NHS Scotland

3.2.15 Three key areas were identified to drive the modernisation of health services:

- Developing the workforce and infrastructure to support health care delivery; professional development, information (including communications) and capital;
- Focusing on improvements to specific clinical services, including primary care, substance misuse and mental health;
- Strengthening systems for managing and monitoring change, clinical governance, healthcare standards and performance monitoring mechanisms.

3.2.16 The partnership between the Prison Service and the NHS to modernise prison health services has delivered tangible benefits. Figure 2-3 outlines the initial benefits realised by the partnership.

**Figure 2-3 Main Benefits Delivered Through the Prison Service - NHS Partnership**

- Significant capital investment to rebuild or refurbish prison healthcare centres.
- The introduction of new NHS Mental health in-reach teams as part of the NHS Plan, expected to cover around half of all prisons by March 2004.
- Work to reduce the health risks posed by infectious diseases, including a programme to offer prisoners vaccinations against hepatitis B.
- Improved provision of drug detoxification programmes and;
- Development support for the prison health workforce, including the introduction of a new NVQ in Custodial Care.

### Transfer to the NHS

3.2.17 The Spending Review 2002 provided the government with an opportunity to review the progress made by the Prison Service / NHS partnership. It was felt that significant progress had been made to take the next step towards the transfer of financial responsibility. The reforms within the NHS, namely the ‘NHS Plan’ and ‘Shifting the Balance of Power’ also made this decision timely given the requirement to improve health and provide continuity of care for all, including those in custody.

3.2.18 In September 2002, the Government formally announced the decision to transfer the budgetary responsibility for prison health from the Prison Service to the Department of Health, with effect from April 2003. Subsequently, responsibility will be devolved to Primary Care Trusts (PCTs) effectively mainstreaming this activity within the NHS. However Ministers have now decided that full devolution to PCTs in England will take place from April 2006, and that this shift will be preceded by local piloting work to draw out lessons for national implementation.

3.2.19 The government has cited a number of factors influencing the delayed timetable for transfer. PCTs in England are relatively new organisations, responsible for delivering a demanding NHS modernisation agenda. There is also a need to ensure that the timetable for transfer is short enough to avoid ‘planning blight’ and loss of momentum in service change within prison health. In a recent article published in the Health Service Journal, a spokesperson for the DoH said that it would be ‘business as usual for the running of prison healthcare this year’, and that ‘nearly 30 PCTs had expressed an interest in joining a prison development network from 2004 onwards. Prisons and PCTs will be selected in the next couple of months to take part in pilot schemes to model the transfer of funds’.
3.2 Potential Transfer of Services to NHS Scotland

3.2.20 The government is currently giving fuller consideration with Welsh Assembly Ministers about how equivalent arrangements may be made in respect of the four prisons in Wales.

Feasibility of Transfer of Prison Health Care Services to NHS Scotland

3.2.21 From the feedback provided by the SPS Nursing Services Manager and the NHS Scotland Director of Nursing representative on the nursing review project group, it is clear that there is considerable support at national level and within health boards for strengthening the links between the SPS and NHS Boards.

3.2.22 However, none of the Directors of Nursing and Scottish Executive Health Department staff who were contacted during this review have expressed any enthusiasm for the option of NHS Scotland taking over responsibility for the provision of primary care nursing services in Scottish prisons.

Conclusions

3.2.23 It is too early to be able to fully evaluate the transfer of prison health care services to the NHS in England. However the SPS may at this time wish to discuss the experience of the prison health colleagues working in the Prison Service in England.

3.2.24 Although the SPS are beginning to work in partnership with NHS Scotland, there is still some way to go in order to realise the benefits of a formalised partnership approach. The benefits of such an approach are clearly demonstrated by the recent experience in England and Wales (refer to fig 2-3).

3.2.25 The postponement in transferring responsibility for prison health to PCTs in England indicates some level of concern that the momentum for change in Prison Health could very well be lost among the competing priorities of PCTs if such a transfer took place at this moment in time.

3.2.26 The recent feedback from Directors of Nursing Services within NHS Scotland is very positive towards strengthening the relationships with the Scottish Prison Service. Clearly the opportunity exists for the SPS to develop formal links or a formal partnership with NHS Scotland. However there is no evidence of any desire on the part of NHS Scotland to take over full responsibility for the provision of the SPS primary care nursing service.
3.3 Potential Private Sector Providers

Overview

3.3.1 This section provides an overview of the potential private sector providers of primary care and specialist nursing services within Scotland. Seven private sector providers were contacted to establish whether they may be interested and capable of providing primary care and or specialist nursing services to the SPS.

Private Sector Nursing Agencies in Scotland

3.3.2 There are approximately 66 private nursing agencies within Scotland providing trained, untrained and specialist nursing staff. The majority of the agencies are local agencies with only one branch. However there are five larger agencies with more than one branch; they are the British Nursing Agency (BNA), Scot Nursing, the Scottish Nursing Guild, the Nursing Agency Direct and BUPA Nursing. The number and location of the branches of each of these five agencies is outlined in Figure 3-1 below.

<table>
<thead>
<tr>
<th>Name of Agency</th>
<th>Number and Location of Branches</th>
</tr>
</thead>
<tbody>
<tr>
<td>BNA</td>
<td>8 Branches:</td>
</tr>
<tr>
<td></td>
<td>• Aberdeen</td>
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<tr>
<td></td>
<td>• Ayr</td>
</tr>
<tr>
<td></td>
<td>• Edinburgh</td>
</tr>
<tr>
<td></td>
<td>• Forth Valley (Stirling)</td>
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<td>• Galashiels</td>
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<td>• Glasgow</td>
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<td></td>
<td>• Highland (Inverness)</td>
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<tr>
<td></td>
<td>• Perth</td>
</tr>
<tr>
<td>Scot Nursing</td>
<td>7 Branches:</td>
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<td></td>
<td>• Aberdeen</td>
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<td></td>
<td>• Alexandria</td>
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<td></td>
<td>• Motherwell</td>
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<td></td>
<td>• Paisley</td>
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<tr>
<td>Scottish Nursing Guild</td>
<td>6 Branches:</td>
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<td>BUPA Nursing</td>
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<td></td>
<td>• Glasgow</td>
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<td>• Edinburgh</td>
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</table>

Private Sector Providers of Specialist Nursing Services in Scotland

3.3.3 Two potential private sector providers of specialist nursing services (i.e. mental health services and addictions services) in Scotland were identified: BMI Healthcare and Priory Healthcare.
3.3 Potential Private Sector Providers

Responses to the Structured Questionnaire

3.3.4 An attempt was made to contact each of the 5 main private nursing agencies listed in Figure 3-1. Each agency was given the same background information about the SPS Nursing Review and asked the same questions to establish whether they would be interested and capable of providing core general primary care nurses, mental health nurses and addiction specialist nurses within the 15 prisons in Scotland. A copy of the background information and structured telephone questionnaire are provided in Appendix B1.

3.3.5 Secta was able to speak to 4 of the 5 nursing agencies; a summary of their responses is contained within Appendix B2.

3.3.6 In addition, 2 private sector providers of specialist nursing services were contacted to establish whether they would be interested and capable of providing specialist nursing services, namely mental health nursing services and addictions specialist nursing services. A summary of their responses is provided within Appendix B2.

Conclusions

3.3.7 Whilst many of the providers expressed their interest in providing primary care and specialist nursing services to the SPS, none of the providers contacted have experience of providing similar services to other organisations.

3.3.8 All of the agencies contacted specialise in supplying temporary nursing staff on a short-term basis to public and private health care providers. In general the longest placement of staff tend to be from 3 – 10 months maximum. One of the agencies commented that it may be difficult to retain staff in these roles; as in their experience staff who take on longer placements tend to want to change placements at the 6-10 month stage. Concern was also raised about the ability to supply specialist addictions nurses.

3.3.9 All of the agencies contacted would be willing to participate in discussions with the SPS and provide an estimate of the likely cost, however in order to do so they would require much more detailed information as outlined in Appendix B2.

3.3.10 Should the SPS wish to explore this option, a more detailed analysis would be necessary to ensure that the change in service provision will deliver significant benefits for patients and staff.
3.4 Conclusions

Overview

3.4.1 This document provides a high-level assessment of the options of transferring responsibility for the provision of primary care nursing provision in the SPS to the NHS in Scotland or private sector providers. This section of the report summarises the key findings of the research undertaken and provides recommendations on the way forward.

Summary of Key Findings

3.4.2 The recent decision to postpone the transfer of responsibility for prison health to the NHS in England as a result of the huge agenda facing PCTs has meant that it is too early to fully evaluate the experience in England.

3.4.3 The partnership between the prison service and the NHS to modernise prison health services has delivered many tangible benefits for prison health in England (refer to figure 2-3).

3.4.4 Given the proposed reforms and changes outlined in ‘Partnership for Care’, the new Scottish Health White Paper, and the feedback from DNS colleagues in NHS Scotland, there is no compelling reason to consider transferring the full responsibility for prison nursing from the Scottish Prison Service to NHS Scotland.

3.4.5 Although 3 of the 6 private sector providers contacted expressed an interest in providing primary care and specialist nursing services to the SPS, none of the providers were able to provide any evidence of providing either primary care or specialist nursing services on a permanent basis to any organisations within Scotland. There is therefore no precedent which the SPS could use to assess whether or not contracting out the primary care service to the private sector would deliver clinical / operational benefits and or better value for money.

Recommendations

3.4.6 Given that the primary care nursing service and specialist nursing services are currently provided in-house, any change in service provision should be based on the expectation of significant benefits including:

- Improved availability of appropriately skilled nursing staff.
- Improved clinical quality of service.
- Reduced costs and/or greater value for money.

3.4.7 In addition the long-term security of the provider model must also be assessed, (i.e. the extent to which continuous service delivery to the required standards can be guaranteed).

3.4.8 From the research undertaken by Secta, there is no evidence that a change in the responsibility and arrangements for the provision of primary care nursing services within the NHS would yield greater benefits than continuing to provide the service in-house.

3.4.9 Since private sector agencies in Scotland have no experience of supplying permanent staff to health care providers, and there is no evidence that the transfer of services to NHS Scotland is a viable option, it is recommended that the SPS retain the provision of primary care nursing services in-house.

3.4.10 It is also recommended that SPS pursues the development of a formal partnership arrangement with NHS Scotland, as this is likely to deliver significant benefits for both patients and staff.
3.5 References

- Prison Health – Transfer of Budgetary Responsibility Q & As for Governing Governors and Others.
- DNA List – The Definitive list of Licences Nursing Agencies in Scotland.
3.6 Appendices

Reasons for Transferring the Responsibility for Prison Health to the NHS

Extract from ‘Patient or Prisoner? A New Strategy for Health Care in Prisons’

- Prisoners are entitled to the same level of health care as that provided in society at large.
- It is no longer sensible to maintain a health care service for prisoners separate from the NHS.
- The NHS is a high quality, cost effective service, defining the nation’s standards for public health care. Setting these standards, assessing the nations needs for healthcare and ensuring sufficient funding and the availability of properly qualified staff to meet these needs, is often a very difficult and highly technical task.
- It is fundamentally unsound for the prison service to attempt to replicate these functions by operating independently of the NHS. There is no need for two parallel systems, and serious potential disadvantages from having two systems. For instance when two services compete to recruit from the same limited pool of doctors and nurses the smaller service is likely to lose out.
- The health care service for prisoners has tried to guard against becoming isolated and being perceived, as a ‘poor relation’ when compared to the NHS, yet this has inevitably become the result of independence. This must now be accepted and action taken to ensure there is equality of healthcare for all, whether prisoner or free.
- The vast majority of prisoners will return to the community and their healthcare will be provided by the NHS on their release. It is illogical that during the time that they are prisoners, their healthcare is provided through separate channels.
- A prisoner’s health and health care before offending has an impact on what happens in prison, both to the individual prisoner and more widely. A prisoner’s healthcare in prison can be a major factor in their well-being and chances of re-offending on release. However obvious these statements, they emphasise the interdependence of healthcare in prisons and in the wider community. Only by the NHS accepting responsibility for healthcare in prisons can two essentials equality and continuity of care be ensured.
3.6 Appendices

Benefits of Transferring the Responsibility for Prison Health to the NHS in England

Extract from 'The Future Organisation of Prison Health Care'

‘The Future Organisation of Prison Health Care’ highlighted the benefits of the NHS taking on responsibility for commissioning and providing Prison Health Care as:

- Continuity in planning between the NHS and the prison service.
- Public health issues examined and linked to wider issues local to the prison.
- Common standards between the two services.
- Continuity of health care between prison and the wider community.
- Health care staff trained to work in either prison or the NHS.
- A common system of audit and evaluation.
- A common commitment to evidence-based practice.
- A common commitment to setting and improving standards as for example in the patient’s charter.
3.6 Appendices

Summary of the Joint Working Group’s Recommendations

Extract from 'The Future Organisation of Prison Health Care'

- Prison health care should be the joint responsibility of the prison service and the NHS.

- A formal partnership between the prison service and the NHS should be established with funding and departmental accountabilities remaining broadly the same. The Prison Service should remain responsible for the primary care delivered in prisons and the NHS for community mental health and visiting NHS specialist support reaching into prisons and secondary care provided in NHS hospitals.

- Health Authorities and Prison Managers should develop local prison health improvement strategy (HIS) to form part of the wider NHS Health Improvement Programmes (HIPs). HIS should be reviewed jointly on an annual basis. Action arising from the HIS should take the form of long-term service agreements between the prison, the health authority and healthcare providers.

- Prisons and Health Authorities should jointly plan and commission the provision of needs based prison health care aiming for seamless provision between the prison and community.

- Initially these arrangements may rely heavily on the existing prison healthcare system, the group envisaged that through time the NHS would be the main provider through primary care groups and trusts. The use of the private healthcare sector should also not be ruled out where it can demonstrate quality and efficiency of care to NHS standards and integrated as appropriate with the NHS.

- A clustering of services to meet the needs of geographically related prisons or for commissioning specialist tertiary services should also be considered.
3.6 Appendices

Structured Interview with Potential Private Sector Providers

Background Information Provided

Secta has been asked to conduct a review of the Primary Care Nursing Service within the SPS. As part of this review we have been asked to conduct some market research on behalf of the SPS, and asked to look specifically at the feasibility of contracting out Primary Care Nursing to the private sector. There are 15 prisons in Scotland and this would involve providing permanent staff within all the prisons.

Questions

Is this, in theory something you may be interested in doing as a company?

- NO
  - If not, why not?
- YES
  - This would involve providing core general nurses, mental health nurses and addiction specialists within the 15 prisons in Scotland. Is this something you feel your company may have the capability of providing?
  - Do you have any evidence to support this? Do you currently provide permanent staff through contracts elsewhere?
  - If the SPS decided they wished to explore this option in more detail, would your company be willing to participate in discussions and be prepared to provide an estimate of the likely cost?
  - If so, what information would you require to provide a cost estimate at this stage?

If so, what information would you require to provide a cost estimate at this stage?
3.6 Appendices

Summary of Responses from Potential Private Sector Providers

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<th>Summary of Response</th>
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| BNA      | • BNA would be interested in providing primary care nursing staff to the SPS and would be able to provide nurses, care assistant, psychiatric nurses and addiction specialist nurses.  
• Normally supply agency staff throughout Scotland. However BNA also supply permanent staff for longer periods to the Blood Transfusion Service, and private industry. However normally these staff will be provided for a few months until they transfer to become employees of the company concerned.  
• If the SPS decided to explore this option in more detail the BNA would be willing to participate in discussions and provide an estimate of the likely cost. To provide a breakdown of the likely cost BNA would require the following information:  
• Full job description for each of the nursing roles, and locations in order to provide rates. |
| ScotNursing | • Several attempts were made to contact Scot Nursing, unfortunately Secta were unable to speak to the relevant personnel. |
| Scottish Nursing Guild (SNG) | • SNG would be interested in providing primary care nursing staff to the SPS, and would be able to provide able to provide nurses, care assistants, psychiatric nurses; and addiction specialist nurses.  
• Normally supply agency staff throughout Scotland. The longest staff placements tend to be 3-6 months. SNG do not hold and contracts to provide permanent staff on an ongoing basis.  
• If the SPS decided to explore this option in more detail the SNG would be willing to participate in discussions and provide an estimate of the likely cost. To provide a breakdown of the likely cost BUPA would require the following information:  
• the number of nurses and location;  
• details of the rota system;  
• the number of trained and untrained nurses required. |
### 3.6 Appendices

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| BUPA Nursing              | • BUPA would be interested in providing primary care nursing staff to the SPS and would be able to provide nurses, care assistants and psychiatric nurses. In BUPA’s experience addiction specialist nurses may be more difficult to provide, as there aren’t very many of them available.  

• Normally supply agency-nursing staff. The longest staff placements tend to be 6 to 10 months maximum. BUPA do not hold any contracts to provide permanent staff on an ongoing basis. BUPA also provide permanent recruitment services to place nursing staff on a permanent basis. A concern raised by BUPA is the potential difficulty in retaining staff in these roles; in BUPA’s experience staff that do take on a longer placement tend to want to change placement at the 6-10 month stage.  

• If the SPS decided to explore this option in more detail BUPA would be willing to participate in discussions and provide an estimate of the likely cost. To provide a breakdown of the likely cost BUPA would require the following information:  

• By location:  
  • the total number of nurse’s required;  
  • skill mix;  
  • total number of hours per week;  
  • shift patterns; and  
  • the proposed start date in order to develop a plan with timescales. |
| Nursing Agency Direct     | • Nursing Agency Direct would not be interested in providing primary care nursing staff to the SPS. They are currently considering closing the agency.                                                                         |
| Priory Healthcare Services| • Priory Healthcare would not be interested in providing specialist nursing staff to the SPS. They are currently concentrating on their core business of providing acute psychiatric facilities for inpatients and day case patients at their hospital site in Glasgow. However should they decide in future to move into providing medium secure facilities it may be something they would then be willing to consider. |
| BMI Healthcare Services   | • BMI Healthcare services would not be interested in providing specialist nursing staff to the SPS. The decision to consider providing such services in future would only be considered by Managing Director based in London. |
4.1 Introduction

4.1.1 The Scottish Prison Service (SPS) Nursing Services Review Group has been set up to identify the current and future requirements for nursing staff, based on the healthcare needs of the prison population, and to examine how the nursing service might best be provided, taking account of all relevant clinical, personnel and managerial issues.

4.1.2 The purpose of the Nursing Services Review is as follows:

“To provide strategic and operationally achievable options together with clear recommendations as to how SPS nursing services might be organised to best meet the nursing needs of the prisoner population, while ensuring value for money.”

4.1.3 The focus of the review is illustrated in the following diagram:

![Diagram](image)

4.1.4 Included in the brief was the requirement to:

“Carry out a validation exercise as to how primary care nursing services are currently provided”

4.1.5 This report considers the extent to which the existing SPS healthcare services meet the identified needs of prisoners and how effectively the nursing resource is utilised and deployed. It forms the basis from which the Primary Care Nursing Service Framework has been developed.
4.2 Health Screening

4.2.1 The SPS Health Care Standard requires all prisoners to undergo health screening on arrival at prison. Prisoners are also assessed when they are transferred between prisons or from an outside hospital for in-patient care.

4.2.2 There are approximately 30,000 admissions each year to the prisons in Scotland; each of these requires a healthcare assessment on admission. In practical terms this results in one or two nurses needing to undertake an examination, including a clinical risk assessment, of between approximately 10 and 30 prisoners per day within a very short period of time. This leads to the examinations not being completed to the standards required by the SPS and potential clinical risks not being identified in a timely way.

4.2.3 As previously stated, interviews with nursing staff indicate that the screening service is often very rushed and inadequate at identifying some important health problems. This is exacerbated by the lack of access to previous medical records.
4.3 Health Promotion

4.3.1 Standards for the Health Care of Prisoners set out the need for the SPS to provide services to prisoners which prevent illness, promote good health and enable them to make reasoned choices regarding the adoption of healthy lifestyles.

4.3.2 There is no specialist health promotion activity in prisons, although nursing staff promote health generically as the opportunity arises in the course of their work.

4.3.3 Prisons have worked towards delivering health promotion programme and activities. They have participated in national community led events such as World AIDS Day, Drinkwise Scotland and No Smoking Days promotion initiatives over the past years.

4.3.4 The Health Promotion Framework, launched November 2002, sets out how prisoners will be given the opportunity while in custody, to engage with services to improve their health and provide them with information to enable them to make reasoned choices on lifestyles they lead.

4.3.5 The SPS has now established new partnerships with the Scottish Executive Health Department, NHS Health Scotland and NHS Boards to develop the Framework for promoting Health in Scottish prisons to ensure that the focus on promoting health and preventing disease is carried forward in Scottish prisons.

4.3.6 As there are currently no specialist health promotion staff within SPS consideration should be given to appointing or training specialists to ensure maximum benefit is achieved from the new framework.
4.4.1 For a prisoner deciding what to do about a problem, some of the factors he/she weighs up are the same as a member of the public, e.g. how serious might the problem be, who can best deal with it? However, some aspects of this equation differ. For prisoners, there is a number of factors, which favour the use of formal care where informal care services would have been used in the community.

4.4.2 These factors include:

- Many prisoners are worried about their health and may have exaggerated concerns about the seriousness of the health problem;
- Some types of informal care are not available to prisoners e.g. access to health information, the advice of family members, over the counter medication;
- There is little of the inconvenience normally associated with using formal care in the community.

4.4.3 Several factors restrict self-care in Scottish prisons. Prisoners are not generally knowledgeable about health or self-care and information may not be available. They may have health beliefs (such as fatalism), which will limit self-help.

4.4.4 Prisoners are also necessarily isolated from their families and informal social networks. Finally, prisoners tend to become institutionalised. In other words, in prison the resources for a prisoner to manage his or her own problems are not available.

4.4.5 This means that prisoner is more likely to turn to the prison primary care services, and in particular the nursing service. The result of this is that primary care in the prisons system is over burdened with more frequent consultation for less important medical conditions than in an equivalent community setting. This causes significant problems.

4.4.6 There is clear evidence that this is the case within the SPS and that the nursing service is overstretched. This reduces the time available for the detection of important health problems and ultimately is leading to some de-skilling of nursing staff.
4.4 Self-care and Informal Care

4.4.7 Some key issues relating to informal care are shown below:

- Very limited health promotion and self-care information is available to prisoners on a routine basis. Posters and leaflets are available on a number of prison related health topics such as hepatitis and drug misuse; however, these do not tend to be directed towards encouraging self-care.

- Prisoners do not have access to NHS 24 for health advice. Although it may not be appropriate for every prisoner to have access to NHS 24, consideration should be given to pilot schemes.

- Other than paracetamol and Gaviscon, which can be supplied by prison officers, over the counter medication available with the community is not available within prisons. A large proportion of nursing time is spent administering drugs, which would be self-administered within the community; in some instances in certain establishments, an estimated 25% of nursing time could be freed up if self-medication and self-care was promoted.

- Prisoners have some access to voluntary and self help groups e.g. The Samaritans visit HMP Edinburgh. Prisoners’ value access to such services and opportunities should be created to expand this access.

- Prisoners are effectively ‘de-skilled’ whilst in prison and are less self-reliant than would be the case in the community.

4.4.8 Developing a self-care model across the service would free up a significant scale of nursing resource and would also help prepare prisoners for managing their own health needs when they are back in the community.
4.5 Primary Care

4.5.1 The Scottish Prison Service care standards specify that prisons should provide primary care services to a standard equivalent to that available from general practices in the community. This is expected to include medical consultations, referrals to secondary care, continuing care, minor surgery and trauma care, contraception services, maternity care and counselling. It is also expected to include health promotion in accordance with the health care standards.

4.5.2 Other than acute emergencies, prisoners’ health care needs and requests are managed via the nurse triage system with each prison, on a daily basis. The two main types of triage are:

- **Self-Referral Forms** – which are assessed, prioritised and actioned by nursing staff to ensure the prisoner is referred to the correct service.

- **Face to face triage with every prisoner** who has a health care need or request – which are assessed, prioritised and actioned by nursing staff to ensure the prisoner is referred to the correct service.

4.5.3 Neither of the triage systems has a standardised protocol across the prison service. This potentially exposes the systems to clinical risks.

4.5.4 Only four prisons (YOI Polmont, Greenock, Cornton Vale and Perth) apply the self-referral form method. The prisons that use the self-referral form are able to demonstrate that this encourages the prisoner to take ownership of their health care and ensures a more efficient use of nursing time.

4.5.5 The ‘face to face model’ is very medicalised and encourages prisoner dependence on the health care services within the prisons. It is clear that many of the contacts are for administrative reasons such as booking an appointment with the dentist.

4.5.6 Prisoners’ often turn to primary care services because of restrictions on self-care. Primary care consultation rates and admission to prison health care centre varied between types of prison with the rate in women prisons and high security prisons being considerably higher. The primary care consultation rate is considerably higher than that found in the community.

4.5.7 Any attempt to reduce the burden on the primary care team will increase use of informal care to deal with some of the problems usually addressed by formal services. It is therefore important to identify the reasons for primary care consultations among the prison population.

4.5.8 Unfortunately there are no comprehensive data on the diagnosis of prisoners who consult nursing staff. However, there are extensive data on the use of primary care in the community. Observations of GP sessions in prisons have confirmed that the more common reasons for consultation in the community are also important in the prison population.

Pregnancy & Maternal Care

4.5.9 Women receive their maternity care either in the prison or at a nearby hospital. Clear systems are established between the NHS and the women prisons. Liaison between the NHS midwifery services and the SPS nurses are well developed and effective in ensuring high quality care.

4.5.10 Whilst links are good, they are largely informal and are as a result of relationships built up locally. The manager of Health Care has indicated that additional work needs to be done to improve ante and postnatal care.
4.6.1 The Scottish Prison Service Health Care Standards state that specialist services should be provided within the prison, appropriate to the health care needs of the prisoners. In relation to secondary care, the principal issue that emerged during the review was access to and use of inpatient beds.

4.6.2 Prisoners have access to the full range of NHS beds provided in the community. However, in practice difficulties are experienced in gaining access to NHS in-patient beds. The two main reasons for this are:

- Difficulties in securing prison officer supervision for a prisoner while in NHS care;
- The NHS is unable to offer in-patient beds due to competing clinical needs resulting in lack of bed availability.

4.6.3 In addition, some prisons have health centre beds. These provide a less intensive level of care. The SPS has a hub and spoke bed model, with hub prisons offering an in-patient bed facility to surrounding prisons.

4.6.4 The guidelines for the use of the prison beds are not consistently applied nationally. Bed occupancy is low, with length of stay varying from 24 hours to eight weeks in one case. The case mix within the bed areas often requires to accommodate prisoners with such diverse needs as mental health, postoperative surgery patients and medical patients. However, these figures conceal wide variation in bed usage. Because of the pressures of overcrowding for example, health care centre beds are not always used for health care.

4.6.5 The hub and spoke model does not meet patients’ needs effectively and is not appropriate within a primary care model of care. Options that should be considered:

- No change to the current in-patient bed model;
- No in-patient beds within SPS;
- In-patient beds on one SPS site only.

4.6.6 Facilities should also be created within the prison halls for prisoners who are vulnerable and require a supported quiet area.

4.6.7 It is acknowledged that there are other aspects of secondary care not addressed in this report, specifically access to NHS outpatient services and the provision of ‘in-reach’ services. These issues will be considered in the context of the implementation of the new service model and the development of stronger links with NHS Scotland.
4.7 Chronic Disease Management

4.7.1 To deliver high quality chronic disease management and ensure that optimum clinical outcomes are achieved it is vital that:

- Current evidence based guidelines are applied;
- The prisoner is managed by an appropriately skilled multi professional clinical network;
- The multi professional team treat a sufficient critical mass of patients to maintain clinical skills;
- Professional education and updates are in place;
- Prisoners understand their condition and are encouraged to self manage whenever possible;
- Routine clinical audit is undertaken to evaluate the effectiveness of programmes.

4.7.2 Given the varying and often very small numbers of prisoners requiring chronic disease management within each prison, there are three main options:

- The SPS and the NHS deliver services jointly;
- The SPS sets up clinical networks across several prisons to ensure standards and critical mass are achieved;
- The NHS delivers an in-reach service.

4.7.3 The SPS needs to consider the most cost-effective means of managing chronic diseases.

Epilepsy

4.7.4 There are no SPS Health Care Standards or Clinical Nursing Guidelines relating to the care and management of prisoners with epilepsy. The Scottish Intercollegiate Guidelines Network (SIGN) has produced evidence-based guidelines on the diagnosis and management of epilepsy in adults. On reviewing a sample of case notes within each prison it became evident that this guideline is not being consistently applied across all SPS Health Care Centres.

4.7.5 Most prisoners with epilepsy will have already been diagnosed prior to imprisonment. In this case, reception screening and liaison with the patients’ GP are important in establishing the diagnosis and how epilepsy is currently being managed.

4.7.6 Only one prison, Polmont, has a nurse led clinic for epilepsy, which is run by the prison nursing staff. In view of the relatively small cohort of prisoners with epilepsy in each prison the management of epilepsy requires to be reviewed to ensure an evidence based approach is being delivered.
4.7 Chronic Disease Management

Asthma

4.7.7 As detailed in Section 4, asthma is the most common chronic disease amongst Scottish prisoners and has a significantly higher prevalence than the Scottish population. Surprisingly, only four prisons have a specialist clinic for prisoners with asthma.

4.7.8 There is a wide range of accepted guidelines available on the management of asthma. These are based on a mixture of evidence and expert recommendations. SIGN has produced evidence-based guidelines on the management of asthma in primary care. The British Thoracic Society has also produced guidelines on the management of asthma. On reviewing a sample of case notes within each prison it became evident that these guidelines are not being consistently followed across all SPS Health Care Centres.

4.7.9 As previously stated it is widely known that some groups of prisoners wish to take inhalers to add to the inhalation effect of illegal drugs. Particular caution should therefore be applied when diagnosing or confirming the diagnosis of asthma. Evidence based diagnostic tests should strictly be applied.

4.7.10 In view of the prevalence within prisons, asthma clinics should be established within each of the prisons or prisoners should have access to specialist services.

Diabetes

4.7.11 There is also a wide range of accepted guidelines on the management of diabetes e.g. SIGN and Framework. Again, a review of case notes revealed that evidence based guidelines are not being consistently followed.

4.7.12 A number of prison diabetes care studies have been reported from both prisoners and a diabetes specialist’s viewpoint. These include no access to dieticians and/or diabetes specialists, lack of self-monitoring facilities, sub-optimal diabetes care, unrecognised metabolic decompensation and self-induced Ketoacidosis in order to gain admission to outside hospitals.

4.7.13 The nurse led services and levels of expertise available within each prison vary. Only four prisons have diabetic clinics. There would appear to be varying links with the NHS specialist nurses and diabetic networks.

4.7.14 It is essential if good diabetic control is to be maintained that these prisoners have access to evidenced based care from within the SPS system or have access to shared care with the NHS.
4.7 Chronic Disease Management

Ischaemic Heart Disease

4.7.15 Prisoners have some influence over their own cardiovascular risk through their choice of diet, smoking behaviour and exercise, although the institution largely controls diet and exercise. By offering a diet low in saturated fat and salt but high in polyunsaturated fat, fruit and vegetables, prisons can influence cholesterol levels, blood pressures and risk of heart disease.

4.7.16 Many activities aimed at preventing ischaemic heart disease, such as smoking cessation programmes, are carried out in prisons. Some prisons offer well man/woman clinics, where cardiovascular risk factors are systematically investigated.

4.7.17 Extensive evidence on the management of ischaemic heart disease and cardio-vascular risk factors has been synthesised into a number of evidence-based guidelines. These have in common an increasing emphasis on estimation of the absolute risk of cardiovascular events and using this as a basis for the decision to treat.

4.7.18 The approach that only patients in whom there is reasonable chance that treatment may be offered should be screened has important implications for who should be screened for high blood pressure and raised serum lipids.

4.7.19 Among younger patients a very small proportion are at high risk of a cardiovascular event, whereas among older patients, a high proportion are at risk. What this means in practical terms is that it is likely to be unproductive screening male and female prisoners under 40 for high blood pressure or raised cholesterol. Because a higher proportion of black people have high blood pressure, it may be worthwhile screening black prisoners between the ages of 30 and 39.
4.8 Blood Borne Viruses

4.8.1 The risk of acquiring hepatitis B, hepatitis C and HIV infection can be reduced by adopting safer sexual practices and by avoiding unsafe practices such as sharing equipment by drug abusers.

4.8.2 Disinfecting tablets were re-introduced into Scottish prisons system in 1993 following a serious outbreak at HMP Glenochil, when 14 prisoners were infected with HIV and 8 with hepatitis B as a result of needle sharing. The Medical Officer can prescribe condoms if there are clinical grounds to believe that it is in the best interests of the prisoner’s health.

4.8.3 There is a specific vaccine against hepatitis B; a complete course requires three injections over a period of three months. SPS recommends immunisation against hepatitis B for all prisoners and staff as good practice. Changes to the timescales between immunisations have been made in some prisons as a result of the high turnover and transfers of prisoners. It was found that many prisoners were not having their courses completed.

4.8.4 Health Care Standard 7 addresses the area of ‘Communicable Disease’. In addition a recent collaboration between SPS, NHS Scotland and the Scottish Centre for Infection and Environmental Health, (SCIEH) has produced an Infection Control Manual across the estate.

4.8.5 Each prison has some internal resource or expertise related to the management of Blood Borne Viruses (BBV). Each prison holds clinics (the frequency of which are dependent on uptake) for BBV and all prisoners are given the opportunity for screening at admission assessment. A Health Centre Manager has recently been seconded to a new post of Infection Control Advisor for the SPS.

4.8.6 However, there is no uniformity across the service in how the BBV agenda is managed. Each prison has adapted and improvised to get the best service possible, but manages according to availability and willingness of NHS consultants or other external agencies (such as the Brownlee Centre at Gartnavel Hospital). Some prisons are fortunate and have the availability of consultants free of charge, others have entered into contractual agreements and some cannot secure a consultant resource at all because of local NHS difficulties in recruitment or the burden of work that the existing consultant has within the NHS is too high.

4.8.7 Cornton Vale reported the uptake of the BBV service as very high and have had to make adjustments in other areas to service this need.
4.9 Services for Mental Disorders

4.9.1 The current prison population is about 6,400. Surveys show that as many as 90% of prisoners have a diagnosable mental health illness, substance abuse problem or, often both. Among young offenders this figure is even higher, 95%. Mental illness can contribute to re-offending and problems of social exclusion.

4.9.2 Historically the prison service has not been effective as it could be in providing mental health services for prisoners, nor in recognising the particular mental health needs of specific groups of prisoners; women, people from minority ethnic groups and young people.

4.9.3 The SPS has recently introduced a Mental Health Strategy as a means of developing and modernising mental health services provision within the prison setting. It sets out a vision of where SPS want mental health services for prisoners to be in 3-5 years and identifies some of the issues that will need to be addressed in getting there.

4.9.4 The need to improve mental health services in prisons is one of the top priorities to emerge from this Needs Assessment and will be a key consideration in developing a specification for the SPS primary care nursing service (stage 3 of the review).
4.10 Suicide and Self-harm

4.10.1 The work of the Suicide Risk Management Inter Agency Working Group has added to a positive approach and clearly recognises that all those who come into contact with the Criminal Justice System have a part to play in identifying those who may be at risk.

4.10.2 The SPS has a Suicide Risk Management Strategy, ‘ACT to CARE’ in place. The key aim is to assume a shared responsibility for the care of those ‘at risk’ of self-harm or suicide, to work together to provide a caring environment where prisoners who are in distress can ask for help to avert crisis. The ACT to CARE approach is well supported by all staff and applied very effectively.

4.10.3 It was clear that during the prison visits that the communication and collaboration between nursing and operational staff related to suicide management impacted greatly on the success of the strategy. It would be a very positive step if other areas of the care and custody agenda received equal attention.
4.11 Services for Alcohol and Drug Misuse

4.11.1 The management and rehabilitation of substance misuse within the SPS is viewed as a key priority. The SPS addictions strategy sets out four clear aims:

- To keep illicit substances of misuse out of prison, including drugs, alcohol and volatile substances, meeting the public’s expectations of secure custody;

- To bring substance misusing prisoners into an effective treatment process, taking advantage of the opportunity offered by imprisonment to engage with those often excluded from, or not yet ready to access, other services;

- To keep substance misusing prisoners in contact with addictions treatment, enhancing and consolidating the opportunity offered by imprisonment to engage with them;

- To manage effective transition between prison and community, locking-in the gains made and improving inclusion opportunities after release.

4.11.2 A range of treatment options is available to prisoners at different stages of their sentence. Treatment is delivered by a multi-disciplinary team within the context of an individualised care plan, based on assessed needs. Options for very short sentenced prisoners include addictions assessment, methadone maintained, 1:1 work and harm reduction.

4.11.3 Prison standards for entry into or maintenance on the methadone programme are a challenge for some prisons that are faced with having to deal with community prescribing habits.

4.11.4 Many prisons with an experienced addictions nurse who are supported by community colleagues are developing their own sub protocols to manage local issues and challenges. This can have the effect of prisoners who are transferred between prisons for various reasons being exposed to and having preferences for certain regimes. This creates programme management tensions within and between prisons.
## 4.12 Summary of Key Issues

### Self Care
- If minor illnesses continue to account for the bulk of health care consultations within prisons, how is the service going to meet the prisoners real health needs? The model of care needs to change significantly.
- Ways to increase the availability of health promotion and self-care information must be found.
- What models of care can be introduced to reduce the nursing time on semi informal care? Enhanced primary care skill mix requires to be introduced e.g. pharmacy services and health care assistants.
- Developing a self-care model across the service would free up a significant scale of nursing resource.

### Primary Care
- It is recommended that the self-referral triage model should be applied across all Scottish prisons.
- The self-referral triage system must be confidential and meet the needs of prisoners with learning difficulties.

### Secondary Care
- Health Care staff and governors should actively develop links with the secondary care providers.
- The future SPS bed model should be reviewed and changed to ensure effective and safe care.
- In order to enhance physical access to secondary services new escort workforce plans should be agreed and implemented (necessitating a review of the escort contract).

### Health Screening
- The health screening process is often rushed and incomplete due to time constraints and the volume of prisoners.
- The volume of prisoners requiring health screening will continue to rise.
- The screening process requires to be reviewed and redesigned by all those involved.

### Mental Health
- Not all prisons have dedicated mental health teams to manage the specialist mental health care needs of prisoners.
- The education and supervision of mental health nurses varies across the prison service.
- Evidence based mental health guidelines are not being consistently applied across the SPS and there is limited evidence of a multi professional approach to mental health care.
- Prisoners have limited access to secondary care services, particularly, inpatient services and there is limited evidence of jointly working with the NHS.
- The need to improve mental health services in prisons is one of the top priorities to emerge from this Needs Assessment and will be a key consideration in developing a specification for the SPS primary care nursing service (stage 3 of the review).
4.13 Notes

I. The Health Promoting Prison. A Framework for Promoting Health in the SPS. SPS. 2002
III. Diagnosis and Management of Epilepsy in Adults: a Quick Reference Guide, SIGN Publication No.21, November 1997
V. Thorax (1997); 52 (suppl. 1) and Thorax (1993); 48 (2) S1-S24
5.1 Introduction

5.1.1 The Scottish Prison Service (SPS) Nursing Services Review Group has been set up to identify the current and future requirements for primary care nursing staff, based on the healthcare needs of the prison population, and to examine how the primary care nursing service might best be provided, taking account of all relevant clinical, personnel and managerial issues.

5.1.2 The purpose of the Nursing Services Review is as follows:

“To provide strategic and operationally achievable options together with clear recommendations as to how SPS nursing services might be organised to best meet the nursing needs of the prisoner population, while ensuring value for money.”

5.1.3 The first stage of the project, the ‘Needs Assessment’, was undertaken from August 2002 to January 2003 and included;

- A detailed assessment of the healthcare needs of prisoners
- An assessment of the extent to which the existing model of nursing service provision meets the healthcare needs of prisoners and makes best use of the resources available
- Recommendations for the main areas of work for the next stage of the project

5.1.4 Following approval of the stage 1 report by the Executive Group, the Nursing Services Project Board has been charged with developing a detailed service specification for primary care nursing services within SPS. In order that such a specification can be produced the Project Board has drawn up this Service Framework, which sets out the long-term strategic direction for primary care nursing. The Service Framework provides a policy context within which decisions concerning the shape of the service at a local level can be made. It also sets out the Scottish Prison Service’s proposed strategy for addressing the key nursing development issues.

5.1.5 The Service Framework, which will be implemented over the next three years, aims to help nurses to respond positively to new opportunities and establish the conditions for satisfying and rewarding careers. It provides strategic direction and is aimed at facilitating the implementation of the SPS Nursing Review.

5.1.6 This document should be considered in conjunction with the following papers from the first stage of the Nursing Services Review:

- Healthcare Needs Assessment
- Service Provider Option Appraisal
- Assessment of Current Services
5.2 Healthcare in the Scottish Prison Service

Overview

5.2.1 This section describes the overall provision of healthcare services to prisoners in Scotland and thus provides the context for the Primary Care Nursing Service Framework.

Core Principles & Philosophy

SPS Mission Statement

5.2.2 The Mission Statement of the Scottish Prison Service is:

- To keep in custody those committed by the courts;
- To maintain good order in each prison;
- To care for prisoners with humanity; and
- To provide prisoners with a range of opportunities to exercise personal responsibility and to prepare for release.

SPS Values

5.2.3 The Values of the Scottish Prison Service are:

- Integrity, frankness and honesty in dealing with people;
- Fairness and justice, respecting the needs and rights of staff and prisoners;
- Mutual support, encouraging teamwork and commitment;
- Caring for the safety and well-being of staff and prisoners; and
- Openness about our aspirations, our successes and our failures, coupled with the willingness to learn.

5.2.4 Goal 5 of the Scottish Prison Service states that as a Service, we all:

- Live our Values;
- Commit ourselves to our Mission;
- Work with each other and related organisations to achieve our goals;
- Feel competent and confident;
- Know that our contributions are effective and valued; and
- Use our resources wisely and well.
5.2 Healthcare in the Scottish Prison Service

Healthcare Service Aims

5.2.5 The SPS aims to:

- Provide a range of primary care services to prisoners, including medical, nursing, dental and pharmaceutical care;
- Provide a responsive service that meets the needs of prisoners suffering from mental health problems;
- Ensure that appropriate through-care arrangements are put in place for prisoners both on reception to, and liberation from custody;
- Provide services to prisoners that may prevent illness and promote health and give opportunities to enable reasoned choices to be made regarding the adoption of a healthy lifestyle;
- Encourage self-care among prisoners, enabling them to take responsibility for their own health and well-being;

5.2.6 Prisoners are entitled to:

- The same quality and range of health services to which they would be eligible in the community;
- A comprehensive health assessment on reception into prison from the community;
- Testing for, and the management of, blood borne viral infections;
- Immunisation against communicable diseases such as Hepatitis B, Hepatitis A, Meningitis C, and rubella;
- Substitute and detoxification prescribing for those who have problems with drug misuse.

5.2.7 The SPS values its workforce and aims to ensure that nursing staff are:

- Able to make effective use of their skills and experience
- Working in a safe and appropriate environment
- Given the appropriate training and professional development
- Provided with opportunities to progress their career within SPS

5.2.8 Nursing Staff within the SPS (at all grades) will be given encouragement to develop Clinical Support networks, which will support staff through their daily professional work.
5.2 Healthcare in the Scottish Prison Service

Demand for Healthcare Services

5.2.9 The scale and structure of healthcare services within the SPS are driven by the demand for healthcare services, which is in turn influenced by the size and mix of the prison population, the geographical distribution of the different types of institution and the healthcare status and needs of prisoners. This section summarises these factors, with more detailed information being contained in the separate Healthcare Needs Assessment and Assessment of Current Services reports.

The Scottish Prison Population

5.2.10 There are currently sixteen prison establishments in total, fifteen of which are directly managed by the Scottish Prison Service, and one managed by a private contractor. The prison estate is diverse, comprising of establishments of varying sizes, which serve different roles. The prisons have a widely distributed geography, the majority of which are within the central belt of Scotland.

5.2.11 Prisons are primarily classified by age, sex, status (remand/convicted) and length of sentence. There are separate prison facilities for male and female prisoners, and separate institutions generally serve the needs of young offenders and adults.

5.2.12 The following table provides a breakdown of the current prison population by site and category (for the 15 SPS-run prisons);

Figure 2 - 1: Scottish Prison Population as at 15 August 2003

<table>
<thead>
<tr>
<th>Prison</th>
<th>Category</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aberdeen</td>
<td>Local</td>
<td>237</td>
</tr>
<tr>
<td>Barlinnie</td>
<td>Local &amp; LTP Reception</td>
<td>1,071</td>
</tr>
<tr>
<td>Castle Huntly</td>
<td>LTP</td>
<td>159</td>
</tr>
<tr>
<td>Cornton Vale</td>
<td>Female</td>
<td>255</td>
</tr>
<tr>
<td>Dumfries</td>
<td>Local</td>
<td>194</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>Local</td>
<td>703</td>
</tr>
<tr>
<td>Glenochil</td>
<td>LTP</td>
<td>494</td>
</tr>
<tr>
<td>Greenock</td>
<td>Local &amp; Female</td>
<td>313</td>
</tr>
<tr>
<td>Inverness</td>
<td>Local</td>
<td>145</td>
</tr>
<tr>
<td>Low Moss</td>
<td>STP</td>
<td>303</td>
</tr>
<tr>
<td>Noranside</td>
<td>LTP</td>
<td>134</td>
</tr>
<tr>
<td>Perth</td>
<td>Local / Mixed</td>
<td>653</td>
</tr>
<tr>
<td>Peterhead</td>
<td>SO (LTP)</td>
<td>314</td>
</tr>
<tr>
<td>Polmont</td>
<td>YOI</td>
<td>619</td>
</tr>
<tr>
<td>Shotts</td>
<td>LTP</td>
<td>463</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>6,057</strong></td>
</tr>
</tbody>
</table>
5.2 Healthcare in the Scottish Prison Service

Projected Trends

5.2.13 Projections of average daily prisoner populations, which are based on trends observed over a period of 10 years, are shown below. The figure shows a projected growth of 25% over the next ten years.

5.2.14 This increase will also be reflected in the transient population, i.e. new prisoners and those moving from one establishment to another. Currently there are approximately 30,000 admissions each year to prisons in Scotland, each of whom requires a healthcare assessment. It is reasonable to assume that this group will also increase by approx 25%, i.e. to 36,000. Of the 30,000 admissions, approximately 5,500 are first-time prisoners.

5.2.15 This continued growth in the prison population and the resulting increase in health care activity have significant implications for the future model of health care and its staffing requirements. The detailed service specification that will be developed for the primary care nursing service will address the impact of the rising prison population.

Figure 2-2: Projected Prisoner Population

Projected daily average number of prisoners

Source: SPS Business Plan 2001
5.2 Healthcare in the Scottish Prison Service

Healthcare Needs Assessment

5.2.16 A key feature of the Primary Care Nursing Service Framework is that it is needs led, i.e. the services provided are directly and proportionately focussed on the most prevalent and significant health problems.

5.2.17 The main findings of the healthcare needs assessment are as follows (full details are contained in a separate report):

- Minor illnesses account for the bulk of consultations with nursing and medical staff in the prison population.
- In general the physical health of prisoners is worse than that of the people of equivalent age in the general population.
- Around a quarter of adult prisoners engage in activities likely to put them at risk of infection with HIV, Hepatitis B or Hepatitis C.
- There are a number of health problems and needs that are specific to women in prison. These include maternity care, gynaecology and care of babies in prison, as well as a range of health education services such as family planning.
- Estimates indicate that the rate of psychological disturbance and personality disorder is twice as high as in the general population.
- Prisoners tend to suffer from more than one mental health problem. Those with more serious neurotic disorders are more likely to suffer from functional psychosis and personality disorders. Alcohol and drug misuse also tends to be associated with personality disorders.
- Prisoners tend to have below average levels of intellectual functioning
- Suicide rates are generally higher in prisons than in the community.
- Many young offenders have temperamental, emotional and behavioural problems that manifest as self-harm and suicidal behaviour.

5.2.18 The healthcare needs assessment exercise has formed the basis from which the new service model for primary care nursing has been developed. The SPS will continue to monitor the healthcare needs of prisoners to ensure that the primary care nursing service maintains the appropriate focus.

Organisation & Delivery of Healthcare Services

5.2.18 The primary health care of prisoners is funded and organised separately from the National Health Service (NHS) and is the responsibility of the SPS.

5.2.19 The NHS is responsible for funding and delivering secondary and tertiary care to prisoners. The NHS also delivers in-reach services within prisons, such as visiting consultants and specialist nursing services. These services vary from one prison to another and arrangements with the NHS are made locally.
5.2 Healthcare in the Scottish Prison Service

5.2.20 The healthcare services provided within Scottish prisons are shown in Figure 2-3.

**Figure 2 - 3: Current Model of Health Care Provision**

<table>
<thead>
<tr>
<th>Core Services</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care nursing</td>
<td>Scottish Prison Service</td>
</tr>
<tr>
<td>Medical services</td>
<td>Medacs (private contractor)</td>
</tr>
<tr>
<td>Pharmaceutical services</td>
<td>Moss Pharmacy (private contractor)</td>
</tr>
<tr>
<td>Dental services</td>
<td>Individual contract with practitioner held by each prison</td>
</tr>
<tr>
<td>Optician</td>
<td>Individual contract with practitioner held by each prison</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Optional/ Additional Services</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychology</td>
<td>SPS service available for group sessions in some prisons</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>Individual contract with NHS Scotland Trusts held by some prisons</td>
</tr>
<tr>
<td>Chiropody</td>
<td>Individual contract with NHS Scotland Trusts held by some prisons</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>Individual contract with NHS Scotland Trusts held by some prisons</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>Individual contract with NHS Scotland Trusts held by some prisons</td>
</tr>
</tbody>
</table>

**In-Patient Facilities**

5.2.21 The SPS has a hub and spoke in-patient bed model with each hub prison offering an in patient bed facility to surrounding spoke prisons.

5.2.22 Figure 2-4 details the prisons and the number of in-patient beds. The purpose, usage and required complement of in-patient beds are currently under review.

**Figure 2 - 4: Location and Numbers of In-Patient Beds**

<table>
<thead>
<tr>
<th>Prison</th>
<th>Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barlinnie</td>
<td>18</td>
</tr>
<tr>
<td>Perth</td>
<td>10</td>
</tr>
<tr>
<td>Polmont</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
</tr>
</tbody>
</table>

5.2.23 The first stage of the review highlighted some issues concerning the use of and need for inpatient facilities within Scottish prisons. The SPS has therefore initiated a specific review of in-patient facilities - detailed below are the options that have been considered as part of the in-patient bed review:

- No change to the current in-patient bed model;
- No in-patient beds within SPS;
- In-patient beds on one SPS site only.
5.2 Healthcare in the Scottish Prison Service

5.2.24 As part of the review process views are being sought from Prison Governors on the potential impact of having in-patient beds on only one site. It is believed that such a bed model will have the following benefits:

- Strategic fit with SPS primary health care model;
- Improved utilisation of nursing staff skills;
- Facilities are fit for purpose;
- Provides value for money for the taxpayer;
- Nursing resources are realigned to meet specific healthcare needs.

5.2.25 It is the recommendation of the Nursing Services Review Group that SPS in-patient beds should be provided in one unit, designed specifically for that purpose and located in a central area. The unit should be a national facility and therefore be under the management of the Head of Health Care. There should be detailed protocols governing the use of the in-patient beds and the arrangements for any follow-up care required.

5.2.26 A consultation process with regards to the future provision of in-patient facilities within the Scottish Prison Service is currently underway. If, following this exercise, it is agreed that there will be a change to the configuration of SPS in-patient facilities, a detailed implementation plan will be developed. This will address such issues as the location of in-patient beds and any required staffing changes.

Future Developments in the Scottish Prison Service

5.2.27 On 5 September 2002, the Deputy First Minister and Minister for Justice announced the outcome of the Consultation period following publication of the Scottish Prisons Estates Review on 21 March. There are plans for 2 new prisons in Scotland, one of which will be a Private Build / Private Operate establishment. The second prison may be taken forward in the public sector or as a privately built, publicly operated prison providing the Ministers are content that the proposals offer value for money to the taxpayer, that they are affordable and that they will deliver.

5.2.28 New House blocks, with integral healthcare facilities, are being developed in the following establishments:

- HM YOI Polmont
- HMP Perth
- HMP Glenochil
- HMP Edinburgh

5.2.29 The new health care facilities will have the benefits of enhancing the efficiency of nursing time and reducing the need for prisoners to be transferred to health care centres for treatment and care.
5.3 The Primary Care Nursing Service

Overview

5.3.1 This section focuses specifically on the primary care nursing service, explaining its purpose, objectives, scope and role within the overall delivery of healthcare to prisoners in Scotland. It also describes the proposed new service model.

Vision

5.3.2 Set out below is a new vision for the future of nursing within the SPS, and for the people working as nurses:

<table>
<thead>
<tr>
<th>SPS Vision for Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective evidence based health care that meets the needs of prisoners, delivered by highly skilled, well supported and motivated nursing staff</td>
</tr>
</tbody>
</table>

Objectives of the Service

5.3.3 The roles of the service are to co ordinate prison healthcare services and provide primary care nursing services to prisoners.

5.3.4 The objectives of the primary care nursing service within the SPS are described below:

- Co ordinate the health services required by the prisoners;
- Ensure the network of healthcare services are in place;
- To promote the prisoner self care model where appropriate;
- To deliver primary care nursing services to prisoners, including specialist primary care, mental health and additions services;
- To promote and deliver evidence based nursing care;
- Assure quality service by developing a comprehensive approach to Clinical Governance;
- To monitor performance against service agreements;
- Healthcare Services provided by the SPS are directly focussed on the most prevalent and significant healthcare problems of our prisoner-patient population.

The Scope of the Service

5.3.5 The scope of nursing service covers a range of services and tasks, as detailed opposite:
5.3 The Primary Care Nursing Service

Figure 3 - 1: Scope of Service

Primary Care Nursing Services in SPS

- Health assessment on admission to prison or transfer from another prison
- Health promotion;
- Health screening and follow on treatments, such as immunisations;
- Co ordination of the triage system;
- Treatment of minor illness and injuries;
- Drug prescription and administration;
- Chronic disease management;
- Emergency response;
- Dedicated mental health nursing services – primarily offering assessment and 8-10 week programmes of care;
- Dedicated addictions nursing services – coordinating the clinical aspects of the addictions service;
- Liaison with NHS clinical staff to support the delivery of secondary care services in the health care centres;
- No night duty nursing services other than prison health care centres with in-patient beds

Administration of Medications

5.3.6 There is a strong view that consideration should be given to increasing the level of self-medication and developing an enhanced ‘community pharmacy model’ which would release nursing time.

5.3.7 The need to meet both legal and financial requirements for ordering and receipt of medicines has resulted in a very paper-weighted system. Consideration needs to be given to an alternative approach. Moving to a fully electronic system, based on Electronic Transfer of Prescriptions (ETP) being piloted by NHS Scotland provides a potential future solution.

5.3.8 Considerable and valuable nursing resources are required to meet the current demands of administering both the ‘general’ and supervised medications. An alternative approach needs to be sought that would release nursing staff and allow them to be engaged in more productive direct nursing care. HMPS is considering introducing a policy that would make in-possession supply the normal situation, with Medical Officers having to justify supervised administration for any medicines. The SPS should consider this position, or wait for HMPS to publish its policy and then bring theirs into line.

5.3.9 The ordering, receipt, storage and supply or administration of medicines to prisoner-patients is a very time consuming activity. Currently, it occupies an unnecessarily large proportion of nursing time, and is a major factor in nursing staff leaving the SPS. Consideration needs to be given to alternative approaches in the supply of these services. Essentially, this is a skill mix issue, which could be addressed by employing suitable support staff in establishments and could, in the longer term, be considered for inclusion in the contract for pharmaceutical services.
5.3 The Primary Care Nursing Service

The Primary Care Nursing Service Model

5.3.10 The proposed new nursing service model for primary care is shown in the diagram below. The model relates the provision of nursing services to the healthcare needs of the prisoners and facilitates the flexibility required to ensure that the necessary nursing skills are effectively applied.

5.3.11 The formalised, consistent specialist team model is designed to:

- Provide a service focussed on the most significant healthcare needs
- Ensure equity of access to services across SPS
- Deliver improved clinical outcomes
- Utilise nurses’ specialist skills more effectively
- Provide opportunities for shared learning and peer review
- Enhance recruitment and retention
- Facilitate integration with the relevant NHS Scotland services
5.3 The Primary Care Nursing Service

Nursing Roles
5.3.12 The main tasks for the distinct roles outlined in the service model are summarised below:

Figure 3 - 3: Proposed Nursing Roles

<table>
<thead>
<tr>
<th>Role</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generic Role</strong></td>
<td>• Assessment, care planning, management of prisoner health needs</td>
</tr>
<tr>
<td>(For all nursing staff)</td>
<td>• Record keeping</td>
</tr>
<tr>
<td></td>
<td>• Communication with multi professional teams</td>
</tr>
<tr>
<td></td>
<td>• Education, audit and research</td>
</tr>
<tr>
<td></td>
<td>• Link with the NHS</td>
</tr>
<tr>
<td></td>
<td>• Health promotion</td>
</tr>
<tr>
<td></td>
<td>• Public health</td>
</tr>
<tr>
<td><strong>Specialist Primary Care Nurse</strong></td>
<td>• Admission screening</td>
</tr>
<tr>
<td></td>
<td>• Co-ordination of triage</td>
</tr>
<tr>
<td></td>
<td>• Treatment of minor illness and injuries</td>
</tr>
<tr>
<td></td>
<td>• Emergency response</td>
</tr>
<tr>
<td></td>
<td>• Chronic disease management</td>
</tr>
<tr>
<td></td>
<td>• Administration of routine medication, i.e. injections, Controlled Drugs etc.</td>
</tr>
<tr>
<td><strong>Mental Health Nurse and Addictions Nurse</strong></td>
<td>• Assessment and management of mental health needs via daycare, therapeutic counselling and group work</td>
</tr>
<tr>
<td></td>
<td>• Assessment of personality disorders and learning disabilities</td>
</tr>
<tr>
<td></td>
<td>• Dual diagnosis, assessment and treatment, in partnership with Addiction Nurse Service.</td>
</tr>
<tr>
<td></td>
<td>• Liaison with NHS Mental Health Teams (Throughcare etc.)</td>
</tr>
<tr>
<td></td>
<td>• Provide detoxification support and advice</td>
</tr>
<tr>
<td></td>
<td>• Link with the mental health teams, drug action teams and Cranstoun workers</td>
</tr>
<tr>
<td></td>
<td>• Assess and identify patient need</td>
</tr>
<tr>
<td></td>
<td>• Implement treatment plans and group work etc.</td>
</tr>
</tbody>
</table>
5.3 The Primary Care Nursing Service

5.3.13 A high-level assessment of the potential financial impact of moving to a new service model has been undertaken by the external consultants supporting the Nursing Services Review. This assessment indicates that the implementation of specialist roles and teams can be achieved within the current budget for primary care nursing.

5.3.14 The reduction in the number of in-patient beds/facilities, the ending of night duty, the introduction of a prisoners’ self-care model and the transfer of non-nursing duties to administrative staff will free up primary care nursing resources to enable the implementation of new roles and service models.

5.3.15 The process and timescales for implementing this service model, and the new nursing roles, are explained in section 9 of this document.
5.4 Developing the Nursing Workforce

Overview

5.4.1 The nursing profession within the SPS is central to the delivery of an effective health care service. Nurses provide and co ordinate the SPS healthcare service 365 days per year. Their contribution is crucial to the delivery of high quality care and treatment in the SPS, and to the success of health promotion and illness prevention.

5.4.2 The SPS values the contribution of the nurses and wants to improve their education, their working conditions and their prospects for satisfying and rewarding careers.

The Changing Context for SPS Nursing

5.4.3 Following the consideration of a number of options for the future provision of the SPS nursing service it has been confirmed that the service will continue to be provided in house. It is however recognised that there will be enhanced networking with the NHS nursing services.

5.4.4 The context of nursing care is changing within the SPS; therefore a Strategic Development Plan is required to respond to changes in the prison health care service and to the changing patterns of prisoners health needs.

Projected Prisoner Population Trends

5.4.5 The Needs Assessment, which details the prisoners future health needs and trends, emphasised that the prisoner population is projected to grow by a further 25% over the next ten years.

5.4.6 This continued growth in the prison population and the resulting increase in health care activity have significant implications for the future model of health care and its staffing requirements.

Healthcare Needs are Changing

5.4.7 The first stages of the Nursing Services Review included details of the key health needs of Scottish prisoners. A key feature of the Primary Care Nursing Service Framework is that it is needs led, i.e. the services provided are directly and proportionately focussed on the most prevalent and significant health problems.

5.4.8 The nurses must be able to adapt their practice to reach and target these groups. For many nurses it means more working across organisational boundaries and with other health care providers to forge alliances and develop innovative health strategies and approaches.

5.4.9 There will be increasing emphasis on integrated care, chronic disease management, disease prevention and on encouraging and supporting healthy lifestyle choices and prisoner self-care.

Technology is Changing

5.4.10 The SPS nursing service will benefit from improved information management and technology. Nurses will be able to access electronic patient records and libraries, which included the latest guidelines and evidence on which to base their practice decisions.
5.4 Developing the Nursing Workforce

The SPS Health Care Service is Changing

5.4.11 It is anticipated that a number of changes in the delivery of practice will have to be considered in order to meet the changing needs of our health care service.

5.4.12 The Review has highlighted the need to consider increasing the level of self-medication and developing an enhanced community pharmacy model, which would potentially release valuable nursing time.

5.4.13 Potential changes in service delivery include:

- Strengthening In-Possession supply of medication to prisoners
- Electronic Transfer of Prescriptions
- Supply and Administration of medicines by employing suitable support staff in establishments
- Treatment of Minor Ailments and Injuries by Nursing staff (i.e. Group Protocols)

Changing Roles within Nursing

5.4.14 Nurses have a strong tradition of adapting to changes in society and of responding positively to new health care needs.

5.4.15 The implementation of the SPS Nursing Review will have a significant impact on the roles of nursing staff based in the prison health centres.

5.4.16 Most fundamentally the promotion of the prisoner ‘self-care’ model and the modernisation of the nurse triage system will enable nursing skills and time to be reapplied to specific roles targeted at meeting the prisoners greatest health needs. These include:

- Specialist primary care nursing, including chronic disease management;
- Specialist mental health teams;
- Specialist addictions services.

Constraints and Limitations

5.4.17 The context of care is changing but nurses are often constrained and that limits development and innovation. The SPS needs a modern and responsive workforce of well-motivated, well-trained professionals equipped to respond to the challenges ahead.

Recruitment and Retention

5.4.18 More people must be attracted into the SPS nursing service. In recent years the SPS has suffered shortages of nurses and the workforce is aging. The nursing shortages experienced have caused difficulties in delivering the required standards. Therefore, the profession needs to be reviewed and renewed.

5.4.19 The SPS need to recruit sufficient numbers not only to remedy shortages, but also to enable the flexible conditions expected of a modern service, and to offer nurses the scope to provide care to the professional standards expected.
5.4 Developing the Nursing Workforce

Education and Training

5.4.20 Life long learning is no longer a slogan, and access to education and development is no longer an aspiration for the few, but a necessary part of the job and career. Nurses have to be educated and reeducated to maintain their competences to match current and future health care requirements within the SPS.

Pay and Careers

5.4.21 In order to retain and recruit the necessary nursing staff the pay and career structure will require to be modernised, taking cognisance of the NHS’s framework and Agenda for Change.

Working Lives

5.4.22 In recent years, the SPS has actively worked towards improving the working lives of staff within the organisation. These policies continue to be reviewed and developed.

Agenda for Action

5.4.23 The SPS has to modernise working arrangements and progress through learning and development.

5.4.24 In order to realise the full potential that nurses have to offer, the SPS needs to focus on:

- Developing new roles, and a modern pay and career structure;
- Recruiting more nurses;
- Enhancing clinical governance;
- Strengthening education and training;
- Strengthening nursing leadership;
- Improving working lives.

5.4.25 The plans in respect of each of these are set out in the chapters to follow. They provide a clear account of the development intentions.

5.4.26 The developments proposed and the subsequent actions will enable nurses to face the challenge of change and to continue to make a difference within the SPS health care service.

Developing the Nurse Staffing Structure

5.4.27 The present nursing structure is limited in its design and does not meet the challenges facing a modern Healthcare organisation. A more flexible career structure that supports not only the delivery of a patient centred approach, but the aspirations and career developments of the nursing workforce is essential to recruit and retain the calibre of professional nursing staff required to deliver high quality care throughout the SPS.

5.4.28 The Nursing Review provides the opportunity for a modern career framework for SPS nurses and will help provide a more satisfying and rewarding career.
5.4 Developing the Nursing Workforce

5.4.29 The posts should be structured to strengthen the professional leadership and will be designed around plans for better health outcomes and improving the quality of services.

5.4.30 The nursing structure will be reviewed taking cognisance of the principles as detailed in figure 4.3 below. The over-riding principle to emerge from the Nursing Services Review is that primary care nurses within the SPS must be able to focus on nursing duties – administrative duties should be carried out by non-clinical staff and prisoners should be supported with self-care. The clarification and development of the primary care nursing structure will be based firmly on this principle.

**Figure 4 - 3: Nursing Structure Principles**

<table>
<thead>
<tr>
<th>Principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Flexible and modern career structure;</td>
</tr>
<tr>
<td>• Redesign of roles;</td>
</tr>
<tr>
<td>• Improved skill mix;</td>
</tr>
<tr>
<td>• Specialist roles;</td>
</tr>
<tr>
<td>• Individual and geographical responsibilities;</td>
</tr>
<tr>
<td>• Career pathways and progression;</td>
</tr>
<tr>
<td>• Leadership;</td>
</tr>
<tr>
<td>• Specific support and/or posts for professional conduct matters, practice development (both locally and at HQ), preceptorship and support of students;</td>
</tr>
<tr>
<td>• Flexible entry points;</td>
</tr>
<tr>
<td>• Nursing and general management roles.</td>
</tr>
</tbody>
</table>

5.4.31 A short life-working group including both RCN and POA(s) Representatives needs to be established to develop a future nursing structure that represents a modern flexible career that clearly supports Clinical Governance and ensures that nursing within the SPS is seen as a real alternative to the NHS.

5.4.32 In relation to pay, given the considerable work presently undertaken by the NHS within the Agenda For Change remit, it would benefit the SPS to review its recommendations and support a structure akin to it.

**Recruitment and Retention**

5.4.33 Increasing the numbers of trained nurses coming into the SPS is vital. The SPS needs more nurses to address current shortages and to keep pace with the demands of providing an effective and accessible nursing care service for prisoners.

5.4.34 The SPS is suffering, as is the NHS, from a reduction in the availability of qualified nursing staff.
5.4 Developing the Nursing Workforce

5.4.35 Fortunately, all evidence suggests that nursing within the SPS remains a highly attractive career. However, given the national recruitment problems within the nursing profession, there is a need for a sustained approach to attract more nurses into the SPS.

Sustained Recruitment Campaigns

5.4.36 Recruitment to the SPS has to be comprehensive and multi faceted if it is to attract the necessary workforce to sustain the service needs in the future.

5.4.37 Previous campaigns have been successful, however, there is now a requirement for a sustained campaign.

5.4.38 Future campaigns will include:

- Recruitment Fairs;
- Dedicated web site;
- Secondments to and from the NHS;
- Return to practice support;
- Cadetships;
- Targeting staff being discharged from the Armed Forces;
- Nursing Banks and Agencies;
- Joining forces with NHS Regional Recruitment Centres.

5.4.39 In addition return to practice funding, similar to that offered to the NHS, will be sought.

Improved Systems of Workforce Planning

5.4.40 It is vital that service planning, the workforce and resourcing are joined up at all levels of the organisation. The contribution made by nurses within the SPS should be maximised.

5.4.41 An integrated workforce planning system will be developed within the SPS in order to enhance operational and strategic planning.

5.4.42 In some prison settings a richer skill mix will be required to achieve the required standards, cost effectiveness and satisfactory health outcomes. In others support workers will be able to play a more significant role, subject to proper training and supervision.
5.4 Developing the Nursing Workforce

Improving Working Lives

5.4.43 In recent years, the SPS has actively been working towards improving the working lives of staff within the organisation. Policies that are currently in place include:

- Career Breaks;
- Part Time Working;
- Special Leave Policy and;
- Internal Mediation Facilities

5.4.44 Currently, the Special Leave Policy is under review. There are plans to consider the development of a “Parenting Policy”, but this is in the early draft stages. Other policies aim to address Standards of Behaviour and Victimisation, Bullying & Harassment which all aim to improve the working lives of staff within the organisation.

5.4.45 All staff are actively encouraged to approach their Line Manager with any concerns or questions they may have in relation to their working lives. Advice can also be sought from the Equality and Diversity Unit based within Headquarters.
5.5 Professional Development

Overview

5.5.1 The scope of the Nursing Services Review included assessing the extent to which the Scottish Prison Service is fully addressing the key professional issues for primary care nursing staff. This section of the Service Framework explains how the SPS will continue to respond to the needs of nurses in relation to Clinical Governance, Life-Long Learning, Continuous Professional Development and Training.

Clinical Governance

5.5.2 Clinical governance is about openness, admitting and learning from mistakes to prevent reoccurrence, rather than the culture of blame that in some instances has occurred in some organisations where mistakes are concealed for fear of consequences.

5.5.3 The nursing service will be supported to develop a strong quality orientation focussing on standards development, monitoring and audit methodologies, and increasing evidence based care. Their practice will be guided by profession self-regulation supported by Clinical Support and by the CPD associated with mandatory periodic registration.

5.5.4 These activities need to be developed, strengthened and linked to annual appraisal and personal development plans.

5.5.5 In order to achieve evidence based quality care through a Clinical Governance framework, consideration should be given to enhancing the Nursing Services by introducing Lead Nurse and Practice Development posts. This will not only support the effective delivery of care, but also offer staff the opportunity to progress their career in a modern healthcare environment consistent with our NHS colleagues.

5.5.6 These posts should be structured to strengthen the Professional Leadership and will be designed around plans for better health outcomes, and improving the quality of services.

Clinical Governance Framework

5.5.7 The SPS introduced a Clinical Governance Guide for managers and health care practitioners. This approach now requires to be further developed and supported within the SPS.

5.5.8 The purpose of clinical governance in the SPS will be to ensure that prisoners receive high quality and evidence based clinical care. The revised clinical governance framework will promote a learning organisation environment across the following areas:

- Clinical risk management;
- Clinical audit;
- Research and effectiveness;
- Staffing and management;
- Education, training and continuing professional development;
- Use of information from outcomes and process measures.

5.5.9 The revised framework will also address the accountability and responsibility for clinical governance across the SPS structure, and the necessary support and facilitation required.
5.5 Professional Development

Life-Long Learning and Continuing Professional Development

5.5.10 The vision for continuous quality improvement and the introduction of clinical governance rests on a clear commitment to continuing professional development and lifelong learning by the nurses and the SPS.

5.5.11 The SPS is committed to the introduction of personal development plans linked to performance appraisal and organisational objectives.

5.5.12 There is clear recognition of the need for more flexible mechanisms and structures for Continuing Professional Development (CPD) for nurses. In planning and providing CPD, the SPS wishes to ensure that it is:

- Purposeful and prisoner centred;
- Targeted at identified education needs;
- Educationally effective;
- Part of the organisational development plan in support of the local and national key performance indicators;
- Focuses on the development needs of clinical teams across professional and service boundaries;
- Designed to build on previous knowledge, skills and experience;
- Meets clinical support requirements; and
- Designed to enhance the skills of interpretation and application of knowledge based on research and development.

5.5.13 CPD programmes need to meet local service needs as well as the personal and professional development needs of individuals. Flexible approaches are required to better support changing roles and career pathways and to foster professional ownership.

5.5.14 The learning that takes place at work through the following can be a rich source of learning.

- Experience;
- Critical incidents;
- Audit and reflection;
- Supported mentorship;
- Clinical Support; and
- Peer review.

5.5.15 The mandatory requirements for post registration education requirements and practice for nurses are entirely consistent with this approach.
5.5 Professional Development

Training Strategy

5.5.16 The Nurse Training Strategy underpins the future development of the Nursing care provision within the SPS. It is imperative that the nurses, who are a substantial part of the Health Care Service in the SPS, are continuously trained and developed to meet the changing needs of the prisoner patient population.

5.5.17 A review is presently being undertaken to enhance this Strategy by incorporating a number of education and learning approaches, which will strengthen educational, learning and training opportunities for nurses working within the SPS.

5.5.18 A future Training and Learning Strategy will include:

- Induction and Orientation packages for all grades of Nursing staff;
- Facilitation;
- Events, short course and conferences;
- Support competencies - needs led;
- Support and meet Continuing Professional Development needs;
- Partnership;
- Post-registration education and practice;
- Self directed learning;
- Reflective Practice;
- Access to E-Library services;
- Access to local learning / educational reading material;
- IT Support; and
- Identified Learning Representatives [Royal College of Nursing].
5.6 Management & Leadership

Overview

5.6.1 The ‘diagnostic’ stage of the Nursing Services Review identified a number of issues and problems related to management roles and responsibilities. The review also highlighted the need to develop and strengthen nurse leadership within the service.

5.6.2 This section of the Service Framework clarifies the main managerial roles and responsibilities within the primary care nursing service and describes the relationship between line management and professional leadership.

Line Management Roles

5.6.1 Figure 6-1 details the individual and shared roles of the Prison Governors and the Nursing Services Manager.

**Figure 6 - 1: Roles of Prison Governors and Nursing Services Manager**

<table>
<thead>
<tr>
<th>Prison Governor</th>
<th>Prison Governor and Nursing Services Manager</th>
<th>Nursing Services Manager (Headquarters)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Leadership &amp; Direction of strategy</td>
<td>• Recruitment of senior nursing staff</td>
<td>• Workforce planning for nursing</td>
</tr>
<tr>
<td>• Planning, monitoring and delivering the business</td>
<td>• Management of clinical risks</td>
<td>• Clinical governance – strategic leadership</td>
</tr>
<tr>
<td>• Management of resources, including human, financial, plant, equipment and buildings</td>
<td>• Clinical governance – operational leadership</td>
<td>• Strategic nurse leadership</td>
</tr>
<tr>
<td>• Audit and administrative practice</td>
<td>• Performance of nursing staff – appraisal (PPMS)</td>
<td>• Training and development of nursing staff</td>
</tr>
<tr>
<td>• Contribution to Service improvement</td>
<td>• Responsibilities regarding Professional Conduct</td>
<td>• Strategic planning of resources – nursing and health</td>
</tr>
<tr>
<td>• Providing a clear leadership style for staff and the prisoner population</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5.6.2 The benefits of the role definition in figure 6.1 are:

- Clear lines of accountability and responsibility;
- Improved performance;
- Improved effectiveness and efficiency;
- Improved communications at all levels.
5.6 Management & Leadership

Strengthening Nursing Leadership

5.6.3 The SPS programme of modernisation presents a challenging leadership agenda. Visionary leadership is required to help build modern and dependable services, and to inspire and sustain the service during a significant period of change.

5.6.4 The SPS requires to develop leadership skills of more nurses to meet this challenge.

5.6.5 The SPS nurse leadership model comprises of the following key components:

- Giving purpose and direction to the delivery of nursing care;
- Making a professional impact on the health care of prisoners;
- Strategic development of nursing and health care;
- Getting the best from nursing staff;
- Creating a learning culture; and
- Focusing on delivery of high quality health care.

5.6.6 The SPS is committed to the training and on going development of nursing staff in both clinical and managerial roles.

5.6.7 The revised Training Strategy will ensure that all grades of nursing staff have an opportunity to access training and learning that reflects their position and future needs.
5.7 Partnership & Integration

Overview

5.7.1 The Scottish Prison Service is committed to working in partnership with NHS Scotland and other agencies to deliver effective healthcare services for prisoners. This section of the Service Framework explains how the primary care nursing service will be integrated with NHS Scotland.

Integration with NHS Scotland

5.7.2 Listed below are the areas in which the SPS wishes to develop an integrated approach with NHS Scotland:

- Workforce planning;
- Clinical governance;
- Shared models of care;
- Shared learning and peer review;
- Clinical networks; and
- Quality Improvement in Scotland.

5.7.3 The SPS will initially focus on the development of shared models of care. It is intended that the SPS nursing service will provide the high volume primary care components and there will be a hybrid model of care between the NHS and the SPS to deliver the low volume specialist nursing care.

Professional Relationships

5.7.4 There is a clear need for a formal link between the SPS Nursing Services Manager and the Director and Chief Nursing Officer of the Scottish Executive Health Department, that will provide the SPS Nursing services with a clear strategic direction on national nursing issues. The Nursing Services Manager should therefore join the regular meetings of the Director and Chief Nursing Officer and the Directors of Nursing from NHS Trusts. Existing arrangements between the SPS Nursing Services Manager and those Professional Nursing Officers at the Scottish Executive with responsibility for key national initiatives should be encouraged and continued.

5.7.5 If the SPS is to achieve comparability with the services of the NHS then communication on major health policy as delivered by the Scottish Executive Health Department is essential. Access by the Nursing Services Manager to the Director and Chief Nursing Officers meetings would provide the SPS with that information and guidance.

5.7.6 By establishing a presence at the Director of Nursing meetings, the Nursing Services Manager will provide SPS Health Centres the opportunity to develop closer links between establishments and their local NHS counterparts.

5.7.7 The Nursing Services Manager will continue to liaise and develop professional working relationships with major NHS services, i.e. NHS Scotland, NES, and Quality Scotland Foundation etc.

5.7.8 The Nursing Services Manager will continue to lead on developing initiatives with these agencies, but assist establishments to link in with these services when required at a local level.
5.8 Performance Management

5.8.1 This section of the framework explains the various means by which the effectiveness of the primary care nursing service will be measured. There will be two separate but inter-linked approaches:

- Success Criteria – assessing the benefits of changing the Primary Care Nursing Service Model
- Performance Indicators – assessing the outcomes of the services provided

Success Criteria

5.8.2 It is clearly essential that any changes to the organisation and provision of Primary Care Nursing Services deliver perceptible benefits to service users, providers and key stakeholders. The following table provides examples of the criteria that may be used to measure the success of any changes to be implemented following the Nursing Services Review:

**Figure 8 – 1: Potential Success Criteria**

<table>
<thead>
<tr>
<th>Service Component</th>
<th>Criteria/Measure</th>
</tr>
</thead>
</table>
| Meeting Health Needs | • Increased number of specific specialist chronic disease management clinics/interventions  
|                     | • Increased number of packages of care for prisoners diagnosed with a mental health need  
|                     | • Increased number of prisoners on detox programmes  
|                     | • Increased number of prisoners on self medication programmes  
|                     | • More appropriate use of inpatient beds  
| Nursing Interventions | • 100% triage using the new model  
| Risk Management | • Reduction in nursing time spent on drug administration  
| User/Stakeholder Satisfaction | • Increased nursing time on nursing duties and reduced nursing time on non-nursing duties  
| | • All prisons to have moved to the new model of primary care, mental health and addictions roles  
| | • Reduced number and frequency of critical incidents (clinical)  
| Workforce/Human Resources | • Increased satisfaction levels from prisoners, nursing staff, prison officers, governors and external agencies  
| | • Increased recruitment and retention rates;  
| | • Reduced sickness/absence rates;  
| | • Increased skill mix  
| | • All prisons to have stopped nursing night shifts |
5.8 Performance Management

Performance Indicators

5.8.3 Figure 8.2 details the issues against which the primary care nursing service can be evaluated. This is a high-level list and will be developed to the appropriate level of detail within the implementation phase of the Nursing Services Review.

Figure 8 – 2: Key Performance Indicators

<table>
<thead>
<tr>
<th>Performance Area</th>
<th>Measurements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation</td>
<td>• U.K. frameworks e.g. Kings Fund &amp; Charter Mark</td>
</tr>
<tr>
<td>Access Targets</td>
<td>• Compliance with National Standards</td>
</tr>
<tr>
<td></td>
<td>• Prisons and Young Offenders Institutions (Scotland) Rules 1994, Rule 8.2(a)</td>
</tr>
<tr>
<td>Health Indicators</td>
<td>• Infection Control Guidelines</td>
</tr>
<tr>
<td></td>
<td>• Standards for Health Care</td>
</tr>
<tr>
<td></td>
<td>• Strategy for Clinical Governance</td>
</tr>
<tr>
<td></td>
<td>• Moss Pharmacy Contract</td>
</tr>
<tr>
<td></td>
<td>• Medical Services Contract</td>
</tr>
<tr>
<td></td>
<td>• ACT to Care</td>
</tr>
<tr>
<td></td>
<td>• Health Promotion Framework</td>
</tr>
<tr>
<td></td>
<td>• Mental Health Strategy</td>
</tr>
<tr>
<td></td>
<td>• Cervical Screening Rates</td>
</tr>
<tr>
<td></td>
<td>• Number and types of adverse Clinical Incidents</td>
</tr>
<tr>
<td></td>
<td>• NHS Scotland Standards</td>
</tr>
<tr>
<td>Prisoners’ Experience</td>
<td>• Number and type of complaints</td>
</tr>
<tr>
<td></td>
<td>• Ad hoc assessments</td>
</tr>
</tbody>
</table>

5.8.4 The Scottish Prison Service will continue to develop and implement a robust Performance Management framework that will monitor service provision, and the extent to which it meets prisoners’ healthcare needs, at both national and local level.

5.8.5 Throughout the Nursing Review, accessing reliable Healthcare and Nursing Manpower data has been difficult to achieve. Consideration has to be given to the development of reliable systems, which will record, collate and analyse necessary information as and when required.

5.8.6 The guiding principle for performance management within SPS is that the healthcare services should be of equal standard to those provided in NHS Scotland – the SPS will therefore continue to apply NHS Scotland quality targets, adapted for the specific circumstances of prisons in Scotland.
5.9 Implementation

5.9.1 The Scottish Prison Service has set out a significant development agenda, which is designed to meet the challenges ahead. This section sets out the process by which the new service model and framework will be implemented across SPS. It includes key tasks and timescales.

5.9.2 It is anticipated that the Service Framework will be implemented over a two-year period commencing September 2003, with the main changes and benefits being realised in the financial year 2004/05. The action highlighted in the text serves as signposts for planning, and as milestones by which to monitor progress.

Figure 9 – 1: Draft Action Plan

<table>
<thead>
<tr>
<th>Issue</th>
<th>Action</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Model</td>
<td>• Review nursing structure</td>
<td>September 2003</td>
</tr>
<tr>
<td></td>
<td>• Confirm proposals for in-patient facilities</td>
<td>September 2003</td>
</tr>
<tr>
<td></td>
<td>• Review and propose new nursing establishments</td>
<td>December 2003</td>
</tr>
<tr>
<td></td>
<td>• Agree 2004/5 establishments</td>
<td>March 2004</td>
</tr>
<tr>
<td></td>
<td>• Develop plan for achieving required skill-mix</td>
<td>April 2004</td>
</tr>
<tr>
<td>Pay Modernisation</td>
<td>• Agree 1 year settlement;</td>
<td>October 2003</td>
</tr>
<tr>
<td></td>
<td>• Agree principles for future modernisation</td>
<td></td>
</tr>
<tr>
<td>Improving Working Lives</td>
<td>• Implement review recommendations e.g. cease nursing nightshifts</td>
<td>April 2004</td>
</tr>
<tr>
<td>Clinical Governance</td>
<td>• Complete risk analysis</td>
<td>March 2004</td>
</tr>
<tr>
<td></td>
<td>• Develop new framework</td>
<td>March 2004</td>
</tr>
<tr>
<td></td>
<td>• Agree resource to support new framework</td>
<td>April 2004</td>
</tr>
<tr>
<td>Professional Development</td>
<td>• Produce draft Training and Learning Strategy</td>
<td>September 2003</td>
</tr>
<tr>
<td></td>
<td>• Implement Training and Learning Strategy</td>
<td>July 2004</td>
</tr>
<tr>
<td>Nursing Leadership</td>
<td>• Develop outline programme</td>
<td>December 2003</td>
</tr>
<tr>
<td></td>
<td>• Commence programme implementation</td>
<td>April 2004</td>
</tr>
<tr>
<td>Partnership &amp; Integration</td>
<td>• Put in place mechanisms for agreeing NHS and geographical network</td>
<td>December 2003</td>
</tr>
</tbody>
</table>

5.9.3 Fundamental to the success of the implementation of the Nursing Review and this Service Framework is the secondment of a dedicated part-time Project Co-ordinator who will drive the implementation of the action plans and ensure the benefits are fully realised.

5.9.4 The appointment of a Project Co-ordinator, and the assignment of individuals to take responsibility for the tasks outline above, will be taken forward following approval of the Primary Care Nursing Service Framework.
Membership

MR ALEC SPENCER
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MR JOHN PORTER
Nursing Services Manager, SPS (Project Manager)

MR LYNDON BRADDICK
Pharmacy Adviser

MR JOHN DAVIDSON
Health Care Manager, HM Prison Perth

MR JIM DAWSON
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