Provision of health and social care in the adult prison estate

RCP Cymru Wales response

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Provision of health and social care in the adult prison estate

Thank you for the opportunity to respond to your consultation on the provision of health and social care in the adult prison estate in Wales. This response focuses on the provision of secondary care (and more specifically, palliative and end of life care) to the adult prison population. We would be happy to organise further written or oral evidence if that would be helpful.

Wales has the highest imprisonment in Western Europe.[1] Demographic shifts in the prison population have meant increasing numbers of prisoners dying behind bars.[2] Recent research has shown that there is a significant demand for palliative care in prisons: deaths through respiratory disease and cancer are predominant and one in ten prisoners has a terminal illness at the time of sentencing.[2]

The effectiveness of current arrangements for the planning of health services for prisoners

Respondents were agreed that in light of the ageing prison population in Wales, and the number of people with comorbidities, there should be a more strategic and joined up approach to providing palliative and end of life care for prisoners. It is vital that prisoners, their families and their advocates are at the centre of service planning, especially around end of life care needs.

One member told us that she felt the situation had been transformed in recent years with improved IT systems meaning that she is able to communicate with secondary care colleague via a secure NHS email. She thought it was the in-house workforce which has transformed delivery of palliative care in recent years, including the GPs and senior nurses who are based in prisons. However, changes to GP provision tend to affect relationships and styles of working.

> *'For us as a [secondary care] service it feels as if the prison [is] a secure village, with a primary care gatekeeper. We have no additional time or training to deliver our role, other than my particular interest and experience. The links between prison and secondary care are very different depending on the [particular situation].'* (Consultant physician)

Initiatives to support the prison population are often part of bigger national projects, which are delivered through universities and the third sector. This approach has its advantages in terms of funding and planning, but is potentially less effective in delivering sustainable, long-term change as it can lose sight of local knowledge and deter ongoing links.

Current pressures on health and social care provision are in Welsh prisons

Respondents told us that prison staff are very committed, though short staffed. They demonstrate compassion and a willingness to support patients with both physical and mental health concerns.

> *'We are always stretched with clinical time. A prison visit takes a whole [clinical] session and we usually go in pairs, with one doctor and one nurse to maximise the breadth of the assessment.'* (Consultant physician)

There are sometimes structural difficulties with communication, including between health professionals inside and outside of prison. There is often little to no family support for prisoners.

Primary care out-of-hours services are not readily available for hospital wing residents in end of life care, and investigations for palliative care patients are not always dealt with as quickly or as smoothly as they could be. Handover into and out of prison is not always straightforward for those with chronic conditions: there is a small population of complex patients where this has been an issue.

One consultant physician described the challenge of prisoners accessing timely outpatient appointment for a chronic medical condition. For security reasons, prisoners are accompanied by two prison officers on any hospital appointment and the prisoner is not allowed to know the date of their appointment until much closer to the day. This can led to a failure to attend due to more pressing issues – a court appearance, a family visit or the prison being on lockdown. The use of telemedicine/videoconferencing potentially could improve service delivery for these follow-up outpatients.

Some medical specialties such as sexual health and blood borne virus (Hepatitis C) services provide in-reach services very effectively in parts of Wales (eg Betsi Cadwaladr UHB). These are currently being reviewed by Public Health Wales. Other medical specialties could potentially support the primary care team who deliver the majority of medical care in prisons.

Meeting the complex health and social needs of older people in prison

Respondents told us that there is always room to improve the care we provide for older people in prison. Many prisoners have challenging home lives, which adds another layer of complexity to caring for an ageing population. For example, there may be family breakdown in their background, with nowhere to go upon discharge.

> *'My concern is the large number of prisoners who are discharged with nowhere to go so that they are immediately homeless and at high risk of re-offending and returning to drug and alcohol misuse within minutes of leaving prison. [They must] all have a secure environment to move to straight from prison and appropriate support.'* (Consultant physician)

If a patient is seriously ill, this needs to be factored into their future. Health boards must start planning for the fact that this population will have palliative and end of life care needs. A planned death within the hospital wing can be a prisoner's preference and staff should be supported to enable this to happen.

> *'I have come across dialysis, dementia, dying, and in many respects I have seen more care and dignity for these patients in prison [with] access to 24/7 support. Their preferred place of care has also often been prison and absolutely been deliverable.'* (Consultant physician)

Resources available to fund and deliver care in the Welsh prison estate

Respondents agreed that prison health services would welcome investment, especially in developing ways of multidisciplinary working. It would be helpful if health boards took a more strategic approach to planning organisational change and anticipating the impact of an older prison population.

Current barriers to improving the prison healthcare system and health outcomes

> *'It is a structural silo. I go to the prison as a clinician [and] in 10 years, no one from the prison has asked our opinion about the clinical interface. I hope this is not the case for psychiatry, emergency medicine etc. Yes, of course there are generic issues and standards, but you don't tend to get change without local collaboration.'* (Consultant physician)

Delivering end of life care in HMP Cardiff

Access: Clinical visits are only by prior appointment; it is not a flexible system. The prison in Cardiff is located in the city centre which can cause problems with heavy traffic and parking difficulties. Visiting the prison 'out-of-hours' in an emergency situation is impossible. Visitors need photo ID and are dependent on staff collecting and accompanying them; this can mean waiting at reception for a variable length of time, depending what unforeseen events are occurring at the time. Visitors are required to leave mobile phones at reception which has an impact upon service provision at their own hospital.
Accommodation: Doctors are always given a private area to speak with, examine and discuss the prisoner's needs. Notes and information are generally readily accessible. Equipment and support can be readily accessed as needed – including hospital beds, commodes, and occupational therapy. The prisoner can be accommodated in the hospital wing as their health needs require. By arrangement, prison staff facilitate an 'open door' approach in the hospital wing, with a more supportive atmosphere and access to the prisoner. Staff will also check on the prisoner on a regular and ad-hoc basis. Informal feedback from prisoners suggests they appreciate this when they are bed-bound and actively dying.
Medication: Medication which is required to manage symptoms needs to be anticipated and ordered to the prison. There is usually a healthy debate around the choice and route of medication. However, staff do ensure the prisoner receives exactly the same medication opportunity for symptom control as they would have in any other setting. If a patient needed a subcutaneous injection during the night to manage a breakthrough symptom, this can present a problem, due to variable staff competency, the locked cell door policy and changing staff attitudes. This requires regular palliative medicine review and proactive planning and control of symptoms.
Communication and attitude: Staff are sensitive and excellent at communicating and facilitating access and information to the prisoner's family/next of kin. Prisoners appreciate these efforts. Managers of services both within and external to HMP often encourage the transfer of the prisoner from HMP to hospital or a hospice. This requires significant negotiation and explanation why this is not in the prisoner's wishes or interests (if they have expressed a desire to be cared for in prison).
End of life care planning: This requires a significant amount of time and planning with a number of different services, including acknowledging the person is going to die; communicating this with staff and authorities verbally and in writing; and planning *where* they are going to die based on the individual's wishes and preferences. This requires negotiation with the parole officer, talking to the prisoner, understanding their views, and helping them to achieve some sense of peace prior to death. In practice, prisoners often prefer to stay in the prison environment, as they consider this home. Clinicians then develop a specific individual end of life care plan so that when the prisoner deteriorates, staff act according to the plan and do not call emergency services to transfer the prisoner to hospital inappropriately. Hospice staff provide training to staff working in the hospital wing.

Longer term palliative care
Individuals with a longer prognosis who require palliative care input are seen either in the prison environment or as an outpatient. They have access to medication, advance care planning and multidisciplinary services. Transfers to other prisons can happen at comparatively short notice. This can leave palliative medicine services trying to catch up and find the right person to hand over information for the purposes of continuity of care.

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[1] Dr Robert Jones. *Sentencing and Immediate Custody in Wales: A Factfile*. Wales Governance Centre at Cardiff University: January 2019
[2] Dr Jim Burton. *What are the Challenges in Providing Palliative and End of Life Care in Prisons?* Cardiff University: 2019 (attached alongside this response)