HSP 34
Ymchwiliad i ddarparu gofal iechyd a gofal cymdeithasol ar yr ystâd carchardai i oedolion
Inquiry into the provision of health and social care in the adult prison estate
Ymateb gan Unigolyn
Response from an Individual

1. **Health and Justice/ HMPPS**
    - There has recently been agreed a set of joint responsibilities for prisoner health between WAG and HMPPS illustrating the need for joint working to deliver good health to our men eg. Meaningful activities, exercise, food etc I think this will represent a watershed in our relationships and partnership working will become more prevalent. It is always going to be difficult when you have devolved health but not justice when you have these close symbiotic relationships but being recognised officially as partners is a big step forward and this should be officially recognised in the inquiry.
    - Major decisions to change aspects of the local prison estate should be discussed with health to understand the implications for them and the men they treat, prior to any formal decisions being made eg. Reconfiguration, we should have been consulted at an early stage in the process as happened in England. This would demonstrate true partnership working and allow Health to fully prepare for these changes.
    - A formal recommendation should be made around upkeep and suitability of the estate for delivering healthcare. As you saw in our healthcare department, some areas aren't fit for purpose or at a suitable level for delivering health but repairs are out of our control to large extent, being the remit of Justice. There should be some formal way to escalate/ resolve these matters in a timely manner.
    - Short sentences don't work yet we, in Wales, incarcerate more men than in England. Work should be done between WAG and the department of Justice and Westminster to work towards reducing this and developing alternate ways of punishing men eg. Community orders etc
    - Communication around release dates and planning, visits and transfers should increase and this would lead to lower levels of DNA (did not attend) appointments and increase capacity within the system. We often operate around a 50% DNA rate which clearly leads to a waste of valuable professional time and then increased waits. There was a White Paper released in around 2017 that suggested governors should be held responsible for the DNA rate and this would have an impact on their incentive scheme; this seems to have disappeared and nothing more has been heard regarding this but I think it would be an incredibly effective tool to reduce waste in the system around DNAs.
    - Release planning should be embedded within our systems to include early communication with healthcare so they may be aware, all complex patients eg. (man with TB/ HIV being deported) should have a timely MDT discharge meeting, all men on medication/ with healthcare issues should have a face to face discharge appointment with a Health worker; we do not have the capacity within the system to do this, this happens in England.
    - Funding for police custody suite clinical functions should sit within the NHS remit, to improve governance and communication and continuity with secure and community services. Tier 2 behavioural support for substance misuse (currently provided by Dyfydol) should also sit here, as below.
    - Prisoner housing pathway – our men often do well in custody and are then released into the community, often to be street homeless or floor space users in Homeless hostels. Their pattern of offending often then springs from there ie. Desperation, lack of coping with the situation in an environment where drugs are readily being

used and available. If we could develop some kind of housing pathway, that didn't lead to a perverse incentive to enter the secure estate to get housing, that would give them a chance of not coming back to us but building a life free of crime, they have little chance when they don't have the basics for life. They don't prioritise their health in these situations, food and shelter are more important so they neglect their health leading to a public health crisis in this group but also broadening the gap between rich and poor eg. A professional in Cardiff has the basics of life so can focus on concerns about his cholesterol levels and hence access testing and treatment, a homeless man (who may be a professional also) spends more time trying to secure his basic needs. An evaluation of the homeless population should also be within the remit of any prison inquiry since there is a massive overlap in this group; dealing with one will have a knock on effect to the other.

- Work reference – men in prison are often highly valued in their work eg. Wing cleaner, working in the laundry, gym orderlies. Funding should be available for them to enter into peer mentor training schemes, which would formally train them and give them a qualification and a greater chance of work, but we could also look to develop some kind of reference for them. I appreciate that is probably fraught with legalities around it but is an aspiration that could be practically very helpful to them and we know that work, reduces morbidity. This would have to be done in partnership with Justice.

2. **Governance and IT**
    - Wales does not have a direct relationship with TPP, the suppliers of System One the prison clinical system, and as such cannot affect change directly with them regarding the system, the opportunity to develop this was recently missed when the contract was renegotiated, this should be addressed.
    - Prisons tend to get forgotten from NWIS programmes (eg. Hardware refresh, WCP pilot) but this has now been rectified, to a degree, since I have been attending a regular meeting and raised this. Prison health should formally be recognised within their terms of reference/ service specification.
    - A reporting system should be used to collect data that should be collated centrally by WAG and compared to similar other prisons across the Welsh and English estate to compare performance. Care should be taken to compare like with like but 'outliers' could then be picked up in terms of performance or changes that could be investigated. In England they use the Health and Justice Performance Indicators that are an extensive and robust data that is collected monthly and reported quarterly. Quof is also embedded which it is not in Wales. Whilst I do know this will lead to increased admin which is not desirable, it will quickly become embedded as normal practice and I genuinely believe will improve clinical performance and quality, as well as screening, and appointment/ clinic audit etc. A Wales specific set of indicators could be developed to try to keep the bureaucracy down but also achieve these ends.
    - NWIS has lost virtually all skill in System One, and there is very little practical skill within the prison teams. They are addressing this by bringing in consultants but this has led to us being significantly behind the prison estate in England.
    - Registration directly with prison health centres: By the end of 2019, a man going into custody in England will be registered with the prison and his notes will follow him. This is much safer and better for all men. This has been a programme of work that has taken several years in England but they are nearly there. This will create a 2 tier system; Welsh men in English prisons will be safer than Welsh men at home in Welsh prisons because their medical team can see their historic record, and we can't do that in Wales. Our Welsh women in the English estate should be able to be part

of this also. There is no plan at this moment for NWIS to take this forward, to my knowledge when I last met them, but I have raised this as a big issue and this should happen as a matter of urgency so we don't prejudice our men by bringing them home. This is all done via connection to the spine and GP2GP notes transfer and requires NHS numbers be entered on the record manually which will take a 'push' of admin time but can be done.

- There are many different community health IT systems and they are not visible to all, this complicates matters significantly. Eg. PARIS, NEO.

3. **Substance misuse services**
    - England developed and introduced Integrated Drug Treatment teams to prisons some years back. This separates substance misuse services from primary care and usually operates as a separate team with a separate GP with a special interest in substance misuse. They start men on opiate substitution therapy on the first night or second day to comfort their withdrawal and they can then have solely an opiate supported detox, or continue to engage with the program and go onto a maintenance programme. It is not without it's issues and is certainly not a perfect system. I know WAG are looking at a specification for substance misuse in prisons and I wonder if this service is better delivered within the first few days of custody, perhaps the 2nd day but evaluation should be made of IDTS rather than blindly adopting it; it was in place when we had the massive rise in SPICE use and deaths in prisons. Funding should follow on from the development of the service specification and a prison specific substance misuse needs assessment based on the specification.
    - Currently this is funded and delivered within our primary budget, with funding for a band 7 liason nurse coming from APB funding, and this is not sufficient to develop this service. We now maintain our men which is appropriate but this has been done with no additional funding and is having a massive knock on effect on the men, the regime and the staff with the length of the queues and the time it takes to dispense these meds. There is no funding for doctor time and this is absorbed into the normal GP day but given that we generally have around 170 men on methadone at any time, this is not sufficient. There is insufficient funding for nurse time also, and we cannot run a service out of hours at evenings or weekends. Funding should follow on as above point above following specification.
    - Tier 2 behavioural services are funded through WAG monies via the police and crime commissioner budgets. This should sit under health, it is a health function and has been recognised as such in England. It would strengthen the governance and partnership working, enable us to encourage BBV testing via the KPI and lead to better outcomes for men, in my opinion. The funding should come in a way that ensures this can only be used for this purpose.
    - Hep C testing naturally sits within this team and consideration should be given to the near patient test for diagnosis so treatment can be started immediately because of our short window of opportunity. This should be included within the specification and then funded accordingly via any follow on funds.
4. **General funding increase**
    - There has been no increase in funding to the prison health budget since the TUPEE in 2012. This needs to be rectified given the changes within the estate but also the fact that the NHS is running this service now means that there is more of a focus on health and we are looking at screening and prevention, as well as trying to deal with acute and chronic health problems. If we can 'mop up' all this chronic disease, hep C, substance misuse etc, they have a chance of returning to their communities with better health and better opportunities which will have a massive knock on effect all over Wales. It is imperative we treat them in prison and stabilise them and take our

opportunities to improve their health and it should be remembered that 'prison health is public health'!

- It would be interesting to do an exercise to look at the funding per capita of a prisoner for health in Wales as compared to England; anecdotally it seems much less and my understanding is that prison health funding is allocated differently to WAG than NHS funding and if there is a disparity then this needs to be addressed from central government funding as a matter of urgency. Caution should be exercised given the much bigger size of the English estate and the savings that can be made with size but it would be a useful exercise, nevertheless.

5. **Clinical Champion/ prison health and justice team.**
    - There is a lack of clinical and managerial leadership at a high level that can co-ordinate responses and partnership working between WAG and HMPPS. There has been some recognition of this and a Welsh prison Healthcare reference group has been set up across the prisons but as usual, there is no funding for this. The Mental health and vulnerable groups team have picked up this work in partnership with a small resource from Public Health Wales. It could be argued that it is within their existing remit but prison health has largely been ignored before so is essentially new work. We have made some important steps forward but it is beset with delays and difficulties because the resource hasn't followed. How can NHS England and Public Health England have so much funding for so much intra-structure when we have nothing around this in Wales? I would take this opportunity to caution you around leaving doctors out of this pathway/ process. There is a useful role to MDT working but the benefits that doctors can bring to roles must not be forgotten; the temptation in the prison health environment, as in a lot of services, is to replace doctor input with nurse input managerially and clinically and whilst there is a place for nurses, it must not be forgotten that doctors bring a different and useful perspective. We must not risk removing doctors so much that it affects recruitment further like in England, by just using them as the 'figure head' that is wheeled out when things go wrong, they should remain integral to the prison health process clinically, strategically and managerially.
    - Consider a clinical champion for this role for all the above reasons, in partnership with RCGP. This could be an ambassador for prisoner health in Wales and could be an exciting opportunity to raise the profile of this highly vulnerable group.
6. **Mental health**
    - Woefully underfunded but resource is currently being bid on and not a moment too soon. The model funded has been a secondary care model since it's inception but this new funding recognises the need for primary care funding, I would say secondary care services are generally well met.
    - Transfers to mental health hospitals are delayed beyond the recommended 28 days mainly due to lack of places in the secure hospital estate but also, I believe, by the time it takes for the required assessments by MH professionals and the interface with MoJ. Funding becomes very complicated if men are resident in England and can increase the delays. MH teams can advise more regarding this given it is their area of expertise.
7. **Staff retention**
    - We have a chronic problem with retention of our Band 5 nursing staff. We train them to a high level and then lose them to similar environments where they can easily attain Band 6; Band 5 is no longer a career grade and given the lack of nurses available, there are always band 6 jobs available to them. Consideration should be made to inflate the banding of the nurses in the prison to Band 6, even if they are not fully compliant with that banding, as a strategic measure to stabilise the

workforce to allow development within the prisons but this would need to be recognised within funding allocation. Training could follow to increase their skills to Band 6.

- GPs – continue raising the profile and work with medical schools and GP training schemes to increase the exposure to this field of medicine.