



## Deep End Report 39

### Prison Health

*On Wed 9 March 2022, the Deep End GP group hosted an online roundtable meeting to explore the challenges of delivering high quality primary health care in Scotland's prisons. Discussion centred on the various systemic factors that affect the organisation and delivery of care, as well as issues with recruitment and retention of GPs in Prison health, but also explored potential system-wide solutions to these issues.*

**May 2022**

# Executive Summary: Prison Health

## Context

- Patients in secure environments are some of the most marginalised members of our society. They often have significant unmet physical and mental health needs, some of which may drive their criminal behaviour.
- There is enormous opportunity during incarceration for healthcare needs to be recognised and addressed, and positive therapeutic relationships to be established. In reality, this is currently extremely challenging to achieve, and the inverse care law is starkly felt.<sup>1</sup>
- Clinicians working on the frontline in prison healthcare report significant workforce and workload challenges, lack of leadership and governance structures, inadequate access to medical records, poor IT interfaces, training issues, variable access to mental health and addiction care, and lack of connectivity with other agencies, to name but a few.

## Challenges to delivering high quality prison health care

Three key themes emerged from the roundtable discussion:

- Lack of leadership: clinical and corporate
- Professional vulnerability of the prison GP
- Unwarranted variation between prisons

## Recommendations

- Improve the leadership and organisational structures within prisons
- Improve the mechanisms to support quality and safety of prison healthcare provision:
- Improve recruitment and retention of the prison GP workforce:
- Strengthen interprofessional relationships and teams
- Adequate resource to enable change

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<sup>1</sup> The Inverse Care Law, first described by Welsh GP Dr Julian Tudor Hart in an article in the Lancet in 1971, states that: “the availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced”

## Full Report: Prison Health

### Challenges to delivering high quality prison health care

The three themes that were identified as barrier to provision of high-quality prison healthcare are described in more detail in the rest of this report.

- Lack of leadership: corporate and clinical
- Professional vulnerability of the prison GP
- Unwarranted variation between prisons

#### Lack of leadership: clinical and corporate

Significant concerns were raised about a lack of both corporate leadership within prisons, and clinical GP leadership. Frontline GPs reflected that this had not improved over a ten-year period and may have in fact worsened. The roundtable discussions on the day largely focused on the lack of GP clinical leadership, and so this is what is summarised in the body of the report. However, this should not detract from the fact that the concerns raised about corporate leadership in both the planning discussions for the roundtable and subsequent feedback received on the content of the report were also very concerning and have been addressed in the recommendations section at the end.

In community-based primary care, the GP is generally recognised as being at the heart of the coordination and planning of processes and pathways and has a clear leadership role within practice teams, as the 'expert medical generalist'. There are established mechanisms and routes for communication both within and between practices, and within the locality. It was felt that this recognised leadership role and these established communication routes were completely lacking in most prison healthcare settings.

Specific issues raised included:

- **Reactive, not proactive, healthcare** – the high-volume complex workload (both clinical and administrative), inadequate GP numbers, and disorganised systems were reported to result in an inability to work in any other way than “medical firefighting”. In addition to the healthcare opportunities lost when healthcare is delivered in this way, GPs expressed high levels of professional frustration at having to work in this way.
- **Professional disempowerment** – as one GP stated: *“there is a sense of things being done to us rather than having any voice, let alone contribution. There is a wealth of experience within GPs but no avenue to express opinion or contribute to service development or improvements”*.
- **Minimal or absent time for GP leadership** – expressed simply as *“not enough to do what is required”*. This translated into a lack of opportunity for GPs to take on Quality Improvement or strategic work. Leadership from GPs working on the frontline was felt to be crucial to success.

- **Fragmentation of care** – there were reports of dedicated specialist services for blood borne viruses (BBVs), sexual health, mental health and oral health but concerns expressed that there appeared to be little investment/priority around the coordination and perspective that a GP can offer, and that is crucial for this group of patients. There was felt to be lack of consideration for the complexity of clinical presentations – trauma (physical and psychological), problem substance use, neglect, advanced and/or undiagnosed pathology. Other services were felt to single-issue focussed, whereas GPs often see the ‘bigger picture’ because of their generalist training. Frustrations were expressed that there was limited opportunity to maximise these skills during a ‘window of opportunity’ for patients during incarceration.
- **There is no feedback loop or opportunity for learning** – GPs reported that they were unaware of what was being discussed at management/strategy meetings and that they also felt ‘unheard’, with no opportunity for involvement. As one GP stated *“What we say seems to have no impact. There is nothing like a GP forum”*.
- **Lack of time or value placed on involvement in service improvement.** An example was given of a nurse colleague (from a hospital background) requesting GP advice on how to design diabetic reviews. This support and development role was then not recognised or allocated time in their work template, which left the GP feeling stressed, demoralised and undervalued. It was felt that *“Each prison seems to be making up its own systems and pathways with no GP involvement – the result is that GPs get more and more dissatisfied at the lack of contribution to making pathways safe and efficient.”*

### Professional vulnerability of the prison GP

Numerous examples were given of the professional vulnerability felt by GPs working in prisons. This vulnerability was a result of several factors:

- **Declining GP workforce** - resulting in unsafe medical workload, a sense of constantly ‘firefighting’ and never achieving a more proactive and preventative style of healthcare with meaningful therapeutic encounters. The declining workforce number was felt to be more of an issue of retention rather than recruitment.
- **Fragmented teams** - there were reports of disjointed working, and challenging interprofessional relationships, which created further stress and impacted on care delivery.
- **Lack of time or priority for planned medical care** – a description of GP clinics being squeezed in (one hour slot) amongst other competing scheduled and unscheduled tasks (e.g. parole reports, medical emergencies).
- **Reliance on nurse assessments** – reports of a strong focus on nurse-led clinics and nurse prescribing, without nursing colleagues necessarily having the confidence or expertise to manage often-complex and undiagnosed healthcare issues. Concerns

expressed that the GPs were expected to hold the clinical risk for decisions made and prescriptions written for patients that they had not seen or assessed themselves.

- **Lack of access to secondary care specialist support/input** – it was recognised that there is considerable potential for health benefit for patients, but “*even things like getting to appointments are not working so well just now*”. This can leave patients and prison GPs even more vulnerable to missed or delayed diagnoses and poor outcomes.
- **Medico-legally risky work** both in terms of the system worked within (lack of governance, inadequate IT and access to medical records, poor interfaces of care, high volume workload, high clinical risk managed, insufficient medical workforce) and the population served (complex needs such as mental ill-health, substance misuse, poor physical health, distrust of professionals) which can result in a high rate of complaints. It was felt that the burden of risk carried by GPs working in prisons was far higher than in community-based general practice. It was also recognised that there was inadequate training available around the medico-legal risks involved of working in secure environments, and a lack of clarity on GP liability in specific situations such as patients in solitary confinement, on hunger-strike or requiring to be moved under restraint.
- **Administrative issues**, including delays with getting test results, delayed access to treatments, delayed payments to staff, paper Kardexes needing to be rewritten by hand at every move to a new prison, medical conditions not being accurately coded in notes.
- **IT issues**, including a lack of up-to-date electronic systems being used, resulting in less safe ways of working. For example: no online ordering software for requesting investigations; outdated and incompatible versions of primary care medical record software (known as ‘Vision’) meaning that ‘prison Vision’ does not link with ‘(community) GP vision’, resulting in loss of informational continuity; prison GP10 (prescription) does not populate the emergency care summary prescription record; paper results / paper forms used for certain tasks when electronic versions would be the norm elsewhere, lack of availability of an electronic prescribing formulary (which automatically means an absence of warnings about interactions or adverse reactions when a prescription is being generated). The bespoke ‘System One’ medical record software in English prisons was rated highly, but is not currently available in Scotland.
- **Lack of reliable access to essential medical equipment** – a specific example was given of an defibrillator machine not being maintained and therefore not available in an emergency.
- **Lack of autonomy or clarity about lines of responsibility/clinical governance**, with examples given of nurses asking GP colleagues to undertake tasks, on the assumption that GPs have overall responsibility, despite there being an absence of formalised or

supported leadership roles for GPs. This was felt to have resulted in inefficiency and challenges with interprofessional relationships and communication.

- **Lack of training and professional development opportunities** – reports of no protected time for continuing professional development (CPD) and little support for additional training in a system where the skills required have been poorly covered in standard postgraduate GP training.
- **Professional isolation** – prison health is a subsection of primary care, but GPs reported feeling separate and isolated from community-based general practice, with poor communication links to local services/pathways/secondary care and no effective communication links between community-based general practices and prisons.
- **Weak interfaces** – as above, but recognised to have specific patient safety issues, with care often fragmented or poorly documented. There were felt to be better interfaces with psychiatry, alcohol and drug recovery services, sexual health, and dental services than with community-based general practices or other specialist services.
- **Discharge processes** - particular challenges were reported in relation to variation across prisons in approach to medications on discharge, with some prisons dispensing 7-day supplies, others 28-day supplies. Inconsistency reported around provision of Fit Notes, or information on how to register with their local GP practice. These issues in particular were recognised as impacting on patient safety and support at the point of liberation, with a significant risk of patients ‘falling between the gaps’
- **Lack of shared learning opportunities** – reports of no existing mechanism for initiatives, improvements or learning to be shared across the prison healthcare community in Scotland (and beyond), impacting on the opportunity for improvement and peer support.
- **Challenge in maintaining clinical competency** – some GPs expressed concern about maintaining their expert medical generalist clinical skills in the prison environment on an ongoing basis. Some described it as similar to working as a junior doctor again in hospital, simply ‘clerking’ in patients at admission.
- **Feeling unsupported by staff/management** – one GP reported feeling so fearful of, and so unsupported by, staff and management that they resigned.

### Unwarranted variation between prisons

- **Variation between prisons – sharing examples of good practice** - clinicians reflected on the lack of ‘joined up’ learning around what was working well, and why, within prisons. Specific examples of good practice in specific prisons included:

- One prison described a responsive, accessible mental health team.
- One prison enabled the development of a Symptomatic Relief Policy (SRP) to facilitate easy-access to over-the-counter medications).
- One prison achieved having the prescribing record on Vision rather than a paper Kardex.

## Other reasons why prison healthcare matters?

Much has been written about the prisoners' challenges in accessing healthcare, and, how this has worsened during the Covid19 pandemic.<sup>2</sup> Participants reflected that improved, high-quality prison healthcare interventions have the potential to be highly cost-effective in:

- reducing future criminal activity and recidivism.
- breaking inter- generational deprivation.
- reducing drug related deaths.
- improving health outcomes and reducing health inequality.
- improving future engagement with health services.
- reducing national spending on policing, prisons, and healthcare.

## Additional national context

Representatives of Scottish Government (SG) attending the meeting shared the following information to help inform discussions, context, and potential points of leverage:

- The SG has established a Prisons Digital Health and Care Provisioning programme (chaired by Jonathan Cameron, Director of Digital Health and Care, with Clinical input from Joe Daly, NHS GGC), which is exploring options for the provisioning of prison IT systems to address issues relating to core clinical systems, prescribing and medicines administration, and interface with wider clinical systems.
- Following a review of the use of prison clinical IT, recruitment is underway for three regional IT facilitators for prisons. The facilitators will work alongside prison healthcare teams to implement report recommendations on actions that could be taken to improve the consistency in the use of clinical systems and to develop and operationalise nationally agreed SOPs.
- The National Prison Care Network has established facet groups looking specifically at medicines, mental health and substance misuse, workforce and education. Craig Sayers is the clinical lead for the Network.
- The SG has committed to delivering a national health and social care needs assessment for the prison population (chaired by Lynn MacMillan) looking at four different domains of need: social care, substance misuse, mental health and physical health. The first phase of this

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<sup>2</sup> [prisoner-health-literature-review.pdf \(nuffieldtrust.org.uk\)](https://www.nuffieldtrust.org.uk/prisoner-health-literature-review.pdf)

work, which focused on assessing social care needs, was completed in 2020 with the [report](#) published in January 2021. The remaining reports will be published in Summer 2022.

It was also recognised that the recommendations in this report have many areas of overlap with other existing national priorities and funding streams such as:

- Drug-related deaths.
- Health Inequalities.
- NHS Sustainability.
- Realistic Medicine.

## **Recommendations:**

Five key recommendations have been identified from the roundtable discussions:

- Improve the leadership and organisational structures within prisons.
- Improve the mechanisms to support quality and safety of prison healthcare provision.
- Improve recruitment and retention of the prison GP workforce.
- Strengthen interprofessional relationships and teams.
- Adequate Resource to enable change.

### Improve the leadership and organisational structures within prisons

- Visible, accountable and supported leadership: both clinical and corporate.
- Clearer lines of responsibility and governance.
- A quality improvement approach to governance structures and processes, with an overarching framework to coordinate all the improvements that are needed.

### Improve the mechanisms to support quality and safety of prison healthcare provision

- Reduce unwarranted variation and waste by simplifying and standardising processes across all prisons.
- Improve IT systems to allow a consistent approach to coding, e-prescribing and record keeping across prisons.
- Create seamless IT interfaces with non-prison primary care settings to allow safe information transfer.
- Simplify and support community GP registration at liberation.
- Simplify and standardise discharge process for medications and fit notes to facilitate safe discharge.
- Establish online platforms to share examples of good practice across prisons (e.g. on the primary care ihub).

### Improve recruitment and retention of the prison GP workforce

- Create recognised leadership roles with clear governance structures and lines of authority and responsibility.



- Improved access to lifelong learning in Inclusion Health (undergraduate, postgraduate) with a clear career pathway.<sup>3</sup>
- Improve training and continuing professional development available to equip GPs working in secure environments, including protected time for study.
- Ensure adequate induction processes and supportive annual job planning and appraisal.
- Create a peer-support network to reduce professional isolation and facilitate shared learning.
- Review existing terms and conditions for GPs working in secure environments and ensure these are attractive and comparable with GP roles elsewhere.
- Introduce regular learning events, including learning from adverse events (e.g. through SEA) to create a culture of transparency, ‘no-blame’, and growth.

#### Strengthen interprofessional relationships and teams

- Specific investment in building healthy teams, with clarity of roles and responsibilities, improved communication, and mechanisms to support each other and learn together is recommended.

#### Adequate Resource to enable change

- Increase the resource available to deliver high quality and safe prison healthcare to meets the complex and currently unmet needs of the prison population, largely by: investing in leadership, and team cohesion; improving governance systems; growing the prison healthcare workforce; improving IT systems; having more consistent access to services; investment in a culture of learning and transparency.
- Match the resource to the level of need (and significant opportunity for health interventions) using a ‘proportionate universalism’ approach.<sup>4</sup>

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<sup>3</sup> See <https://www.gov.uk/government/publications/inclusion-health-applying-all-our-health/inclusion-health-applying-all-our-health> for a definition of Inclusion Health.

<sup>4</sup> “Proportionate universalism is the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need. Services are therefore universally available, not only for the most disadvantaged, and are able to respond to the level of presenting need”. See [this report](#) for more detail.

## Appendix 1: Attendees

Carey Lunan, GP and Chair of Deep End GP.

David Blane, GP and Academic lead for Deep End GP.

Jagruti Hillhouse, GP in HMP Barlinnie (and previous prison officer).

Joe Daly, interim clinical lead of GGC prison health care.

Mary Mitchell, health care operational manager at HMP Barlinnie.

Helen Richardson, GP in Homeless Health Service in Glasgow.

Helen Forde, Health Inequalities Unit at SG (includes Prisoner health team).

Katie Clark, Prison GP.

Andrea Williamson, Inclusion Health GP.

Morag Martindale, locum GP in HMP Perth and previous Clinical Director of Perth CHP.

Nora Murray-Cavanagh, GP in Edinburgh, worked in 3 prisons (2012-14).

Diane Stockton, Consultant in Public Health, Public Health Scotland.

Alice Harpur, Registrar in Public Health, Public Health Scotland (Health & Justice strategy).

Jake Hard, GP worked in English and Welsh prisons for 15years, former Chair of RCGP Secure Environments Group.

Munro Stewart, GP in Dundee, previously worked in HMP Castle Huntly.

Iain McNeil, previously Medical Officer at HMP Barlinnie and lead for Boards covering 3 prisons.

Lynn MacMillan, Health Inequalities Unit at SG (includes Prisoner health team).

### Apologies:

Katriona Paterson

Grace Campbell

Frank Gibbons

Dominique Van der Meererschaut

Andrew Fraser

John O'Dowd

## Appendix 2: invitation email

Dear Colleagues

The [Scottish Deep End group](#) would like to invite you to a roundtable discussion on prison healthcare. This will be held as an online meeting on Wednesday 9<sup>th</sup> March, from 1.30-3pm. A calendar invite and link will be sent nearer the time.

Last year marked this 50<sup>th</sup> anniversary of the inverse care law, which states that:

*“The availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced”*

Patients in secure environments are some of the most marginalised members of our society. They often have significant unmet physical and mental health needs, some of which may drive their criminal behaviour. There is enormous opportunity during incarceration for healthcare needs to be addressed, but in reality, this is extremely challenging to achieve, and the inverse care law is starkly felt. Members of the Deep End group who are clinicians working on the frontline in prison healthcare report significant workforce and workload challenges, inadequate access to medical information, poor IT interfaces, training issues, poor access to mental health and addiction care, lack of connectivity with other agencies to name but a few. We would like to host this roundtable to better understand what drives these issues and what could be done to support those working in prison environments to maximise the opportunity to provide accessible, safe, high quality care for prisoners during incarceration and on liberation.

We very much hope that you can join us to share your expertise and offer your influence to make positive change.

We look forward to hearing from you

Best wishes

Carey Lunan – GP and Chair of Scottish Deep End project

David Blane – GP and Academic Lead of Scottish Deep End project

Jag Hillhouse – GP, HMP Barlinnie