13. HEALTHCARE IN PRISONS

Introduction

13.1 In order to address the specific questions regarding current practice in relation to healthcare centres it is necessary for the Inquiry to understand the extent to which the delivery of healthcare has changed in the past five years. This is described in John Boyington's statement to the Inquiry dated 12 October 2004 at paragraphs 35 to 43: "Changes instituted in the structure for delivery of healthcare in prisons since April 2000". Similarly healthcare screening is now being conducted very differently under a new triage-based health screening procedure described in John Boyington's statement at paragraphs 51 to 56. The Inquiry is also referred to the documents supplied with John Boyington's statement. (A number of these are being re-supplied for ease of reference).

13.2 On 1 April 2003 funding responsibility for primary healthcare services in the publicly run prisons in England was transferred from the Home Office to the Department of Health, and for those in Wales to the Welsh Assembly Government. From 1 April 2004, 18 NHS Primary Care Trusts (PCTs) assumed commissioning responsibility for the primary healthcare services in 34 prison establishments in England. From 1 April 2005 PCTs assumed that responsibility for the great majority of the remaining publicly run prison establishments. The only Prison-PCT partnerships where transfer of commissioning responsibility to the PCT is being deferred until April 2006 are Leicester (Leicester East PCT), Wellingborough (Northamptonshire Heartlands PCT) and Wormwood Scrubs (Hammersmith and Fulham PCT). The Welsh Assembly Government will be devolving commissioning responsibility for the health services in the three public sector prisons in Wales to the three relevant Local Health Boards in April 2006.

13.3 There are four categories of prison healthcare. These are described in Appendix 4 of "The Future Organisation of Prison Heath Care" (see paragraph 31 of John Boyington's second statement) (document 54). These are:
i. Type 1 - Daytime cover, generally by part time staff. (No inpatient facilities)

ii. Type 2 - Daytime/24-hour cover, generally by full time staff. (No inpatient facilities)

iii. Type 3 - Healthcare Centre has 24 hr nurse cover, usually with inpatient facilities.

iv. Type 4 - As type 3 but also serves as a national or regional assessment centre, used by other prisons.

13.4 There is no centrally prescribed complement for establishments within each category and staffing levels and skill mix vary according to the size and client group of each individual establishment. The mental health in reach teams are described in more detail in the section on mentally disordered prisoners.

13.5 The new reception health screening system has been introduced at all prison establishments that receive prisoners direct from the courts. The various processes involved are set out in detail in an information sheet provided to establishments, “First Reception Screening Process and Guidance” (document 55).

13.6 Monitoring the quality of the screening tool and ensuring the screening process is being correctly implemented in establishments will be achieved through planned audit visits to establishments in conjunction with local regional teams. Over time, the responsibility for monitoring arrangements will permanently transfer to the NHS (Primary Care Trusts and Strategic Health Authorities). There will inevitably be a period of transition before the new monitoring arrangements take full effect. Monitoring is also undertaken through audit of compliance with the Health Service for Prisoners Standard, This Audit Standard is referred to at paragraph 4 of John Boyington's statement and in a letter to the Inquiry from Cathy Kennedy of the Treasury Solicitors dated 27 January 2005. (A copy of the current Audit Standard dated May 2004 is document 56). This is, however, now optional for those establishments where the PCT has assumed responsibility for commissioning primary health services (that is in all but the 3 establishments referred to
above). Even where such audit continues the governor is not obliged to implement any ensuing recommendations made by the audit team.

Healthcare screening and the circumstances in which a prisoner is seen by a doctor on reception

13.7 As a consequence of these changes the position now is that on first reception into prison custody any member of the healthcare staff with appropriate skills and trained to use the screen will conduct the First Reception Health Screen. As explained in John Boyington's statement (see page 17, paragraph 55) all staff undertaking reception screening have undertaken training in carrying out the new screening. (Copies of the First Reception Health Screen form in respect of Adult Males and Females are document 57 and document 58 respectively). As can be seen referral to a doctor will depend upon answers to questions about the prisoner’s physical health and referral for a mental health assessment will be to the mental health in reach team.

13.8 The full First Reception Health Screen is for first receptions into custody only. Repetition of this screen is not necessary when prisoners are received on transfer from another prison establishment, or when returning from court, hospital or some other absence, as information from their first screen and subsequent clinical notes will be available.

13.9 There is a mental health screening as part of the health screen. Prisoners who give positive answers to any of the four screening questions will be referred for a mental health assessment. It should be noted that any prisoner charged with murder or manslaughter is automatically referred for a mental health assessment.

13.10 Finally there are screening checks for any other health issues or questions which might require referral to the doctor. At the completion of the health screen the member of staff completing the screening, or doctor in the event of referral to the doctor, is asked to confirm whether the prisoner is fit for normal location, work and any cell occupancy. Should there be a referral to the doctor but the prisoner cannot be seen before first night and cell allocation, the nurse conducting the screen or another member of healthcare team will take the decision.
13.11 Where referral to a doctor is made, how quickly the prisoner is then seen by a doctor will depend upon locally agreed protocols governed by the medical condition that triggers the referral. The First Reception Screen is used only in establishments that receive prisoners directly from court and the level of healthcare at such establishments will be of a broadly comparable standard. At those establishments receiving prisoners from the Courts practices vary. In some establishments there will be a doctor on site during the evening period to see those who are indicated through the screening process. Others will not routinely have a GP on duty in the evening and those needing to see a doctor will see one the next day. Establishments have different practices with regard to out of hours cover including Sundays and Bank holidays. Some will, for example, have arrangements with a service provider for a telephone advice service or a GP out of hours service, but this will not provide routine prisoner screening. Similarly establishments will have differing practices to ensure that all who need to see a doctor are seen. For example it is good practice to have a dedicated First Night Centre routinely checking all IMRs to ensure that all prisoners needing to see a doctor within 24 hours have in fact been seen and for the doctor to do a “round” on the First Night Centre each morning following reception to follow up those that didn’t get seen the night before.

13.12 The nature of any examination which the doctor is required to carry out will depend upon what triggered the referral to the doctor and what he or she considers necessary based on health screening information or information provided by the nurse or other member of the healthcare team or the prisoner. A full mental health assessment will be carried out through referral to the mental health in reach team.

13.13 In some establishments there can be some practical difficulties arising from the screening process, particularly at busy local prisons. Most notably if a prisoner arrives at the prison late (after or shortly before the day staff shift finish time which varies from prison to prison), or if a large number of prisoners arrive during the evening. Either of these eventualities may result in the screening having to continue beyond the official end of the staff member's shift. There is also the risk that the Prison will be in “Night State” before the screening is finished. This means the Prison will be on greatly reduced night
staffing levels. Prisoners are not routinely unlocked therefore after night state commences. For example, at Wormwood Scrubs – a busy local prison, new prisoners who have not undergone a screening are located in dormitory accommodation within the First Night Centre. Screening therefore presents two problems: firstly, it is a serious security risk when a dormitory holding six prisoners is unlocked during “Night State” when staffing levels are greatly reduced. Secondly, the act of calling a prisoner for a screening often wakes the other occupants and is unsettling for them. However, at Feltham the First Night Centre has single cells and therefore unlocking is not a problem.

13.14 Establishments operating with a relatively small healthcare centre who rely on agency nurses may experience some difficulties in ensuring that there is always a nurse trained in the screening method available on reception.

The new clinical record

13.15 As referred to in John Boyington’s statement page 17, paragraphs 57 to 59 the IMR has been replaced by the new clinical record. The Inquiry is referred to the Guidance upon its use (document 59). A blank copy of the form HH003 is document 60.

Availability of clinical records

13.16 Previous clinical records are unlikely to be available at the time of any first reception health screen. The health-screening tool was developed with this eventuality in mind. The position is, however, different at training prisons where prisoners will normally be received with their clinical notes and where the first reception health screen is not used.

13.17 At those establishments receiving prisoners from the Courts, it is unlikely that records will be available from previous unrelated periods of imprisonment or from treatment undertaken in the community. The prisoner will often be delivered directly to the prison from court with little or no advance warning. Previous records are likely to be held at the last discharging prison. In some cases a prisoner may disclose details of previous imprisonment and/or may be using an alias. Even where a prisoner has previously been in custody at
the same establishment, if the prisoner fails to inform the establishment of this fact their notes will not be married up unless their name appears several times on LIDS with different numbers. Where a previous period of custody is known about the notes will be sought by the Healthcare Administrative staff who will then combine them into a single set of notes. These are frequently not available until 48 hours after reception and may be as long as 72 hours after reception where the weekend intervenes. The timescale will be even longer if previous periods of custody were spent at other establishments. It is recognised that the storage, retrieval and sharing of clinical information can be a significant problem. A project funded by the NHS Connecting for Health agency (formerly the National Programme for IT) is underway to tackle this over the next 3-5 years. This should provide an electronic solution to problems of retrieval and inter-prison transfer of records but implementation is still some way away.

13.18 The practicalities of obtaining medical records (which are still largely paper based) from previous periods of imprisonment are such that it is unlikely that they will be obtained early enough in a period of imprisonment for them to provide useful information to inform on risk factors that will influence early decisions on the prisoner’s care and management.

13.19 The ‘Health Services for Prisoners’ Standard requires establishments to make every effort to request any information required from the prisoner’s GP, or other relevant service with which he/she has recently been in contact. This should normally be subject to the prisoner’s explicit consent, although in exceptional circumstances information may be requested and disclosed without consent. Rather than the GP record itself being transferred, a summary of key information would be communicated. It must, however, be recognised that a significant proportion of the people who are received into prison are not registered (or at least are not in active contact with) a GP. It is good practice that, once any previous internal or external records are received, they should be reviewed by the healthcare staff and any appropriate action taken. Where a prisoner is identified as having mental health issues, it is common practice that the mental health in reach team will follow-up the prisoner and healthcare staff will begin to chase records from other prisons and from surgeries and hospitals. It is a common experience
that surgeries and hospitals are frequently reluctant to disclose information. Efforts have been made to resolve these difficulties, for example, through issue of the guidance described in paragraph 21 below, which includes a framework for developing effective inter-agency information sharing, including information sharing protocols. If information is received indicating that a prisoner should be examined again, this will be carried out on the wing through the GP surgery.

Sharing of confidential medical information/information on a prisoner’s mental state

13.20 In addressing the position with regard to when confidential medical information may be shared, including that which concerns the prisoner’s mental state, the following guidance on the use of confidential health information is relevant.

13.21 Detailed guidance was given to establishments in May 2002 in the form of Prison Service Instruction 25/2002, ‘The Protection and Use of Confidential Health Information in Prisons and Inter-Agency Information Sharing’ and its associated Information and Practice note ("I&P") (document 61). It addresses the use of confidential health information within prisons, access to and protection of such information and the sharing of information between the Prison Service and other agencies. This promulgation of detailed guidance on best practice for information sharing within current legal requirements and professional codes of conduct was intended to increase staff confidence in sharing information in appropriate circumstances.

13.22 Disclosure of confidential information should, as stated earlier, normally only take place with the consent of the individual concerned. The guidance sets out the circumstances in which information may be disclosed without consent at paragraph 2.3. It provides that Information can be shared without consent if it is required by statute or a court order. Disclosure without consent can also be made in exceptional circumstances if it is considered essential to protect the individual or anyone else from risk of death or serious harm, or for the prevention, detection or prosecution of serious crime. In such circumstances, the benefits of disclosing the information must be considered to outweigh the patient’s or the public interest in keeping the information confidential.
13.23 The General Medical Council (GMC) published guidance on protecting and providing information in September 2000, the relevant passages of which are reproduced in the PSI referred to above in appendix 1.

13.24 In addition, an information resource, entitled "SECURE" (document 62), has been issued and is updated quarterly. It sets out all the currently available information on sharing information in the NHS and prisons. This has been designed to ensure that healthcare staff understand their responsibilities in relation to information governance and can be used as part of the induction programme for all new prison healthcare staff. A new version of "SECURE" called "FOCUS" (May 2005) focuses on the juvenile estate (document 63).

13.25 Guidance and good practice specific to continuity of care for prisoners with mental health problems can also be found in the Offender Mental Healthcare Pathway document (document 65). Decisions upon sharing information about mental state with non-medical staff are a matter of judgment, depending on the circumstances. It is evident from the Care Pathway document that good continuity of care depends upon the communication of relevant health information about prisoners to those to whom their care is entrusted, particularly as in many establishments prison officers form part of the team. Examples include communication of relevant health screening information to first night officers and induction officers (page 9 Care Pathway document) and the involvement of wing officers in the care plans of prisoners whose mental health needs are being managed on ordinary location (see pages 11 and 13 Care Pathway document). Care Pathways will be covered in greater detail in the next section on mentally disordered prisoners.

13.26 The Inquiry should also note that the guidance to establishments in the I&P concerning confidential health information will be reinforced through the inclusion of further appropriate material in a Prison Service Order on Improving Continuity of Care which is due for issue shortly. This will stress the importance of effective information sharing with other agencies (in particular the NHS) and within the Prison Service, to enable continuity of care for individuals as they pass from the community to prison and back again.
13.27 The nature and extent of the obligation to disclose confidential information about service users, between different agencies and within multi-agency teams is governed by a complex statutory and common law framework, allied to a multitude of government policy and best practice guidance.

13.28 In practice the sharing of confidential information is a key issue operationally and can lead to a problematic relationship between healthcare staff and “discipline” staff who can feel they are not given all the relevant facts due to medical confidentiality issues. In turn, healthcare staff may feel they are being put under increasing pressure to give more and more detailed information on PER forms and that this runs counter to the medical in confidence guidelines by which they are bound. It is submitted that the key to striking the right balance between the need for confidentiality and the safety of others depends upon the understanding by all those working in the prison environment of confidentiality issues and how to handle medically confidential information appropriately. It should be emphasised that the guidance to healthcare staff is that patients should be asked to agree to the disclosure of certain information to teams, which may include discipline officers, who are all then bound by confidentiality clauses. This practice is common in NHS settings. The issue of the SECURE pack of information is intended to ensure that all staff within prisons have access to accurate information and guidance in this regard. The balance of decisions on disclosure must lie with professionals on the ground who are able to weigh up the various issues and circumstances and be accountable for them. It is not possible for guidance to cover every eventuality.