NHS Highland

Health and Healthcare Needs Assessment:

Inverness Prison

PUBLIC HEALTH

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Dedicated to Alexander Hamilton who died on the 19th July 2020. Sandy was an exceptional nurse to all those in the care of this prison. He was a treasured colleague and friend to staff working for the NHS, HMP Inverness and partners.

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Acknowledgements

Thank you to the Advisory Group whose guidance was invaluable in carrying out the work and writing the final report. Thank you to those in the care of the prison, and staff from Highland Council, NHS Highland, Scottish Prison Service and other partners who gave their time to complete questionnaires and contribute to focus groups.

Contents

Executive Summary

The main purpose of this needs assessment was to consider the health and health care needs of those in the care of the NHS health and health care services based within HMP Inverness. Future prevalence estimates of health care needs for the larger prison population in a planned new build were also included.

Inevitably, when engaging with those who are the recipients of NHS health and health care services and also with staff who provide the services, conversations included the wider determinants of health such as the impact of inequalities and concerns over social issues such as future employment opportunities, housing, finance and the impact of stigma.

This report is in six sections.

The first section provides background and contextual information explaining why the Head of the NHS HMP Inverness health care service and the HMP Inverness Prison Governor commissioned this health and health care needs assessment. There is also an explanation for the use of the 'People First' language which the reader may take a little time to get used to. The reason is to avoid using discriminatory or negative language and instead use language that puts the person first rather than the problem.

The second section presents the key results of a data mapping exercise which was undertaken to understand the various qualitative and quantitative data sources. In respect to this male population group, the majority of those in the care of the prison were sentenced for less than four years and/or on remand. There were also some vulnerable people with longer sentences. The data shows that self-assessed health status and wellbeing is worse than in the general population and that harmful behaviours such as smoking and alcohol and drug use is greater than in the general population.

The most common medicines prescribed were in the British National Formulary therapeutic areas for the central nervous system and the second most common was prescribing for musculoskeletal and joint disease. Both of these groupings reflect a high prevalence of a wide variety of analgesic and mental health medications some of which can be used inappropriately. The health care centre dispenses the majority of drugs twice daily and through direct observation. This is a time hungry process because it requires nursing staff to oversee the medication process and prison officers to escort those in the care of the prison to the medical centre. The number of complaints and comments received is also another time pressure on the NHS staff.

The third section of this report describes the outcomes of the stakeholder engagement and gives a voice to those in the care of the prison as well as NHS and Prison Officer staff and other partners.

Overall, those in the care of the prison were appreciative of the health care, dental services and physical activity received. There were differences between the views expressed by those on a 'protected' sentence in comparison to the 'remand' and 'convicted' sentences although all groups raised issues about experiencing high levels of stress and anxiety. For those in the 'vulnerable' or 'protected' category they raised issues that were associated with being in a prison longer such as self care and experiencing ongoing stigma. With respect to those on remand or convicted sentences, more immediate issues were raised such as the loss of the throughcare officer role, anxiety and stress because of housing, financial issues, and the need to maintain family relationships.

NHS and Prison Officer staff taking part in the focus group reported that access to the health care services were better than in the community but improvements were hampered largely by the environment and staffing pressures. Although working relationships between the two groups was positive there was some scepticism expressed towards 'management' and day to day functioning of the prison.

There were differing views expressed (from all focus groups) about the 'Personal Officer' role; one being that this undefined role was 'utopia' and the second being an opportunity for building a trusted relationship. Where this role worked well it was reported to be officer dependant. There was also reported a lack of empathy by some staff towards those with problematic alcohol and drug use. Negative attitudes were

expressed in all focus groups, (apart from the 'vulnerable' focus group), towards those in the care of the prison in the 'vulnerable' category. This group, however, did not report experiencing negative attitudes.

The fourth section provides a summary from a previously published literature review. There are number of topic areas identified and overall mental health remains the key area of concern and whilst prevalence estimates vary substantially the burden of mental health issues is greater than that of the community. Similarly, problematic alcohol and drug use is higher compared to the general population and disproportionately affects those with mental health issues. The growing number of older prisoners with additional needs was also identified as an area to proactively plan for immediately and for the future. The literature review also contains a prevalence table for a range of chronic conditions and has the potential to be used as a planning tool for the new build prison population.

A number of limitations are described in section five, such as the impact of pausing the project because of COVID-19, prison security and the different understanding of 'health' resulting in wide ranging discussions. Complex issues were discussed but many are not in the control of the oversight group to change.

Finally, in section six, a list of prioritised recommendations are presented.

1. Why this health and health care needs assessment?

The health and health care needs of those in the care of prison remains poorer than the general population and the prison setting cares for some of the most vulnerable in society (see accompanying literature review[1]). Inverness Prison and health care services were due to move into a new modernised purpose built building and it seemed timely to consider the health and health care needs of those in the care of the prison prior to this move. At the time of writing, the date of the move is unknown although the tendering process has commenced. The authors expect, however, that many of the recommendations will be of interest to the NHS, the Scottish Prison Service and other service providers and decided to complete the report.

The impact of the COVID-19 pandemic has delayed the report by at least twelve months. From March 2020 HMP Inverness and NHS health care had to change how they operated and how services were delivered. It is anticipated that some of these changes may supersede the findings of this report and that many issues/problems have been amplified. It has not been possible to go back and revisit this agenda, but recognise that the impact of COVID-19 and lessons learnt will be the subject of future service audits, improvements or research.

1.1 Aim

To investigate and understand the current health and health care needs of those in the care of the prison and then to recommend how the health care services and other related services might be improved.

The health and health care needs assessment (HNA) also estimates the future health care needs for the larger prison population in the planned new build.

1.2 Objectives

- To understand the current health and health care needs of prisoners in Inverness using data, evidence and engagement of prisoners and staff
- To understand the current health and health care provision in Inverness prison using data and engagement of prisoners and staff
- To summarise the evidence base for prisoner health and health care
- To make evidence based, locally informed recommendations to improve the health and health care needs of prisoners now and potentially at a future site

1.3 Scope

The scope of this HNA is health and health care needs and provision. It is anticipated that this would include health care services, health behaviours (smoking, drug use, healthy eating and physical activity) and address the wider determinants of health such as the impact of inequalities and housing. The initial engagement of staff and people in the care of the prison will inform the scope and focus of this health care needs assessment.

The work commenced in September 2019 and was completed in Spring 2020. The impact of COVID-19 resulted in a delay publishing the final report.

The authors of the report agreed to use language suggested, where ever possible, by the advisory group to describe the prison population. People-first language emphasises the individuality, equality and dignity of people rather than defining people primarily by a problem or issue that can have negative associations. This is aligned to the Scottish Drugs Forum 'People First Language Matters' campaign[2]. The agreed description for the commonly used term of 'prisoners' is 'those in the care of the prison'. There are some occasions where this language is not used and this relates to work undertaken by other people particularly in the literature review.

1.4 About Inverness Prison

HMP Inverness serves courts in the Highlands, Islands and Moray, a large and diverse catchment area embracing rural and urban communities. The prison has a design capacity of 103, but currently averages a daily population of 117. The prison population includes those on remand both male adult and male young persons, male convicted adults serving up to four years and various other male offenders who are awaiting to go to their prison of allocation or need to spend time in the care of a prison with a high level of management and support. Those in the care of the prison in this last category tend to be serving long term sentences.

The present prison was opened in 1902, having relocated from nearby Inverness Castle to what was, at that time, the rural parish of Porterfield. There were 25 male and 10 female offenders in accommodation comprising of 49 cells. The accommodation halls within the confines of the original wall have changed internally over the past 100 years, although their facades have remained the same. A number of extensions and extra buildings have been incrementally added to cope with rising and changing demands. The original cells were barely furnished but now they have been modernised and have in-cell sanitation, bunk-beds, fitments, electric power and television sets.

The working environment and terms and conditions for staff has changed considerably moving from that of 'turnkey' to actively engaging with those in the care of the prison for prevention, rehabilitation, recovery and desisting from future offending. Prison health care services were transferred from the Prison Service to the NHS in 2011 and a local General Practice provides primary care[3].

1.5 Our approach to the health needs assessment / management

Advisory group

In the autumn of 2019 an advisory group was established to guide the overall approach of the health needs assessment (See appendix 1 for the membership list). It was agreed by the advisory group that other consultees could be invited to contribute as the project developed. These are listed in the 'other' category in Table 1.

Table 1: Advisory Group and consultees

Organisation/Agency	Discipline represented
NHS	Public Health; Drug and Alcohol Recovery Services; Dentistry; General Practice; Mental Health; Pharmacy; Physiotherapy; Psychiatry.
Prison Service	Governor; Senior team
Highland Council	Education
Other (consultees)	Sexual health team Chaplain Department of Work and Pension work coach Fife college education team Public health nurse for travelling community Prison dentist and oral health practitioner Prison officer lead for My Compass outcome tool

The authors of the report were also in contact with the Public Health Special Interest Group for Prisons. This group reports to the Scottish Directors of Public Health, Public Health Scotland.

At the onset of the project 'terms of reference' were agreed (see appendix 2), Caldicott Guardian agreement was sought and approved, and an equalities impact assessment completed (see appendix 3).

The group met on four occasions (September 2019, December 2019, February 2020 and March 2020) to either plan the work or to discuss findings of the data. The final document was due at the end of May 2020 but because of the COVID-19 lockdown on 23 March 2020 the project was paused.

Recommendations

R1: Reconvene the health and health care prison group to consider these recommendations and to either develop an action plan or utilise existing Prison/NHS planning mechanisms.

R2: Reconvene the health and health care prison group to discuss and reflect on the impact of COVID-19 on how HMP Inverness responded and lessons learnt.

R3: Development of / or refresh an existing healthy prison workforce plan; include a training programme addressing the topics and needs identified in this HNA.

2. Data

A data map was developed to track the different types of qualitative and quantitative data that might be available for this health and health care needs assessment. Appendix 4 has more detail including the data sources (thank you to NHS Lothian Public Health colleagues for sharing their health intelligence work). Once the list was developed, a pragmatic approach was taken about what was reasonably practical in the time scale and within the resources available.

Two questionnaires were developed and findings are reported in this section. The questionnaires were developed with advice from the advisory group and were piloted with assistance from members of the advisory group.

The questionnaires were:

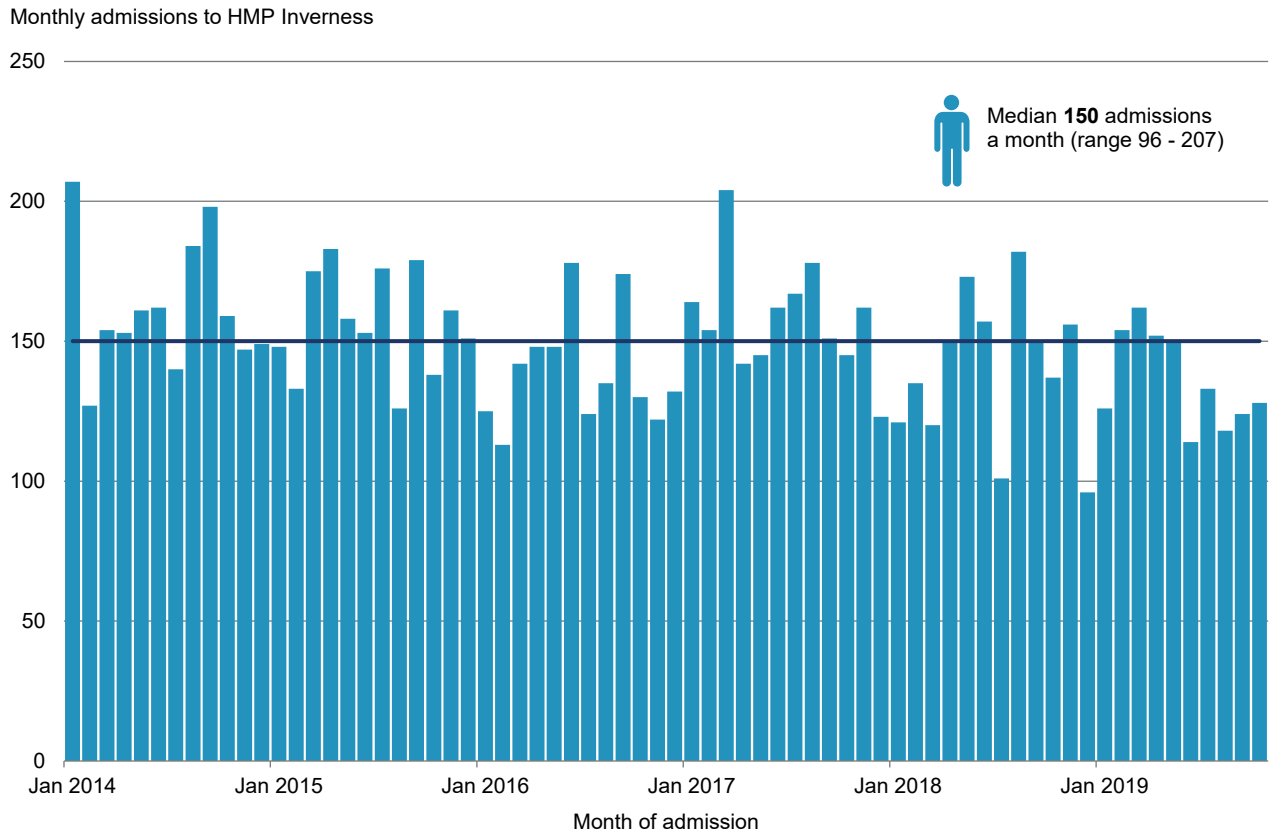
- HMP Inverness Healthcare Questionnaire: for people in the care of the prison. See appendix 5.
- HMP Inverness Healthcare Questionnaire: NHS, SPS and advisory group members. See appendix 6.

2.1 Demographics of the prison population

Data about the prison population are based upon Scottish Prison Service PR2 information management system datasets provided by Scottish Prison Service staff for the period January 2014 to October 2019. PR2 is an administrative system which, as with any large scale recording system, may be subject to possible errors with data entry and processing.

2.1.1 Number of admissions

Figure 1: Monthly admissions to HMP Inverness, January 2014 to October 2019

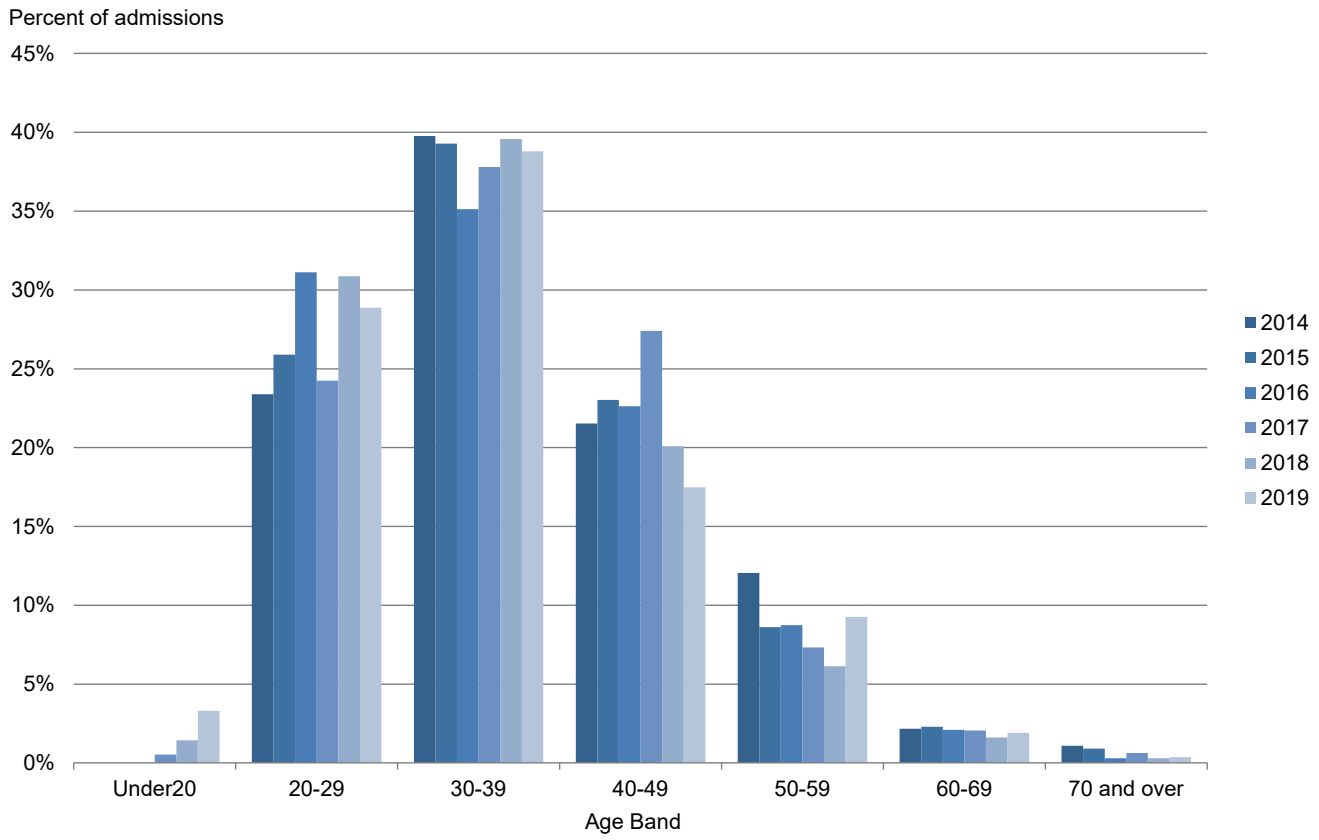


Source: Scottish Prison Service PR2 Information Management System

Figure 1 shows the number of admissions to HMP Inverness between January 2014 and October 2019, and includes the number for those in the care of the prison sentenced and remand. These data demonstrate the high turnover of people in the care of the prison. During this time period there were over 10,400 admissions with a median of 150 per month. Of those sentenced, 19% received a sentence length of 0-3 months and a further 25% 4-6 months. 7% received a longer term sentence over 5 years.

2.1.2 Age Profile

Figure 2: Age profile of admissions to HMP Inverness by ten-year age band



Source: Scottish Prison Service PR2 Information Management System

Figure 2 shows the age range of admissions in ten year age bands. The average age on admission was 36.4 years (median 34 years, range 17 to 82). The literature suggests, for those in the care of the prison, aged 50 and above is considered to be older and at the time of data gathering this amounted to 12% of the prison population[4].

2.1.3 Ethnicity, disability and veterans

Figure 3: Demographics of admissions to HMP Inverness by ethnicity, disability and veteran status

Ethnicity
99% white Scottish, white, other white ethnic groups

<1% Mixed, Asian, African, Caribbean, Black or Other ethnic group

No reports of gypsy/traveller ethnicity

Disability
12% self-reported disability annually

Veterans
3% self-reported veteran status annually

Source: Scottish Prison Service PR2 Information Management System

The majority of the prison population are males (95%). A small number of women are recorded each year (5%) usually associated with court appearances or pre-release issues.

The majority of men at HMP Inverness reported their ethnicity as white Scottish (76%), white (21%) or other white (including White English, White Irish, White Northern Irish, White Other, White Southern Irish, White Welsh) 2%.

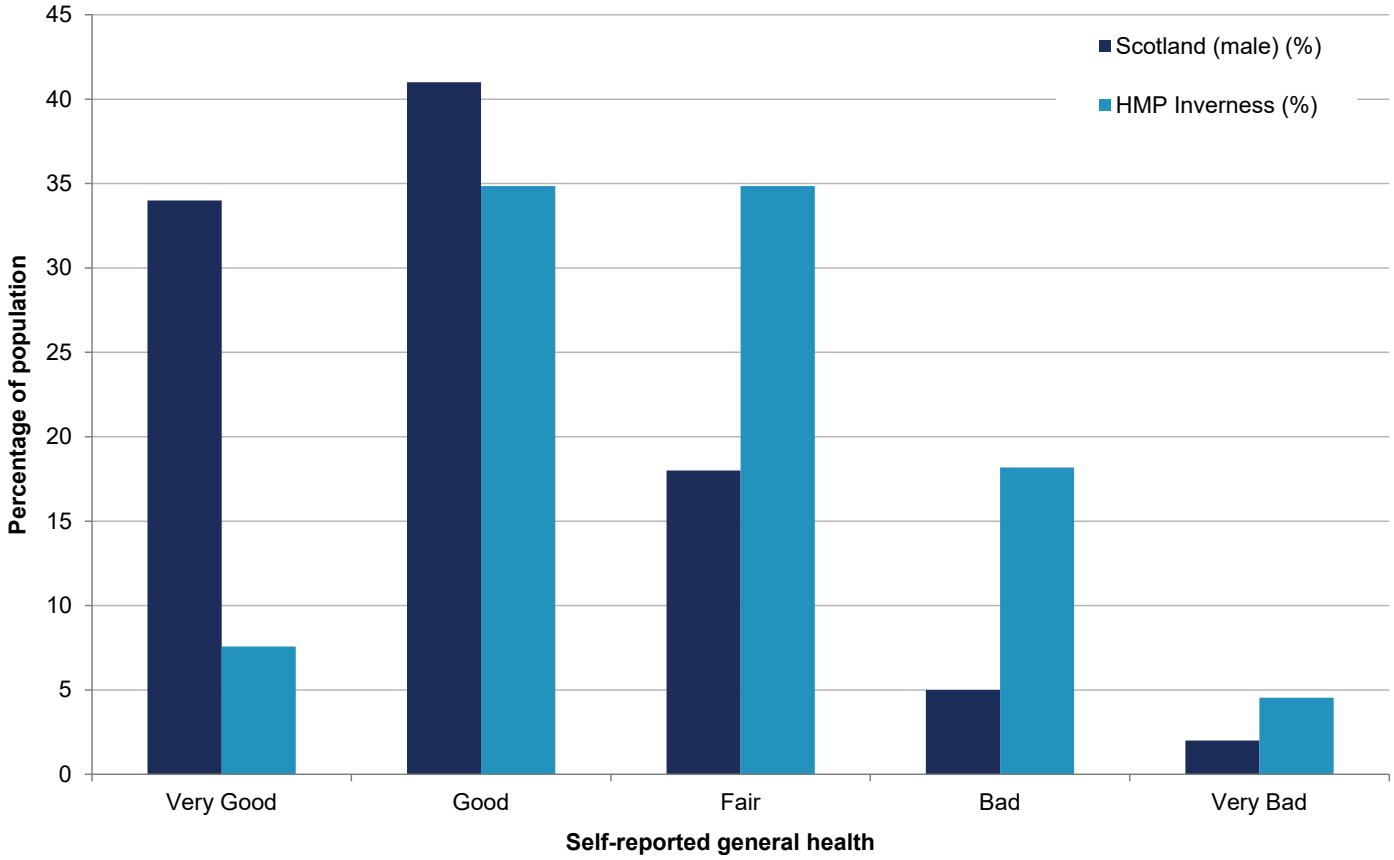
At the time of this analysis there were no reports of gypsy/traveller ethnicity although it is known that gypsy/travellers have spent time in the care of the prison. This might be an artefact of inaccurate data recording or the information was not provided by the person in the care of the prison. Less than 1% of the prison population reported their ethnicity as 'Mixed, Asian, African, Caribbean, Black or Other ethnic group'.

Approximately 200 people (12%) self-reported a disability annually.

A small proportion (3%) of the prison population self-reported veteran status. This has declined from 5% in 2014 to 2% in 2019.

2.2 Self reported general health

Figure 4: Self reported general health



Source: HMP Inverness Prisoner Survey. Base: Valid responses (n=66). Scotland comparison from Scottish Health Survey 2017 supplementary tables Part 1, % for men aged 16+[5]

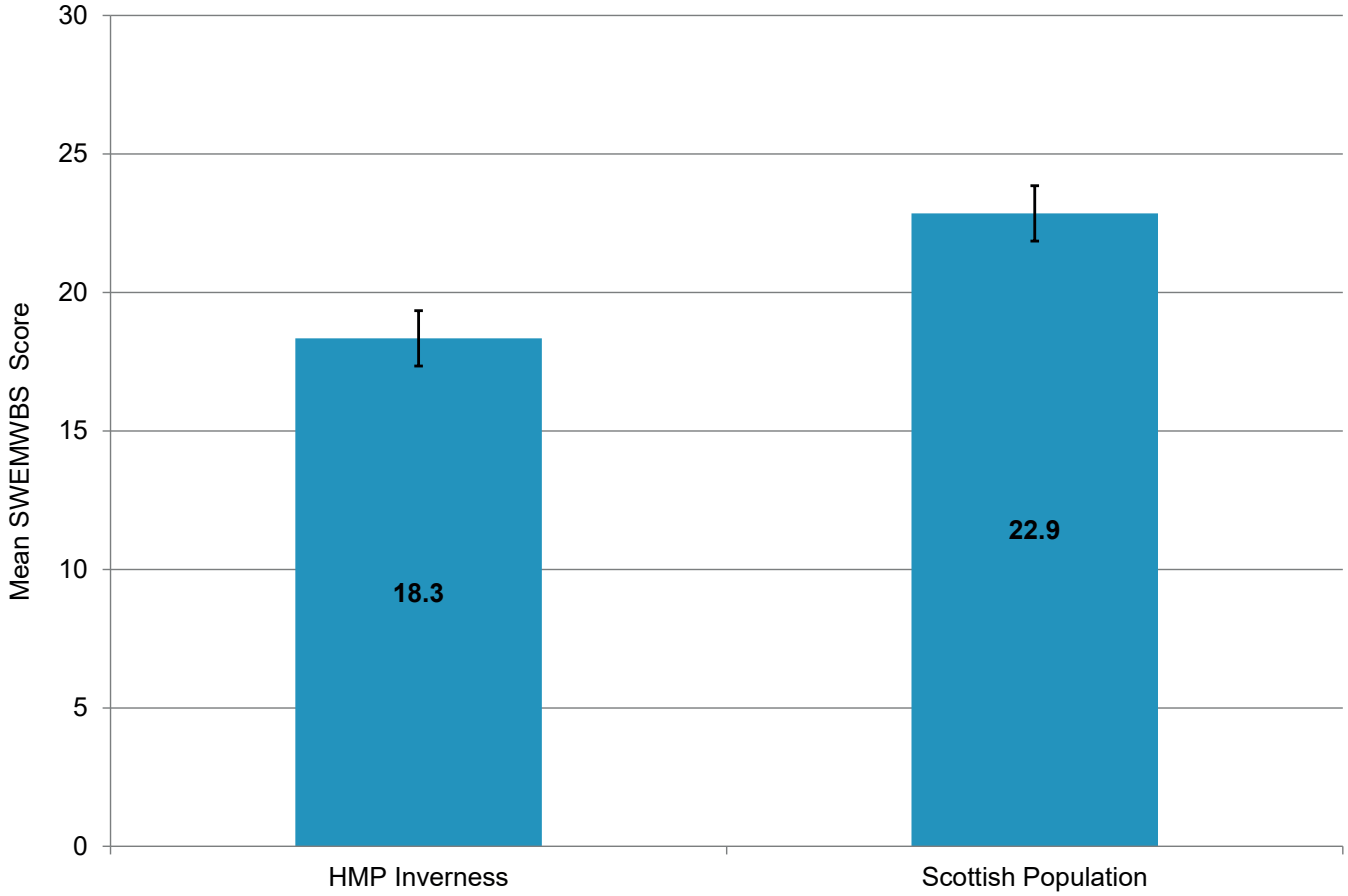
Population measures of self-reported health are used as a general indicator of the burden of disease and are collected through the Scottish Health Survey[5]. Self-assessed general health asks individuals to rate their general health status on a five-point scale: very good, good, fair, bad or very bad.

Evidence from the Scottish Health Survey reports that self-assessed general health is a good predictor of future use of health and care services, with the proportion of adults self-assessing their health as 'bad' or 'very bad' health increasing significantly with age and levels of area deprivation.

Survey data from a health care questionnaire for people living in the care of HMP Inverness shows 22% reported their health as 'bad' or 'very bad' compared to 7% in the general population.

2.3 Mental wellbeing

Figure 5: Mental wellbeing using the short WEMWBS questionnaire



Source: HMP Inverness Prisoner Survey. Base: Valid responses (n=61).

SWEMWBS: Warwick-Edinburgh Mental Wellbeing Scale (7-item). Population norm calculated from 2017 Scottish Health Survey data downloaded from the UK Data Service[6]

The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) is a validated tool used to measure mental wellbeing at a population level[7]. The short version, consisting of seven questions, was used for this needs assessment. The lower the score indicates the lower the person's wellbeing. Figure 5 shows for this population a significantly lower mean (using the short version SWEMWBS) compared to population norms.

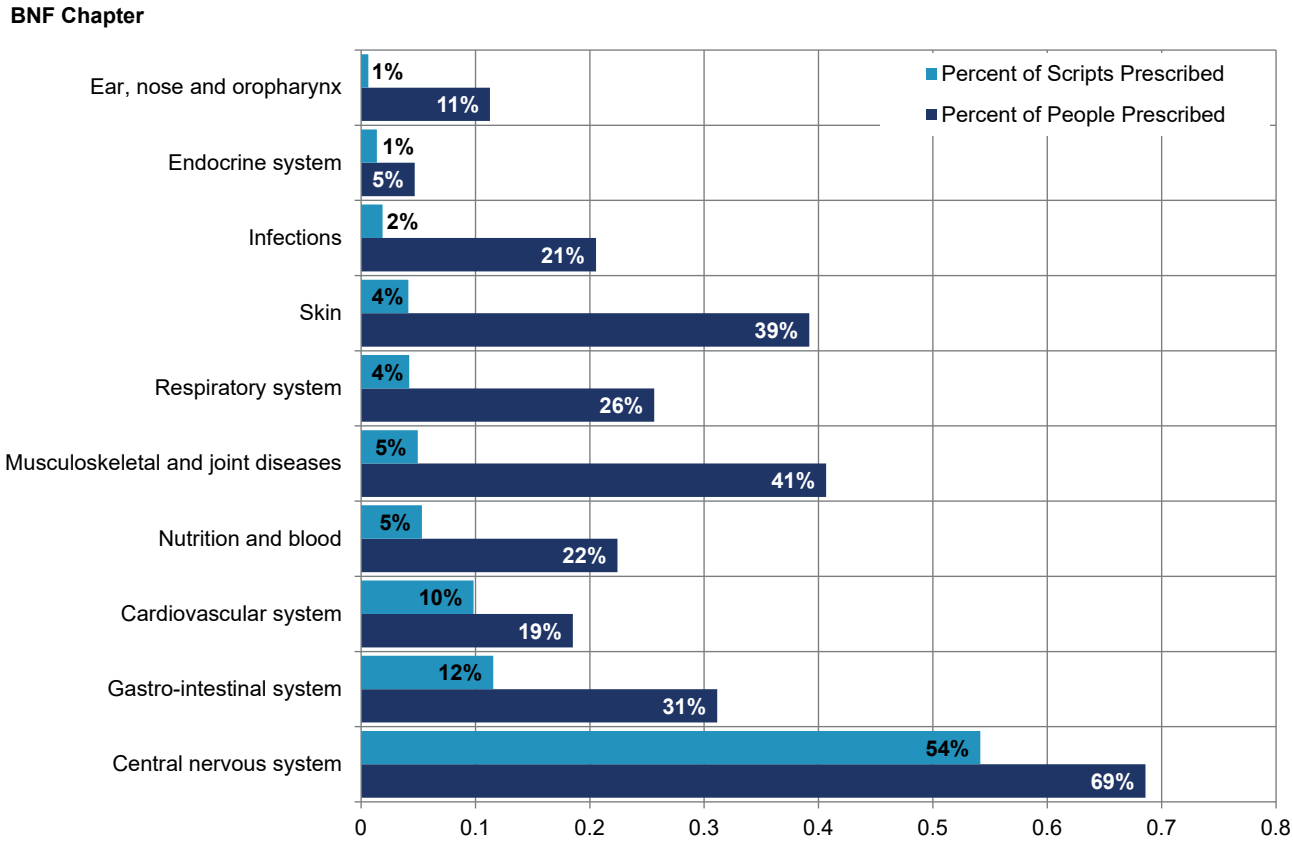
2.4 Prescribing

Data on medicines supplied to HMP Inverness are collected through a pharmacy contract with Lloyds Health care Pharmacy Services. Data were available for a two year time period October 2017 to September 2019 from a series of monthly management reports. These contain summary and individual medicine level prescribing and costing information.

The data give an indication of the use of medicines in HMP Inverness, for example, the number and proportion of people prescribed medication by British National Formulary (BNF) chapter. It does not give an indication of those that require some level of support to effectively and safely take it, other than those prescribed medicines that are normally administered under supervision, for example, controlled drugs. No breakdown was available by age and the data does not link to the clinical indications for the medicines supplied. This should be considered when interpreting these data.

2.4.1 Top 10 medicines

Figure 6: Top 10 medicines supplied by British National Formulary (BNF)[8] chapter



Source: Lloyds Health care Pharmacy Services monthly management reports, October 2017 to September 2019. Number of people prescribed at least one medicine in each BNF chapter in the time period

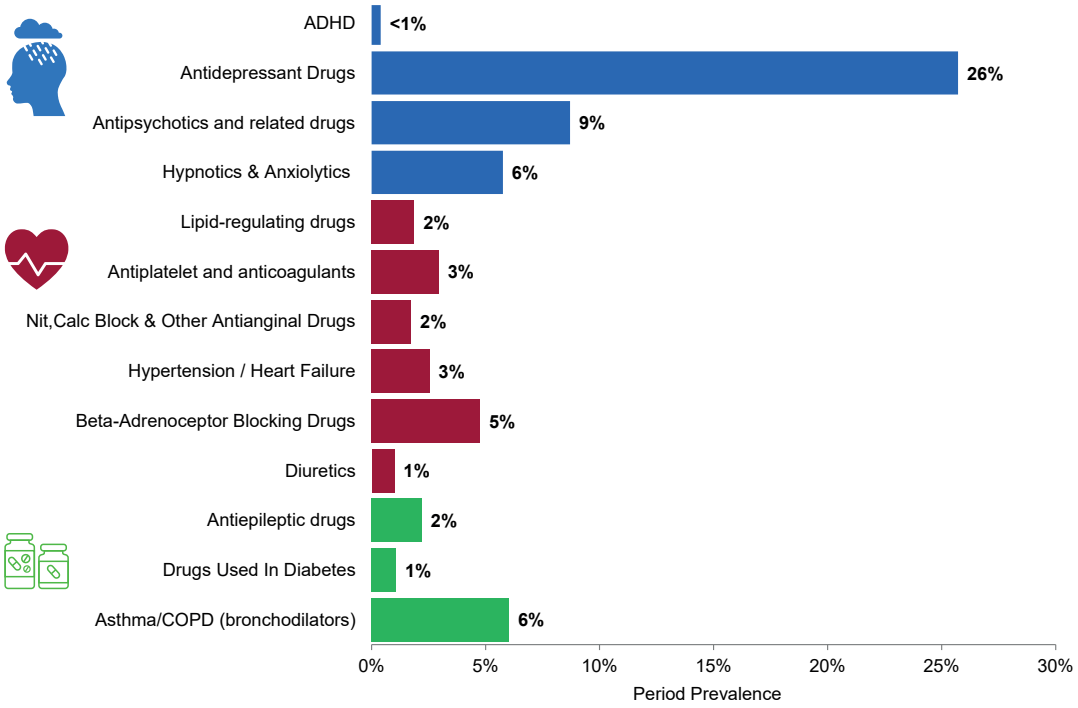
Figure 6 shows the number of prescriptions and the number of people prescribed at least one medicine in each BNF chapter in the two year time period October 2017 to September 2019. In this period there were 23,000 prescriptions written for 745 people.

The most common medicines prescribed were in the BNF chapter for the central nervous system. This includes antipsychotic drugs, anti-depressants, control of epilepsy, opioids analgesics, opioid dependence and alcohol dependence. These data will be an underestimate as no individual level data were available for the prescribing of opiate substitution therapy (OST) drugs such as methadone, suboxone and subutex.

Prescribing for musculoskeletal and joint disease, including non-steroidal anti-inflammatory drugs, were the second most common medicines. Medicines for skin conditions, mainly skin creams, emollients and topical corticosteroids, were also prescribed to a high proportion of people in the care of the prison.

2.4.2 Prescribed medicines for common health conditions

Figure 7: Estimated prevalence of people in HMP Inverness prescribed medicines for common health conditions



Source: Lloyds Health care Pharmacy Services monthly management reports, October 2017 to September 2019
ADHD: Attention Deficit Hyperactivity Disorder, COPD: Chronic Obstructive Pulmonary Disease

Figure 7 shows the proportion of people in the care of the prison prescribed at least one medicine used in the treatment of selected medical conditions. This is a proxy indicator for the point prevalence of common physical and mental health conditions. The estimated prevalence of asthma, diabetes and CHD are broadly similar to prevalence estimates in the 2012 Greater Glasgow and Clyde needs assessment (see chapter 3)[9]. It should be noted that some medications have multiple indications and it was not possible to determine from these data why the medicine was prescribed.

2.4.3 Medicines for problem alcohol and drug use

Table 2: Volume of medicines prescribed for problem alcohol and drug use

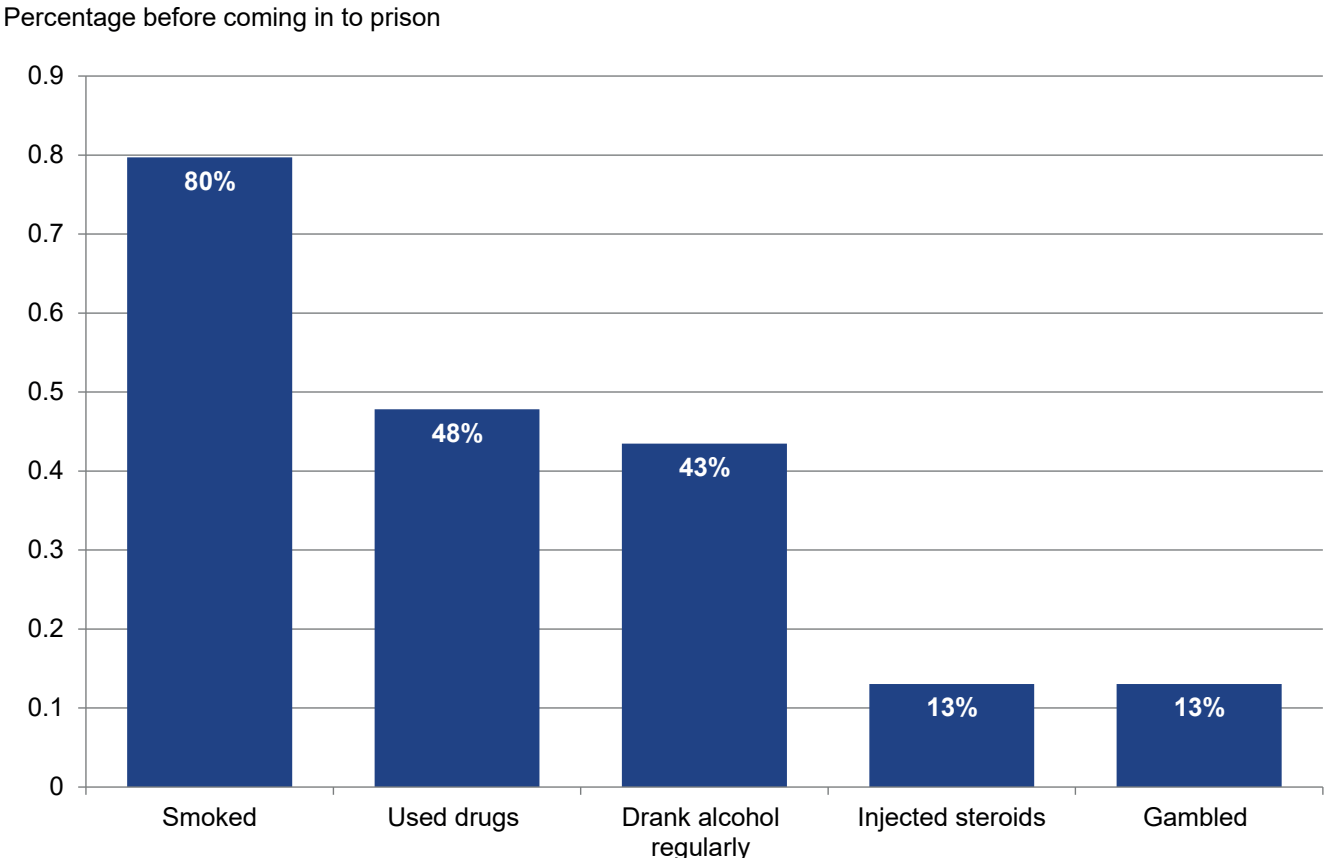
Product	Dispensed Quantity
ACAMPROSATE 333MG TABLETS	1,006
BUPRENORPHINE 2MG and 8MG TABLETS	287
DHC CONTINUS 60MG, 90MG and 120MG TABLETS	2,640
DISULFIRAM 200MG TABLETS	304
METHADONE 1MG/ML ORAL SOLUTION	736,000
NALTREXONE 50MG TABLETS	172
SUBOXONE 2MG and 8MG TABLETS	5,936
SUBUTEX 0.4MG, 2MG and 8MG TABLETS	846

Source: Lloyds Health care Pharmacy Services monthly management reports, October 2017 to September 2019

There were limited data available to describe medicines prescribed for problem alcohol and drug use including alcohol withdrawal and opiate substitution therapy (OST). This is because the majority of prescriptions were recorded under the form type 'Signed Order Institution' and did not include an individual identifier.

2.5 Reported risk factors before coming into HMP Inverness

Figure 8: Reported risk factors before coming into HMP Inverness

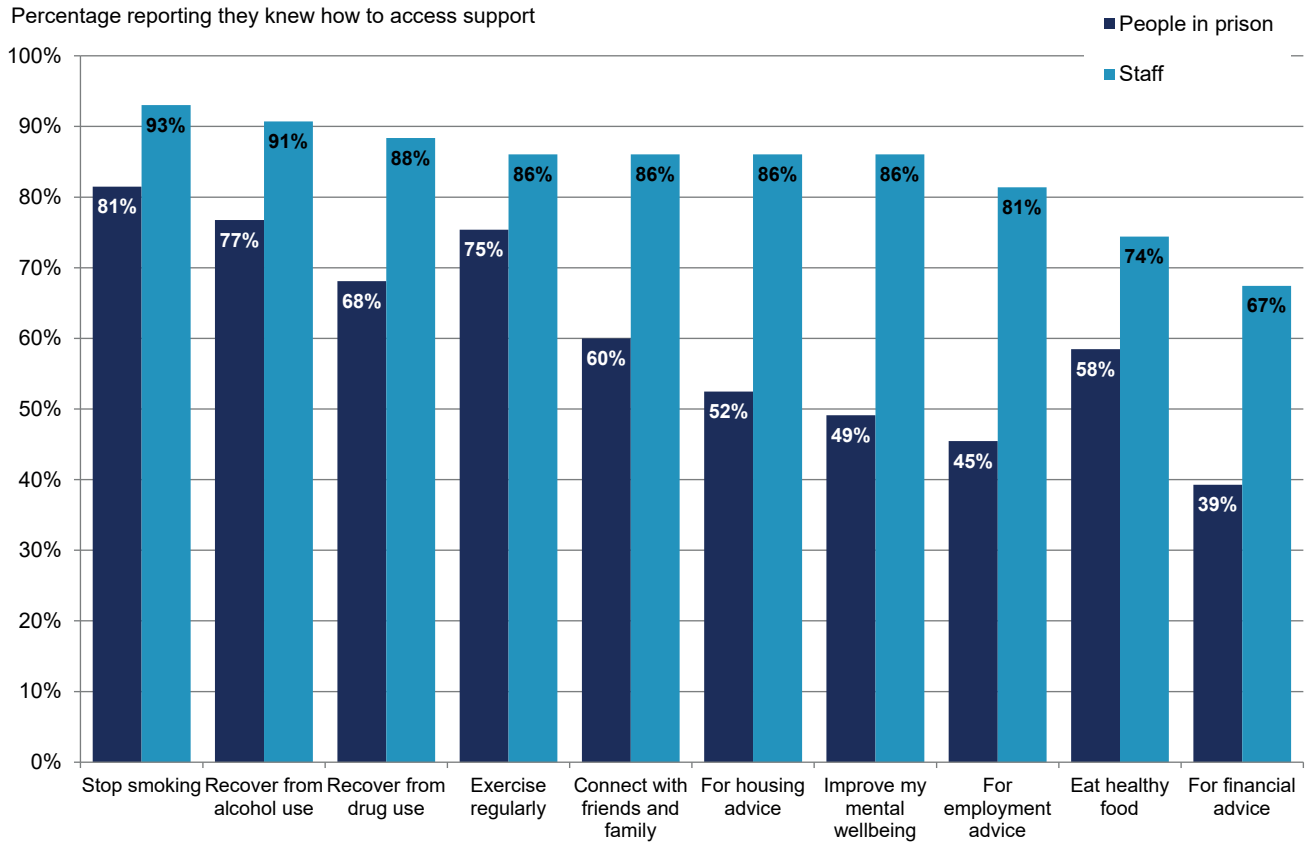


Source: HMP Inverness Prisoner Survey. Base: Valid responses (n=69)

Those in the care of the prison were asked to complete a questionnaire about risk factors before coming into HMP Inverness (Figure 8). Smoking was reported at 80%; 48% reported they used drugs, 43% reported they drank alcohol regularly; 13% reported they injected steroids and 13% reported gambling. Although this is a small sample the data can be triangulated with other data sources, for example, the 2017 Scottish Prisoner Survey reported 77% of those in the care of the prison smoked[10].

2.6 Perspectives on access to support

Figure 9: Perspectives on access to support



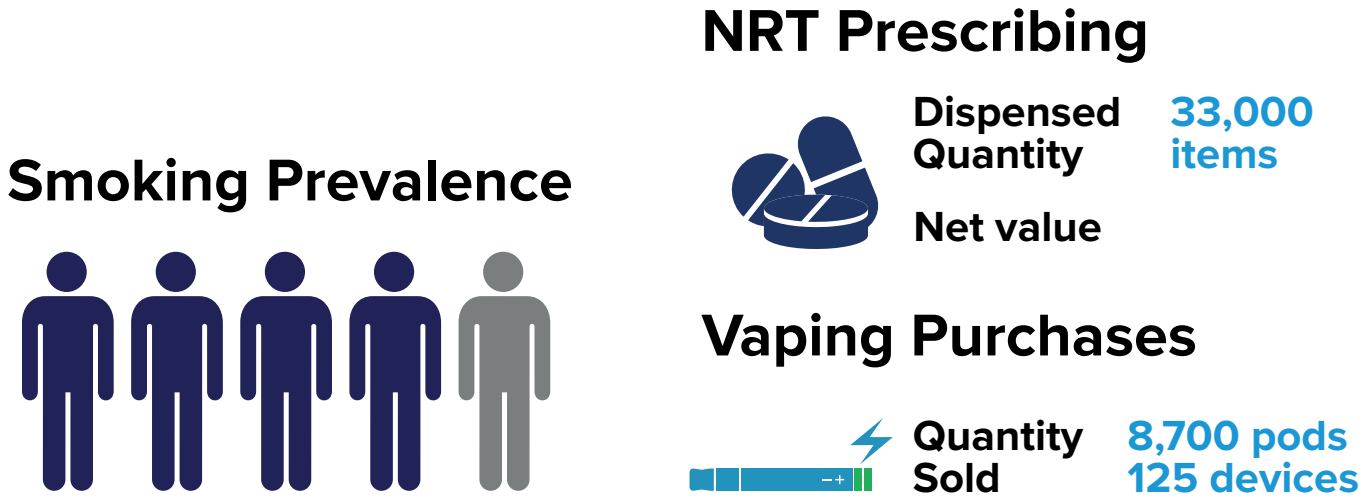
Source: HMP Inverness Health care Questionnaire for People Living in Prison. Base: All responses (n=66). HMP Inverness Health care Questionnaire for staff. Base: All responses (n=44)

Those in the care of the prison and staff were asked whether they knew how to access support for a variety of topics. Figure 9 shows the responses given and shows a high level of concordance with both staff and people in the care of the prison reporting they could access support for most issues. Staff consistently reported higher levels of knowledge.

Both groups felt less confident they could access support for financial advice, employment help and to eat healthy food. While staff reported they could support people in prison to access support for mental wellbeing fewer than half of people in prison felt they would be able to access this support in prison.

2.7 Smoking Cessation

Figure 10: Smoking Cessation

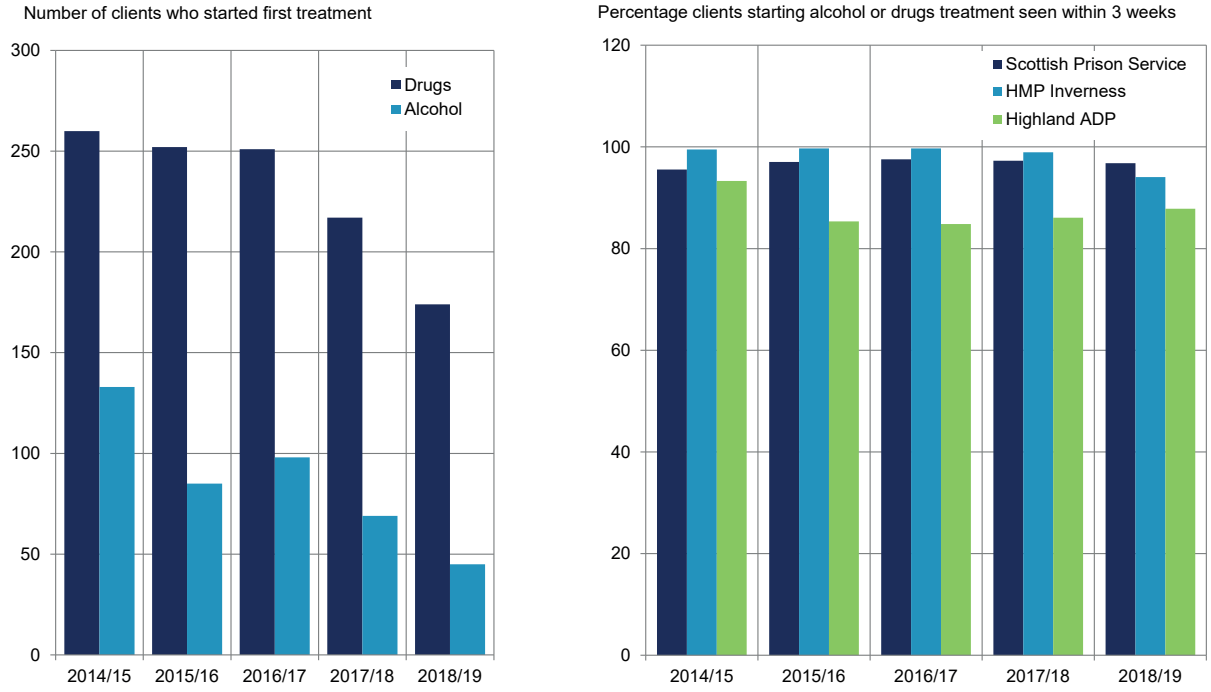


Source: HMP Inverness Health care Questionnaire for People Living in Prison. Base: All responses (n=66).
Lloyds Health care Pharmacy Services monthly management reports, October 2017 to September 2019.
Scottish Prison Service PR2 information management system, 01 January 2019 to 12 December 2019

The HMP Inverness health care questionnaire for those in the care of the prison demonstrated that four in five (80%) people smoked. Pharmacy data indicated that, in a two year period, over 33,000 items of nicotine replacement therapy (NRT) were dispensed, with a net value of £8,300. Vaping purchases were estimated at 8,700 pods and 125 devices.

2.8 Drug and Alcohol Treatment

Figure 11: Drug and Alcohol Treatment



Source: Public Health Scotland. Drug and Alcohol Treatment Waiting Times open data[11]

Figure 11 shows the number of patients who started first treatment and the percentage of patients starting alcohol and drug treatment seen within three weeks. This is a Scottish Government Treatment Time Guarantee[12]. Overall numbers have declined: for alcohol treatment there were 133 clients accessing first

treatment in 2014/15 compared to 45 in 2018/19, and for drug treatment there were 260 clients in 2014/15 compared to 174 in 2018/19.

For those who access first treatment in prison health care, the waiting times declined in the last financial year from over 99% to 94.1%. This is higher than those accessing treatment in the community.

2.9 Complaints and incidents reporting

Complaints and incidents were analysed for the time period of:

- Complaints log 01.01.2019 to 10.07.2019
- DATIX NHS prison incidents 03.10.2014 to 03.10.2019

DATIX is an adverse event incident recording system used by the NHS. This commentary should be considered as a snap shot of all the complaints and incidents received, but following discussion with NHS staff this data is regarded as a good indicator of service issues. If a patient decides to make a complaint about their health care it can either be resolved internally or if it cannot be resolved it is recorded as a DATIX issue. Likewise if a member of staff decides to make a complaint or report an incident they first report it via the complaints/incident log and then if it cannot be resolved is recorded as a DATIX issue. Note that 2019 is not a complete year.

2.9.1 Complaints/incident log

The complaints log for 01 January 2019 to 10 July 2019 was provided by NHS services with 64 incidents logged. Approximately half are sent onto the NHS Highland Feedback Team for further investigation.

- 31 were dealt with internally and the patient was happy with the outcome.
- 29 were unable to be resolved internally and a complaint form was sent out to the NHS Highland Feedback Team.
- 4 records were incomplete.

Table 3: Complaints and incidents made by month

Complaints/incidents each month	Number
January	9
February	5
March	7
April	16
May	13
June	11
July (partial)	3
Total	**64**

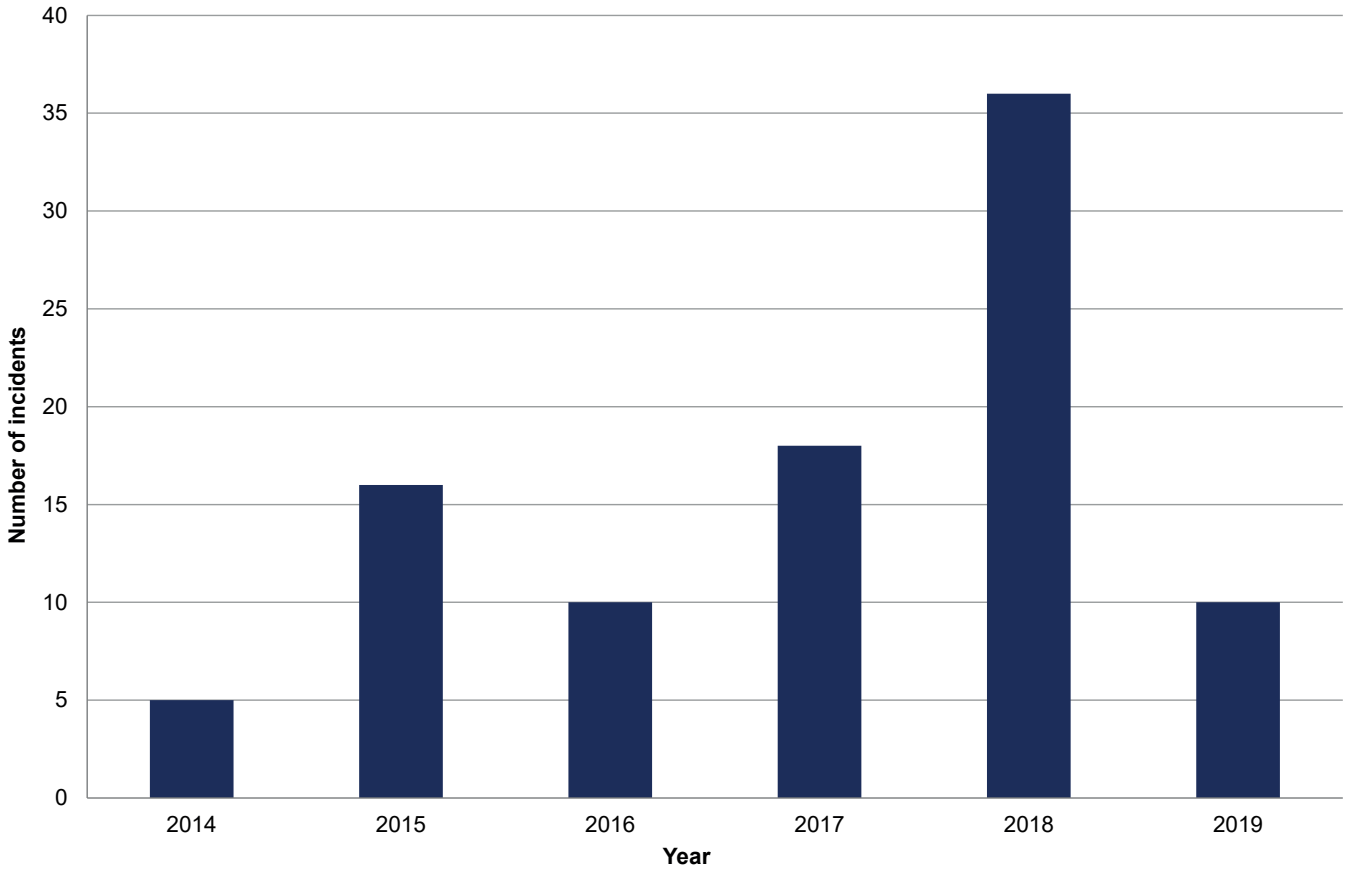
This does not record time spent on each complaint or by how many patients. The log has a number of fields such as ‘date issued ‘date returned’ and ‘date seen by healthcare staff’. Many of these fields are incomplete.

2.9.2 DATIX NHS Prison Incidents

Background information

Data on adverse events recorded between 03 October 2014 and 03 October 2019 were analysed. Within this time period there were 95 incidents associated with prison health care. Excluding 2016, there has been an increase each year and an increase of 50% between 2017 and 2018. 2019 is an incomplete year.

Figure 12: DATIX NHS Prison Incidents



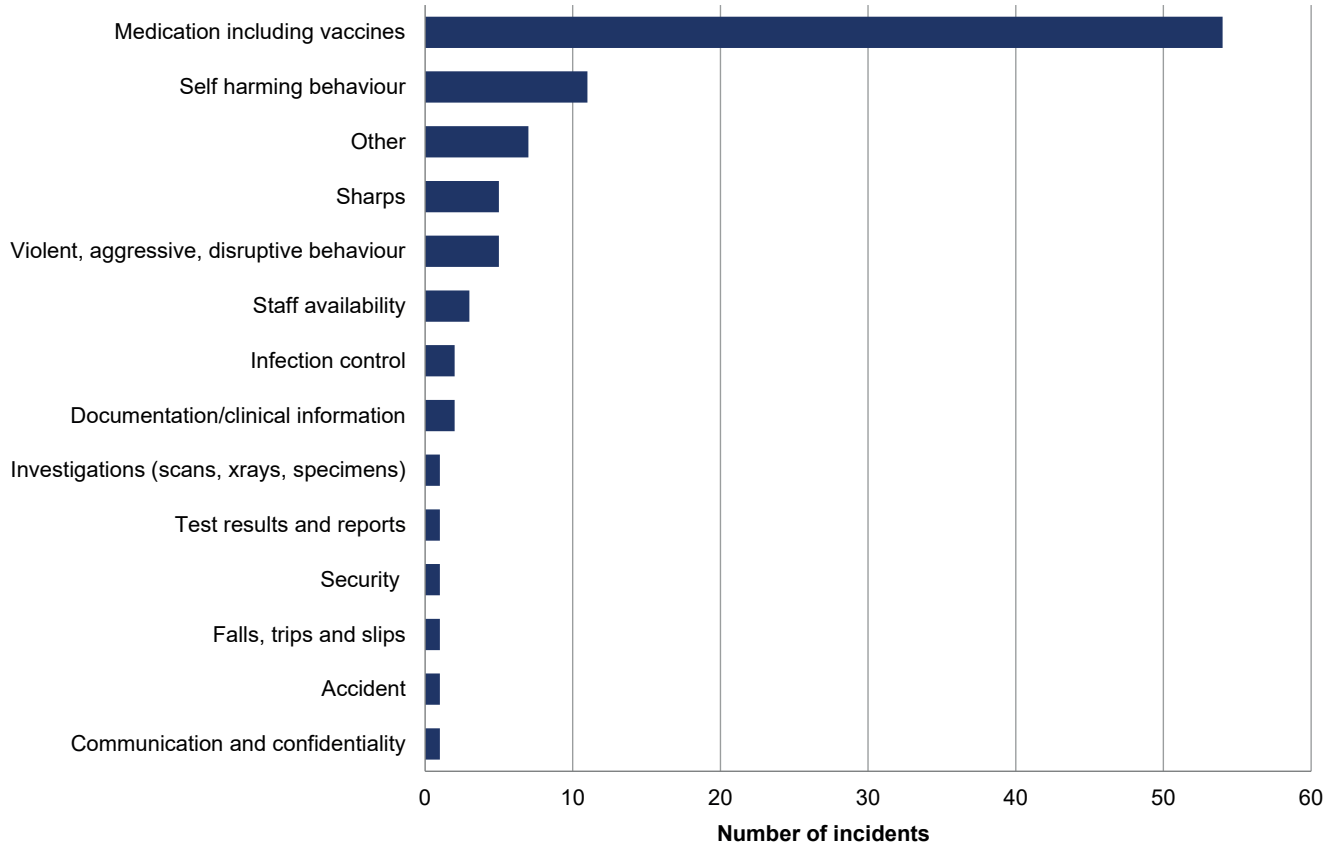
Each incident is categorised and recorded as: patient/client related; property/product/ equipment related or staff. Figure 12 shows the numbers for the different categories and approximately two thirds (67%) of the incidents are made by patients/clients and a quarter (25.5%) are made by staff.

Table 4: Category of incident

Category	Number	Percentage
Patient/client	64	67%
Property, product or equipment	7	7.5%
Staff	24	25.5%
Total	**95**	**100%**

Figure 13 shows that that the majority of incidents relate to the category of 'medication including vaccines' followed by the category of 'self harming behaviour'.

Figure 13: Category of Incident



The following quotes are taken from the report to provide incident examples.

> "Attended client in cell following Code Red alert from prison officers. Client appeared unconscious, large blood loss noted. Laceration to left side of neck. Suicide note found after event."
>
> "Client attended Health Centre stating he had put his hand in his cell mates safe by accident to get tobacco and felt something sharp prick his finger."
>
> "Client self injured left wrist by cutting with disposable razor."
>
> "Prior to administering methadone to client group this morning it was noted that stock balance on controlled drug record book was not the balance in controlled drug cupboard."
>
> "Balance discrepancy, one tablet missing."
>
> "Attended health centre at 1840 appeared to be under the influence of an unknown substance."

Incident outcome and incident consequence

Incident outcome and incident consequence are recorded and are shown in Table 5 and 6.

For this time period the majority of incidents were recorded as 'resulting in no injury or harm, to a person or the service or the organisation (57%)' followed by' incident resulting in injury, harm or ill health to a person or the service or the organisation'(19%). One death was recorded (1%).

Similarly, the recorded consequence shows that the majority of the 95 incidents resulted in a negligible

outcome. 3% of the recorded consequence resulted in an extreme outcome resulting in death or major permanent incapacity/long term damage, serious adverse event or substandard care.

Whatever the categorisation, the level of resource required to deal with any incident should not be underestimated and at times is both extremely costly and/or time hungry.

Table 5: Outcome of incident

Incidence Outcome	Number (%)
Incident resulting in no injury or harm, to a person or the service or the organisation	69 (57%)
Near miss (incident prevented)	14 (13%)
Incident resulting injury or harm, to a person or the service or the organisation	20 (19%)
Death	1 (1%)

Table 6: Outcome consequence

Outcome consequence	No and %
Negligible – no/minor injury or harm nor requiring first aid, no impact/risk to services/ standard of care	68 (72%)
Moderate – reportable, significance injury/harm requiring medical advice/potential impact service/standards of care	10 (10%)
Minor – injury/harm requiring first aid, minimal impact on service provision/standards of care	14 (15%)
Extreme - death or major permanent incapacity/lng term damage, serious adverse event or substandard care	3 (3%)

Lessons learnt

Each time an incident is recorded the member of staff completing DATIX is asked to identify lessons learnt. These are variable but mostly about medication including vaccination, for example, mistakes in prescribing or documentation/record keeping. Other lessons learnt relate to situations where a patient had self harmed, attempted suicide or taken an overdose usually of an unknown substance.

In relation to staff health and safety lessons learnt were recorded as pressures on staff due to sickness absences and aggression from patients.

> This man was put on governors report for being abusive to nurse XXX, discipline staff are aware of his potential of verbal abuse when he feels thing aren't going his way.
>
> Prisoner had been on supervision for taking illegal substances and was seen that morning by the duty GP. Supervision was removed and certain medications were withheld but he was allowed his methadone in split doses that day. He receive this in the morning will no ill effects and again at teatime. He presented later after taking more illegal contraband and was seen by healthcare staff who gave appropriate treatment at the time and called an ambulance to transfer care over to the local A&E department for assessment.
>
> Administration error on the Kardex, staff to double check the information (as they did with this Kardex) to prevent any errors becoming live.

A high number of incidents are reported and are investigated internally by the service and approximately half are passed onto the NHS via the DATIX system. Many of the incidents relate to the process of managing and dispensing the medications including vaccinations. These are inevitably time and resource intensive.

From the observations made by Public Health it was clear that the health staff were extremely stretched, however, from the observations there was little evidence of how data was being used to support service improvements.

2.10 Conclusions – data

- Data quality, from the perspective of this health and health care needs assessment, continues to improve.
- HMP Inverness has a high number of admissions with a median of 150 per month and this reflects the high turnover. Each admission will pass through the health care service.
- From the PR2 data it was found that the average age of those in the care of the prison is 36.4 years, although there are slightly older people than in other prisons. The key characteristics of this population is male, white Scottish (76%), 12% report a disability, 3% self reported veteran status.
- Self reported general health shows that 22% report bad or very bad health compared of 7% of the general population. The mental wellbeing data reports lower scores of wellbeing compared to the Scottish population norms (HMP Inverness 18.3 compared to 22.9).
- By BNF chapter the top medicine prescribed was for the central nervous system (69% of people prescribed) with gastro-intestinal second (31%) followed by cardiovascular system (19%). Antidepressant drugs were the most common prescribed medication at 26%.
- Those in the care of the prison completed a survey that reported prior to coming into the prison 80% smoked, 48% used drugs, 43% drank alcohol regularly, 13% injected steroids and the same percentage gambled. The net value of Nicotine Replacement Therapy prescribing was £8300 purchases.
- In relation to knowledge on accessing services staff consistently reported higher levels of knowledge but both staff and those in the care of the prison felt less confident they could access support for financial advice, employment help and to eat healthy food.
- There are an extremely high number of complaints and recorded incidents by those in the care of the prison. DATIX is used to record occurrences of incidents by staff and some issues by those in the care of the prison. These processes are time hungry.

2.11 Recommendations

R4: Based on the health and health care data map, and prevalence table, select which core indicators to use for ongoing service planning and monitoring and embed them in standard management.

R5: Actively encourage participation in access to medical care, art/education projects with the purpose of encouraging self help and /or peer support programmes to improve general health and increase wellbeing. (Will include chronic disease management).

R6: Recognising and building on the work already in place tailored support for those in the care of the prison to address particular behaviours such as smoking, drug use including steroid use, alcohol intake and gambling, and be set within a context of throughcare.

R7: Review, at least annually, the amount of nicotine replacement items dispensed within the context of the smoking cessation services and a health improvement strategy.

R8: Build on the tailored support already in place for those in the care of the prison to manage mental health issues such as high levels of anxiety and stress and be set within a context of throughcare. Utilising

the enhanced remote consultations options now available to ensure talking therapies are available, consider applicableness of group Cognitive Behaviour Therapy.

R9: For staff and those in the care of the prison provide training and educational opportunities about how, those in the care of the prison, can access support for financial advice and employment help.

R10: Investigate the current medication dispensing processes using improvement methodologies (e.g. waste wheel and ideas forms).

R11: Review how the existing incident and complaints data is used in providing feedback to staff and in reviewing the service.

3. Engagement

3.1 Focus groups including purpose and methods

3.1.1 Purpose

The purpose of the focus groups was twofold:

- to have a dialogue with people in the care of Inverness prison about their health and health care while in prison.
- to have a dialogue with NHS and SPS staff about their perspectives of those in the care of the prison and how they experience health and health care while in prison.

3.1.2 Method

Permission was granted by the Governor and Head of the Health Care Service to speak directly to those in the care of the prison and those delivering NHS health care. Three focus groups were set up over a time period of one month. The method chosen to run the workshop was agreed with the Prison Governor in advance and included no recording or the use of any IT equipment. The data collected, therefore, was discussion and narrative based using icon prompts and recording onto a flip chart. These icons are used throughout the report.

3.1.3 Those in the care of the prison, two workshops

Recruitment of participants to the focus groups was on a voluntary basis. One of the SPS Officers sought volunteers from the accommodation blocks who were escorted to one of the two workshops. The remand/convicted participants were kept separate from the protected/vulnerable participants. Refreshments were provided as an incentive and as a thank you for the participant's contribution and time.

3.1.4 NHS staff and prison officer staff

Recruitment of participants to the focus group was on a voluntary basis and advisory group members organised the recruitment. Refreshments were provided as an incentive and as a thank you for the participant's contribution and time.

A standard format was agreed for all three one hour workshops:

Step 1: Explanation of the purpose of the workshop

Step 2: All participants signed a consent form prior to the start of the workshop. The content of the form was read out slowly and an opportunity given to all participants to ask questions. The typeface chosen for the consent form, for those in the care of the prison, was comic sans and for the staff group arial. This decision was based on a test of change where those in the care of the prison were given a choice between comic sans and arial type faces and selected comic sans. There is some evidence to suggest that comic sans, is more readable, often used in comics, because it is both casual and informal to the reader[13]. See appendix 7.

The signed forms were all collected in, checked and stored by the facilitators.

Step 3: Introduction of Paul.

To provide a focus for discussion a character called 'Paul' was introduced and his story read out. This was based on a 'narrative' approach[14]. The participants were then asked to think about Paul's journey into the Prison, whilst in the care of the prison and at liberation. See appendix 8.

Paul is based on a famous Scottish actor from Glasgow, and about his life including time spent in the care of a Young Offenders Institute[15]. At the end of the workshop one of the facilitators revisited 'Paul' and gave an update about Paul's life and how he became a successful actor.

Step 4: Discussion

One facilitator led the discussion and the other facilitator recorded on pre-prepared flip chart and used icons a summary of the participant's responses. The facilitator steered the discussion through the following stages:

- reception
- continuity of care
- services in prison
- health state
- health improvement/promotion
- throughcare
- anything else including asking the participants to reflect on the previous stages.

At the end of the workshop the flip charts were numbered and the icons fixed into place with sticky tape.

Step 5: Analysis

The data from all three workshops were analysed based on the themes generated through the discussions. This information is available in the 'At a Glance' documents in section 3.2 and 3.3.

3.1.5 Three focus groups were conducted:

- People in the care of the prison remand (3)/convicted (7); date 11.10.2019
- People in the care of the prison protected (7); date 25.10.2019
- NHS staff working in the health care service and Prison Officers (8); date 19.11.2019

3.2 Issues at a Glance: Focus Group Analysis Remand/Convicted/Protected

This is a summary of the issues raised during two focus group discussions (11.10.2019 convicted/remand and 25.10.2019 protected/vulnerable). Issues have been included where the outcome may lead to an action. The summary reflects a person's journey from reception to liberation. Inevitably, the discussions led to broader issues beyond the delivery of NHS health care services and these are recorded.

Overall, those in the care of the prison were mostly appreciative of the health care, dental services and physical activity received. There were differences between the views expressed by those on the 'protected' sentence in comparison to the 'remand' and 'convicted' sentences. For those in the 'protected' category they raised issues that are associated with being in a prison longer such as self care and experiencing ongoing stigma. For those on remand or convicted sentences more immediate issues were raised such as the loss of the throughcare officer role and the need to maintain family relationships. Being able to 'make the best' of being in Prison was seen as 'Prison Officer' dependant rather than accessible to all.

It is of concern that for those taking part in the focus group there were numerous reports of experiencing stigma and that the Personal Officer role was not working. There are also issues of perception that the Prison's regime does not support health and wellbeing or rehabilitation.

This information has been collected from two focus groups: remand/convicted and protected.

Table 7: Issues at a Glance: Focus Group Analysis Remand/Convicted/Protected

Key: C = Convicted; P = Protected; R = Remand
PO = Prison Officer; PA = physical activity

	Reception		Continuous Care/ General Services/Topics		Continuous Care/ General Services/Topics		Leaving Prison
	Basic needs, health (vaping, nurse review and detox) met but requires follow through (ALL) Not enough information about nicotine replacement options (C)(P) Being concerned that families know of arrest (R)		**Health care** More holistic health care needed avoiding 'chemicals' as first line of defence (P) More time with doctor or nurse Basic health care good but 'extended' health care such as physio or hospital poor (P) Complaints not listened to (C) Sexual health not addressed – inappropriate setting		**Family contact** More contact with families at all stages (R) Welcomed family activities e.g. at weekends (R) Hindered by no phone card credit (R) Support required for initial phone call for people on remand (R) Extra costs incurred if families not in the UK (P)		**Throughcare** Housing worries Financial worries and seeking work Desist from scoring Recovery services Health check and GP registration Reconnecting with family (C,R)
	Basic needs - general At point of arrest ensure there is money, clothes, and phone numbers taken from mobile phone (C) Not enough money for phone call (R)		**Medication** Access to NHS services are too long Felt that PO and NHS staff, other than the doctor, makes decisions about prescribing (R) Felt to be restrictive and that dispensing staff labelled everyone a junkie (C)		**Personal Officer** They treat us all as a junkie Staff need to keep their word (C) Approachable (P) Personal officer process does not work (C,R)		**Concerns** Housing worries Financial worries Regular medications, recovery services (R) Loss of tenancy (P) Debt management and impact on families (P)

	**Information overload** (R) Too much information received and needs backup/repeating – different formats	  	**Mental Health** Too much time in the cell (All) 'Talk to Me' invasive No listeners project (C) Inadequate bereavement services (C) Inadequate trained NHS staff able to deal with MH (P) Can be hidden and not easily talked about (P)	 	**Pastoral support** Chaplaincy/attending church – mixed views (P) Bereavement support described as non-existent (C)		
	**Rights/stigma** Being treated as a human being (P)	 	**Dental** Limited availability of products for example for sensitive teeth Use electric toothbrushes (P)	 	**Food** More access to wider variety of fruit and vegetables 7 days week (C) Increased choice on canteen (P) Education about food e.g. Men's Health Days (P)		
		 	**Hygiene** No disabled access to the showers if you are in a wheelchair (C) Shower products poor quality (C,P)	  	**Physical activity** Do not get all of what entitled (C,P) Increase time spend outdoors (C) Change use of women's quarters to accommodate more PA (P)		

			Smoking Vaping makes you feel worse (R) Boredom makes you vape/ smoke more (P)		**Housing** Loss of tenancy and personal items going to landfill; financial support for storage (P)		
	Health and Wellbeing is not supported by the regime and evidence cited was high rate of reoffending. (R) Improvements were person dependant and not prison wide. (P) It was an inappropriate setting to address sexual health issues.						
	Assets/strengths are underused and numerous including building, buddying/mentoring; computer, culinary/cooking, horticulture, laying slabs, languages, listening, PT support, welding. Would boost morale and build self-confidence (P)						
	Whole system does not support rehabilitation – throughcare stopped and personal officers difficult to contact. Mental health and physical health might improve but felt this was person dependant (C) (R)						

3.3 Issues at a Glance: NHS and Prison Officer Staff Focus Group

This is a summary of the issues raised during the focus group discussions held on 19 November 2019. Issues have been included where the outcome may lead to an action. The summary reflects a person's journey from reception to liberation.

Overall, those taking part in the focus group reported that access to the health care services were better than in the community but improvements were hampered largely by the environment and staffing pressures. It was observed that relationships between the two groups taking part in this focus group and also in general were positive. There was, however, some scepticism expressed towards 'management' and day to day functioning of the prison.

Understandably it was noted differences between the two staff groups. NHS staff, were first and foremost advocates for patient care, and the Prison Officers were primarily concerned about safety and security. Both staff groups expressed concern about being chronically understaffed and that there was low staff morale. Two views were expressed about the 'Personal Officer' role; one being that this undefined role was 'utopia' and the second being an opportunity for building a trusted relationship. Furthermore it was reported a lack of empathy by some staff towards those with problematic alcohol and drug use. The topic of sexual health is notable because of its absence. Both staff groups agreed that services were broader and more holistic than previously with the service example being given of 30 years ago being 'three male nurses, paracetamol and a cart'.

SPS staff reported poor management and leadership and cited the rapid turnover of those in the role of Governor as unhelpful.

There was concern expressed about lack of action following this Health Needs Assessment.

This information was collected from one focus group.

Table 8: Issues at a Glance: Focus Group analysis NHS and Prison Officer Staff

Key: OD = overdose; NPS = New Psychoactive Substance;
PO = Prison Officer; PA = physical activity

	Reception		Continuous Care/ General Services/Topics		Continuous Care/ General Services/Topics		Leaving Prison
	**Basic needs, health** Opportunity for screening/identify health needs. Requires follow through. Disability, hearing and visual issues often identified		**Health care** GP access should be increased with 9-5 seen as ideal High volume of complaints received Gap in psychological therapies More NHS staff needed in the roles of health care assistant, pharmacy assistants, mental health and addictions Patients were described as 'ready to make complaints' if they did not receive the desired health care Aging prison population in a 'Dickenson' style prison		**Family contact** Family Officer not always able to carry out role because moved to other duties		**Throughcare** Withdrawal of throughcare officer role a backward step. Has put pressure on other staff to fill gaps such as liaison with housing

		  	**Alcohol and drugs** Gap in alcohol and drug consultant support Perception that drug taking i.e. NPS is increasing and that an OD does not appear to be a deterrent A general lack of empathy by some staff towards people with alcohol and drug problems was identified.	  	**Staffing issues** Staff relationships good but staff shortages cause anxiety, stress and low morale Increase number of health care assistants, mental health and addictions staff Some cultural differences between the two staff groups – tail wags the dog Poor management and leadership – turnover of senior staff including governor		**Concerns** Housing; supported housing only guaranteed for those on protection
		 	**Medication** SPS staff do not like giving out medication (e.g. paracetamol) on the wings Medication such as gaviscon and rennies should be made available through the canteen Perception that the amount of medication being prescribed is increasing and the prescribers are not able to say 'no' Weekly meds not worth anything and used up before the week ends		**Personal Officer** Personal Officer role described as utopia; often general staffing pressures take precedence Definition of role required An outcome measurement such as Outcome Star would help measure change		

	Administration Documentation heavy		**Mental Health** Identified as common issue. Mental health teams and multi-agency case conferences were reported as useful Require more alcohol and drug consultant support and access to psychological therapies Suggested increased use of video links		**Physical activity** Inadequate space for demand Inadequate time spent outdoor and time is limited to one hour in a concreted area		
			Hygiene Reduction in availability of creams/shampoos		**Smoking** Concern expressed about impact of vaping, on staff		
	Health and Wellbeing: In the short term the regime can help improve health and wellbeing. In the long term down to individual choice 'if willing to engage'. Loss of throughcare officer was seen as damaging. Sexual health not raised as an issue in this focus group.						
	Assets/strengths: peer support.						
	Whole system: It was reported that some people deliberately seek imprisonment to avoid homelessness, manage problematic alcohol or drug use, access health care. In general access to services is quicker in prison. Improving community services would contribute to solving this problem.						

3.4 Individual stakeholder feedback

One of the aims of the health and health care needs assessment was to be as inclusive as possible across a range of stakeholders as well as those who are in the care of the prison. When planning the engagement events there were some partners who could not attend so individual discussions were arranged. The following table is a summary of the discussions and the recommendations are listed at the end.

Each stakeholder was asked to describe their role, comment on issues relating to NHS health care and suggest possible improvements.

Table 9: Individual stakeholder feedback

Organisation or agency	Key issues raised * recommendation
Department of Work and Pensions (DWP) (24.10.2019)	*Impact from the loss of the throughcare officer posts particularly when financial support is sought near to and at the time of liberation. Challenge of rent being paid when sentence is longer than six months. *Liberation case conference meetings to include organisations such as DWP, housing and APEX.
Fife College learning and education team (01.08.2019)	Access to the classroom is via stairs and therefore not accessible to those with limited mobility. Short term prison sentences limits choice. *'Do it profiler' global tool to assess social functioning, numeracy, literacy and life skills being considered as a national tool.
Prison Chaplain (16.10.2019)	121 discussions are generally good for the mental health and wellbeing of individuals in the care of the prison. *Explore increased involvement with families starting with monthly meetings. *Provide additional support for those in the care of the prison experiencing bereavement.
Health Improvement nurse with responsibility for working with the travelling community (16.10.2019)	Reported alcohol often a factor behind the sentence. Loss of the Persistent Offenders Project is having a negative impact on individuals within this community. *E-learning module available on NES TURAS (internal learning platform) and available for NHS staff to take.
Pharmacist (09.07.2019)	Pharmacy services are provided by Lloyds pharmacy. Praised the General Practice approach to prescribing with lower rates and closer follow up of the patients. *Continuous turnover of patients results in a lot of waste with tablets being destroyed and should be reviewed. *Moving towards an increase in self possession of medication would decrease the need for escorts to the medical centre.

Dental services/oral health services (30.07.2019)	Many of the patients have multiple dental problems and methadone contains both sugar and acid which causes caries. *The toothbrushes provided by the SPS, although for temporary use, are not fit for purpose. In the event of lost dentures, there is not sufficient time to complete treatment, for patients on a shorter sentence. *Practical skills such as cooking and shopping, would support oral health, money management, maintaining a healthy weight and build self-confidence. *A hotline number provided at the point of liberation for dental registration.
Scottish Prison Service Officer	*For the Prisoner Personal Officer role consider using an outcome monitoring tool such as 'My Compass', a tool developed and piloted in the Prison.
NHS Sexual Health Services	Number of sessions likely to be reduced from two a week to one due to demand. Little to report from this health care needs assessment. *Condoms and lubricant available at liberation.

3.5 Recommendations – summary

3.6.1 Focus Group Remand/Convicted/Protected

R12: Ensure opportunities for those in the care of the prison, who are vulnerable, to participate in 'self help' programmes.

R13: Prioritise the ongoing development of the peer model of support provided by those in the care of the prison to others. Extend this beyond the current model by mapping and utilising (where appropriate) the assets of those in the care of the prison.

R14: Develop a framework and action plan (to include all staff groups and those in the care of the prison) to tackle prejudice and stigma directed towards those in the care of the prison.

R15: Develop processes/pathways to plug the gap left by the loss of the throughcare officer.

R16: As principle, the maintenance of family relationships (as defined by the person in the care of the prison), where appropriate, to be at the heart of health and health care prison policies.

R17: Continued development of the 'personal officer' role as a standard rather than being prison officer dependant. Introduction of an outcome star/My Compass will provide qualitative and quantitative data as well as being a useful management tool.

3.6.2 Focus Group NHS and Prison Officer - management

R18: An increased understanding of the perception of 'management' (both NHS/Prison), for example, the distance those in management are from the front line, and how this can be changed might enhance relationships throughout the prison.

R19: The impact of staffing levels on the morale of staff to be constantly reviewed and appropriate mitigations agreed with staff, staff representatives and professional bodies.

3.6.3 Stakeholders feedback

R20: DWP: Consider the expansion of liberation case conference meetings to include organisations such as DWP, housing and APEX.

R21: Fife College: Consider the implementation of the 'Do it profiler' global tool to assess social functioning, numeracy, literacy and life skills being considered as a national tool.

R22: Prison Chaplain: Explore increased involvement with families starting with monthly meetings.

R23: Prison Chaplain: Provide additional support for those in the care of the prison experiencing bereavement.

R24: Travelling Communities: Promote the E-learning module about raising awareness about working with the travelling community available on NES TURAS (internal learning platform) for NHS staff.

R25: Pharmacy: Review the processes that result in the waste of tablets that are destroyed because of the continuous turnover of patients.

R26: Pharmacy: Develop a process to increase self possession of medication because this would decrease the need escorts to the medical centre.

R27: Dental: Consider increasing practical skills such as cooking and shopping because this would support oral health, money management, maintaining a healthy weight and help build self confidence.

R28: Dental: Raise with SPS national procurement that the Prison issue toothbrushes are not fit for purpose.

4. Literature Review Key Points Summary: What does this mean for HMP Inverness?

Two search strategies from a previous health care needs assessment conducted by NHS Greater Glasgow and Clyde were rerun for the intervening period of 2011 to 2019 and combined with grey literature and policy documents that were relevant. This section is a summary of key points and what this means for HMP Inverness. The literature review, fully referenced, is available from the Highland NHS Public Health Department or by following this link: Prison Literature Review

Common themes about good practice across the topics reviewed were: proactive admission screening, holistic, individualised care, maximising use of peer support and supporting throughcare into the community. Common challenges were staffing, funding, security regimes and prison care and health care cultural differences.

A table of prevalence estimates from the literature is also included section 4.9.

Principle of Equivalence

The principle of equivalence of prison with community care was commonly referenced. There was much debate about the application of this, both in terms of the definition and appropriateness. It was felt to be unclear whether this was intended to be equivalence of process (as usually assumed) or equivalence of outcomes. The argument has been strongly made that the latter would be more appropriate, that more intensive and proactive care would be required in prison settings to reflect the higher health need and serial disadvantage of many people in the care of the prison and that adopting this approach would reflect the true ethos of the principle of equivalence[16,17]. The prevailing belief was that regardless of the interpretation taken the principle of equivalence should be considered a minimum rather than gold standard of comparison[18].

This chapter includes the key points for:

4.1 Health care and physical health

4.2 Communicable disease

4.3 Mental health

4.4 Learning disability and learning difficulty

4.5 Drug and alcohol use

4.6 Older people

4.7 Oral health

4.8 Prevalence estimates from published literature

4.9 Conclusion

4.1 Health care and Physical Health Key Points

Responsibility for health care moved from SPS to NHS in 2011 and while this has led to improved access to wider health care there continues to be challenges including staffing levels and continuity of care through to the community.

Cultural differences between the prison and health care service can lead to frustration for health care staff including a feeling of loss of autonomy and the double challenge of providing care and custody.

The prison population have higher than community levels of need, make little use of health services outside prison but have high usage in prison and fewer options for accessing self care or alternative advice. This results in less staff capacity for chronic condition management and preventative health care.

NHS health checks leading to individually tailored risk assessment and advice is recommended.

Requests for medication are a common reason for health service use and maximising self-possession of medication is supported for fostering independence and maximising staff time.

Death due to natural causes is the leading cause of death in prison with diseases of the circulatory systems and cancer being the most common causes.

As part of a healthy prison culture staff involvement and wellbeing should also be considered.

People in the care of the prison often view prison health care positively as having fewer barriers than in the community.

Health care and Physical Health Key Points: What does this mean for HMP Inverness?

Inverness prison faces the same challenges and patterns of health care service use described in the general literature review. Staff report positive relationships across health and prison services with people in the care of the prison than typically described in the literature.

There is potential for improvements in providing more preventative care through proactive health checks and active chronic disease management. This would be through a combination of identifying and recording chronic conditions consistently at admission, freeing up staff time through, for example, increasing self-possession of medication, use of triage and development of nursing specialist roles including nurse prescribing.

A healthy prison environment requires staff involvement and wellbeing to be prioritised, and suggestions for training and improvements made during staff engagement should be considered for action.

Recommendations

R29: Increase level of preventative care through proactive health checks.

R5: Actively encourage participation in access to medical care, art/education projects with the purpose of encouraging self help and or peer support programmes to improve general health and increase wellbeing. (Will include chronic disease management).

R30: Review nursing specialist functions including use of triage and nurse prescribing.

R3: Development of / or refresh an existing healthy prison workforce plan; include a training programme addressing the topics and needs identified in this HNA.

4.2 Communicable Diseases Key Points

People in the care of the prison are at higher risk of blood borne viruses and tuberculosis.

Hepatitis C is most prevalent of these conditions with affecting approximately 17% of people in the care of the prison with Hepatitis B affecting around 2%.

Ideally screening for all of these conditions should be performed at admission to prison with BBV screening already established across Scottish prisons.

Preventative and harm reduction approaches are less developed and prison staff knowledge about BBVs was limited.

Communicable Diseases Key Points: What does this mean for HMP Inverness?

Inverness prison has well established blood borne virus (BBV) screening at entry and condoms are reportedly available on request from the health care centre. However 44% (n=16) of staff reported they would welcome additional training on blood borne viruses suggesting this is an area which could be improved. In addition, condoms and lubricants should be readily and discreetly available and people in the care of the prison should be aware of how to access them. Tuberculosis (TB) screening does not currently occur but could be an area to develop, however, the number of active cases across Scottish Prisons is very small and this would likely be screening targeted at those from areas of high incidence.

Recommendations

R31: Training for SPS staff in blood borne viruses.

R32: Make condoms, and lubricants available to those in the care of the prison through a number of outlets in addition to the Healthcare Centre and at liberation.

R33: Introduce tuberculosis screening processes.

4.3 Mental Health Key Points

While prevalence estimates vary substantially the burden of mental health issues is greater than that of the community. There is some evidence that mental health issues stabilise or improve during time in prison.

- The best estimates for most common conditions reported were depressive states (49%), personality disorder (40-70%) and anxiety states (29%).
- Psychiatric co-morbidity was common with 70% of people with a mental health condition having two or more conditions.
- Suicide among male prisoners is three to six times greater than the general population and approximately 70% of those who have taken their own lives have been identified as having mental health needs while in prison.
- Core periods of vulnerability to self-harm and suicide are arrival, transfer and release from prison.
- Prisoners from outside the UK are particularly vulnerable to mental health issues and suicidal behaviour in prison with additional barriers of: language, loss of family contact and immigration concerns.
- Recommended suicide prevention interventions are: effective screening at admission, ongoing risk assessment, peer support models, use of chaplaincy, staff training, information sharing, environmental safety and appropriate mental health treatment.
- More effective screening for mental health at admission with less reliance on historical contact or prescribing was recommended. PriSnQuest was an example of a recommended tool.

- Unmet needs among people with mental health conditions were commonplace and those most reported were: daytime activities, psychological treatment, psychotic symptoms and medication. People with problem alcohol and drug use are more likely to be able to access psychological therapies.
- There is some evidence for psychological therapies in prison including Cognitive Behavioural Therapy (CBT) and Dialectical Behavioural Therapy (DBT). Yoga has been found effective in supporting relaxation.
- A Care Programme Approach (CPA) for those with Serious Mental Illness (SMI) is supported.
- Involvement in the creative or arts based activities especially using music and singing have been found to have positive effects on wellbeing, stress, anxiety and pain.

Mental Health Key Points: What does this means for HMP Inverness?

More support to manage the mental health of people in the care of the prison was the strongest theme across staff and those in the care of the prison engagement. This included the desire for more staff training and support and greater access to specialist mental health services such as talking therapies.

Improvements in mental health could be through more rigorous screening, increasing staff training and confidence, enhancing access to talking therapies, re-launching the prisoner listening schemes, developing buddying programmes, and supporting more purposeful, daytime activities. Embedding a trauma informed approach would support understanding of the range of mental health issues and the required responses.

Recommendations

R8: Build on the tailored support already in place for those in the care of the prison to manage mental health issues such as high levels of anxiety and stress and be set within a context of throughcare. Utilising the enhanced remote consultations options now available to ensure talking therapies are available, consider applicableness of group Cognitive Behaviour Therapy.

R5: Actively encourage participation in access to medical care, art/education projects with the purpose of encouraging self help and or peer support programmes to improve general health and increase wellbeing. Examples include listening schemes and buddying programmes.

R34: Embed a trauma informed approach into staff training programmes and in service delivery and planning.

4.4 Learning Disability and Learning Difficulty Key Points

People in the care of the prison are frequently reported as having higher rates of learning disability and learning difficulties and lower rates of literacy than in the community.

These are all distinct issues but can interact, sometimes present similarly and people affected may encounter similar barriers in understanding and navigating new systems.

Most prevalence estimates are over ten years old but approximately 10% of people in the care of the prison have been reported to have a learning disability, up to 50% have dyslexia and 50% have literacy at or below the level of an eleven-year-old.

People with a learning disability in prison are more likely to have co-morbid substance use, mental health problems and a personality disorder in comparison to those in the community.

There is no gold standard screening tool suggested for use in prison though several exist.

Good practice includes screening, staff training, involvement of wider multidisciplinary team, CBT and behavioural interventions, annual health checks and physical exercise interventions.

Learning Disability and Learning Difficulty Key Points: What does this mean for HMP Inverness?

There is no formal screening for learning disability at admission to prison. Those who choose to work with the education and learning team complete a Skills Profiler tool to screen for literacy and numeracy. A 'Do It Profiler' tool has been developed nationally and piloted at two sites which is expected to be rolled out across the SPS estate through education departments. It has been described as screening for learning disability but is a much broader global assessment of a range of skills from social functioning, numeracy, literacy and life skills. It specifically asks whether people have previously been in contact with the learning disability service and whether they have learning difficulties.

Once a date is known for implementation in HMP Inverness there would be benefit in the education team, health care team, learning disability team and mental health team meeting to discuss how to maximise this resource. This could include signposting, referral routes for onward or ongoing assessment or review. As a minimum ensuring anyone who is identified as having previous contact with the learning disability service receives an annual health check if applicable should be implemented. If this tool is not to be implemented nationally, considering the use of a specific learning disability screening tool could be valuable. It does not seem practical to propose an additional screening tool currently given the national plans to roll out the Do It Profiler.

Recommendations

R35: Adopt/agree to use a validated learning disability screening tool during the admission process to prison. This might be the 'Do it Profiler' tool if nationally enforced.

4.5 Drug and Alcohol Use Key Points

People in the care of the prison have high rates of problems with drug and alcohol use compared to the community but reportedly only a quarter of those affected are offered services and only a quarter of those go on to access treatment.

Alcohol use affects a larger proportion of people than drug use but people were less likely to access help in prison for this. Using the Alcohol Use Disorders Identification Tool (AUDIT) screening tool can identify twice as many people.

People in the care of the prison report increased motivation to stop injecting drug use in prison in part due to increased risks and in part due to access to services.

Good practice in prison includes: screening, acute support to detox, Opiate Substitution Therapy (OST), naloxone on release, individualised holistic care plans with goal setting, peer and family support, throughcare and repeated offers of support.

There is some emerging pilot evidence to support small drug recovery wings with intensive psychosocial group support and to support use of chronic pain clinics to reduce co-morbid analgesic use.

Novel Psychoactive Substance (NPS) use appears to be increasing in prisons with synthetic cannabinoids being the most common type. Recommendations for addressing this issue include: symptomatic management, raising awareness of risk, drop in clinics and peer support.

Veterans are the largest occupational group in prison and often have problem drug and alcohol use. The most successful engagement with this group is through peer groups that link to external community services and help preparing for release.

Although not specific to drug and alcohol use, throughcare is pivotal and it is recommended that community integration plans are available for all people in the care of the prison and that there is better co-ordination of care between services including out of area prisoners.

Drug and Alcohol Use Key Points: What does this mean for HMP Inverness?

Drug and alcohol problems were commonly reported as a major health need throughout people's prison journey and addressing gaps in throughcare provision was a priority in both staff and prisoner engagement. Screening for drug and alcohol use at admission and offering support acutely was described as working effectively and well. The recent change in admission protocol includes AUDIT screening for alcohol problems and is likely to identify more people with problem alcohol use. Recovery groups are also operating and were reported as useful by people in the care of the prison. While naloxone is available at release the numbers dispensed are low and have reduced over the past 5 years. Recording naloxone at release is variable. There may be scope to offer alternative opiate substitutes locally which would allow once weekly or monthly treatment which could reduce service demand and make receiving medication less of daily focus.

There could be improvements through reiterating offers of assistance at other points in the prison journey, developing more personalised care plans including release planning, perhaps through more development of the personal officer role and use of the My Compass tool. Further plans for throughcare support in the absence of TCOs are being explored locally. Enhanced use of peer and family support could also be valuable in supporting more individualised planning and engagement.

Recommendations

R36: Continued drug and alcohol screening at admission including use of the AUDIT tool. Review pathways following identification of problematic alcohol or drug use.

R17: Continued development of the 'personal officer' role as a standard rather than being prison officer dependant. Introduction of an outcome star/My Compass will provide qualitative and quantitative data as well as being a useful management tool.

R37: Continue to offer the choice of recovery groups to those in the care of the prison with a view to extend the choice

R38: Enhanced use of peer support and family support.

R39: Continue to provide naloxone upon release and ensure accurate record keeping.

R40: Investigate if alternative opiate substitutes can be dispensed to those in the care of the prison that allow for weekly or monthly treatment.

R41: Continue to develop and provide training to enhance the personal officer role so the officer is confident is in supporting those in the care of the prison with alcohol and drug related issues.

4.6 Older People in the care of the prison Key Points

The population of older people in the care of the prison has increased eight times since 1990 and is forecast to continue to increase.

Greater numbers of older people in the care of the prison will mean a greater requirement for chronic condition management, social care, dementia care and end of life care that prison systems are currently not designed to meet.

People in the care of the prison have a health status comparable with that of people who are 10 years older in community so the literature recommends defining older as 50 years and older for this population.

Older people have higher levels of co-morbidity of both physical and mental health conditions with the latter often presenting differently to younger adults and compounded by individuals being less vocal in reporting symptoms.

Cognitive impairment can lead to disruptive and aggressive behaviour which can enhance issues in prison.

Fear of dying in prison, loss of family contact and concern about accommodation on discharge were common issues for this group.

Good practice examples for supporting older people including those with dementia are: screening for dementia, active health screening, staff training, peer support schemes, activities which support socialising, adapting physical exercise options, modifications to the physical space and multiagency release planning.

Additional recommendations for end of life care include: staff training, having established policies, connections to community or hospice care and releasing to the community where appropriate care cannot be provided.

Older People in the care of the prison Key Points: What does this mean for HMP Inverness?

Between 2014 and 2019 people aged 50 years and over made up 12% of the population at HMP Inverness. While this may be a small proportion of the overall number of people, there may well have been missed opportunities to address their needs. Furthermore, with an increased prison population in the new prison, there will likely be a proportionate increase in numbers and need. The current prison estate is not suitable for older or disabled people with Victorian facilities, no disabled access to the education centre and only one disabled access cell. There is no current screening of cognition for older people or preventative health care screening and admission screening of social care need appears patchy.

Improvements to the current situation and planning for the future could include staff training and awareness raising in relation to the needs of older prisoners, building links with the third sector, social work and local hospice care, providing activities tailored to the older person including exercising, developing a policy for screening and managing dementia, health needs of older people and agreeing an end of life care policy for HMP Inverness.

Recommendations

R42: Develop a health care plan to meet the needs of older men in the care of the prison. This might include screening for cognition, preventative screening and managing dementia, building links with the third sector and social work. It might also include opportunities for physical activity (not necessarily the gym) peer support/mutual aid and self help.

R43: Develop an end of life pathway for those in the care of the prison

4.7 Oral Health Key Points

The prison population have higher than community rates of poor oral health including decayed, missing and filled teeth.

Nearly two thirds only visited a dentist when they had a problem.

Oral health related quality of life is also low, with two thirds of the prison population being unsatisfied with the appearance of their teeth which has a wider psychosocial impact.

There was some pilot evidence for a nurse led triage system for effectively managing demand and supporting a targeted approach.

Oral Health Key Points : What does this mean for HMP Inverness?

Dental provision was described as good by both staff and people in the care of the prison although the gaps in non-emergency provision for those on remand were acknowledged. Oral health advisors also regularly visit HMP Inverness and provide additional information, advice, better quality toothbrushes and interdental brushes. The quality of SPS provided toothbrushes was noted to be poor and not suitable

for longer term use. A hotline number for advice on how to access dental treatment in the community is provided on release.

There could be improvements through highlighting to national procurement the insufficient quality of current toothbrush provision, offering sweeteners alongside sugar and there could be benefit in piloting a triaging system for dental care, although this might require additional staff resource.

Recommendations

R28: Advocate for the review of the national contract with SPS for the purchase of toothbrushes and interdental brushes.

R44: At the time of liberation, provide those in the care of the prison, the hotline number for advice on how to access dental treatment in the community.

R45: Provide sweeteners as an alternative to sugar at all times, for those in the care of the prison.

R46: Pilot a triage process for those in the care of the prison requiring dental care; consider costs and benefits against the requirement of the additional staff resource.

4.8 Prevalence estimates from the literature

The following table lists the prevalence estimates from the literature for range of chronic conditions. This table has the potential to be used as a planning tool for services within the prison (and the new prison when it is built) and aligns with the findings in this health and health care needs assessment. The section headed mental health is further evidence for mental health being of major concern within the prison population, for example high levels of anxiety 29.1% and personality disorder at 47%. Smoking prevalence is likely to be accurate at 83.1% but alcohol use disorder (26%) and drug use disorder (30%) is likely to be a lower prevalence than reported in the literature.

Table 10: Summary Table of Prevalence Estimates from Literature

Topic	Prevalence in Prison (%)	Level of Evidence (country, year)	Sample size
Chronic Conditions			
Epilepsy	0.7%	Systematic Review (Multiple, 2002)[19]	3,111 prisoners from 7 surveys
Diabetes mellitus	5.1%	Cross-sectional survey (USA, 2009)[20]	14,373 prisoners
Chronic Obstructive Pulmonary Disease (COPD)	34.1%	Cross-sectional survey (USA, 2018)[21]	14,373 prisoners
Liver disease	11.9%	Cross-sectional survey (USA, 2018)[21]	199 adults
Hypertension	35.9%	Cross-sectional survey (USA, 2018)[21]	199 adults
High cholesterol	17.8%	Cross-sectional survey (USA, 2018)[21]	199 adults
Arthritis	17.5%	Cross-sectional survey (USA, 2018)[21]	199 adults
Asthma	14.9%	Cross-sectional survey (USA, 2018)[21]	199 adults
Overweight or obese	61.3%	Cross-sectional survey (USA, 2018)[21]	199 adults
Head injury (any severity)	36%-78%	Systematic review (Multiple, 2018)[22]	1,677 prisoners from 4 studies
Chronic non cancer pain	20%	Clinical note review (England, 2018)[23]	58 individuals
Cause of Death			
Deaths in prison due to natural causes	62.2%	Report (UK, 2018)[24]	354 deaths in prison custody
Deaths in prison due to suicide	37.7%	Report (UK, 2018)[23]	354 deaths in prison custody
Leading natural causes of death: Circulatory system Cancer	 43% 32%	Report (UK, 2012)[25]	402 natural cause deaths in prison custody

Communicable Diseases			
Hepatitis B	0.3%-25.2%	Systematic review (Multiple EU/EEA, 2018)[26]	12 single study/pooled estimates
Hepatitis C	4.3%-86.3%	Systematic review (Multiple EU/EEA, 2018)[26]	16 single study/pooled estimates
Mental Health			
Psychiatric comorbidity - 2 or more - 5 or more	 70% 11.7%	Cross-sectional survey (England, 2017)[27]	197 male and 171 female prisoners
Personality disorder	47%	Systematic review Multiple, 2002)[28]	Pooled estimate from 10,797 male prisoners
Anxiety states	29.1%	Cross-sectional survey (England, 2017)[27]	196 male prisoners
Severe and enduring mental illness (psychotic disorder, bipolar affective disorder or current major depression)	4.5%	Single study (Scotland, 2008)[29]	315 prisoners
Major depression	10.2%	Systematic review (Multiple, 2012)[30]	Pooled estimate from 16,021 male prisoners
Psychosis	3.6%	Systematic review (Multiple, 2012)[30]	Pooled estimate from 26,814 male prisoners
Self-harming behaviour	5%-6%	Single descriptive study (England and Wales, 2014)[31]	26,510 male prisoners
Previous contact with mental health services	22.3%	Cross-sectional survey (England, 2017)[27]	197 male prisoners
Has a key worker	31.1%	Cross-sectional survey (England, 2017)[27]	196 male prisoners
Prior psychiatric hospital admission	9.2%	Cross-sectional survey (England, 2017)[27]	196 male prisoners
Learning Disability and learning difficulties			
Learning disability	1%-10%	Briefing paper (Multiple, 2007)[32]	Not stated
Learning disability and co-morbidity with drug and alcohol problems	60%	Review (Multiple, 2008)[33]	Not stated
Dyslexia	4%-56%	Briefing paper (Multiple, 2007)[32]	Not stated
Literacy and numeracy below that of an 11 year old	40%-50%	Briefing paper (Multiple, 2007)[32]	Not stated

Substance Use 			
Alcohol use disorder	26%	Systematic review and meta-analysis (Multiple, 2017)[34]	Pooled estimate from 15 studies/12,739 male prisoners
Drug use disorder	30%	Systematic review and meta-analysis (Multiple, 2017)[34]	Pooled estimate from 13 studies/6,232 prisoners
Smoking	83.1%	Cross-sectional study (England, 2018)[35]	2,102 male prisoners
Older People in the care of the prison 			
Living with at least 1 major illness	80%	Cross-sectional survey (UK, 2001)[36]	203 male prisoners from 15 prisons
Living with 2 or more chronic conditions	61%	Cross sectional study (USA, 2016)[40]	125 prisoners aged 55 years or older
Living with a mental health condition	38.4%	Systematic review (Multiple, 2017)37	9 studies
Depression	28.3%	Systematic review (Multiple, 2017)[37]	9 studies
Dementia	1%-30%	Report (Multiple, 2013)[38]	Not stated
Prescribed medication	77%-85.1%	Cross sectional survey (UK, 2004)[39] and thematic study (Scotland, 2017)[4]	203 male prisoners from 15 prisons and 164 males over the age of 60
Some need with Activities of Daily Living (ADLs)	54%	Cross sectional study (USA, 2016)[40]	125 prisoners aged 55 years or older
Existing personal care needs	10.7%	Cross sectional study (UK, 2013)[41]	262 male prisoners aged 50 years or older
Oral Health 			
No of decayed teeth	Mean 2.4-7.1	Systematic review (Multiple, 2008)[42]	21 studies
No of missing teeth	Mean 3.5-7.4	Systematic review (Multiple, 2008)[42]	21 studies
No of filled teeth	Mean 4.1-6.0	Systematic review (Multiple, 2008)[42]	21 studies
Bruxism (teeth grinding)	29.2%	Cross-sectional survey (Italy, 2014)[43]	280 male prisoners

4.9 Literature review conclusion

This prison literature review has highlighted some of the most pressing issues facing the prison system today. Please see each section for the details. The current evidence base remains disproportionately focused on descriptive evidence rather than on effective intervention and impact.

Despite this shortcoming some core themes have emerged as good practice across topics including:

- proactive admission
- holistic, individualised care
- maximising use of peer support/mutual aid and
- supporting throughcare into the community

Mental health remains the key area of concern and whilst prevalence estimates vary substantially the burden of mental health issues is greater than that of the community. Similarly problematic alcohol and drug use is higher compared to the general population and disproportionately affects those with mental health issues. It is generally accepted that there are many mental health unmet needs within those in the care of the prison. Furthermore suicide in those in the care of the prison is three to six time greater than the general population. It is also know that the periods of vulnerability to self-harm and suicide are arrival, transfer and release from prison. Building on this evidence and knowledge there are many actions that can make a difference such as suicide prevention screening and mental health screening at admission. In the longer term, for those in the care of the prison, it is concluded a need for tailored support underpinned by a trauma informed approach.

5. Limitations

The most obvious shortcoming of this health and health care needs assessment is the time it took from start to completion. As previously mentioned this is because of the COVID-19 pandemic and with the deployment of resources the work stopped after a feedback workshop in 2020. The prison setting also limits the methods employed but given the constraints of the physical environment and security issues (for example no computers/laptops allowed and access to those in the care of the prison) the work was progressed within the time and resources available. Arguably, the mixed method approach did allow for the collection of information from a number of sources and wide ranging engagement, but, this was also a limitation because of the volume of data collected and being able to synthesise it concisely.

The literature review (see Chapter 4) published elsewhere and summaries included in this publication, was an update of the Greater Glasgow and Clyde Prison Needs Assessment in 2012. This would have benefitted by being narrower in focus because of the huge volume of literature to update against what was going to be of use to this health and health care needs assessment.

6. Recommendations

These recommendations are drawn from each section of the report and given a priority level based on the outputs of discussions and workshops.

Priority level

1 = must do as soon as possible

2 = must do within one year

3 = must do within three years

4 = would add value, revisit reprioritise after a year

The first recommendation proposes the health and health care planning group (HCPG) reconvenes to develop an action plan. In order to drive this agenda members of the group, by using project management, should be allocated recommendations and asked to report on progress. The 'Owner/Possible Leads' column is not definitive and should be reviewed by the HCPG.

Table 11: Recommendations

Chapter	No.	Recommendation	Owner(s)/Possible Lead(s)	Priority Level
Introduction				
1	1	Reconvene the health and health care prison group to consider these recommendations and to either develop an action plan or utilise existing Prison/NHS planning mechanisms.	HCPG; NHS; PH; SPS	1
1	2	Reconvene the health and health care prison group to discuss and reflect on the impact of COVID-19 on how HMP Inverness responded and lessons learnt.	HCPG; NHS; PH; SPS	1
1	3	Development of / or refresh an existing healthy prison workforce plan; include a training programme addressing the topics and needs identified in this HNA.	HCPG; HI; NHS; SPS	2
Data				
2	4	Based on the health and health care data map, and prevalence table, select which core indicators to use for ongoing service planning and monitoring and embed them in standard management.	NHS; SPS; Prison health service manager and prison health care centre manager	2
2	5	Actively encourage participation in access to medical care, art/ education projects with the purpose of encouraging self help and or peer support programmes to improve general health and increase wellbeing. (Will include chronic disease management).	GP; HCPG; NHS; SPS	2

2	6	Recognising and building on the work already in place tailored support for those in the care of the prison to address particular behaviours such as smoking, drug use including steroid use, alcohol intake and gambling, and be set within a context of throughcare.	GP; HADP; HCPG; HI NHS; SPS; TSP	2
2	7	Review, at least annually, the amount of nicotine replacement items dispensed within the context of the smoking cessation services and a health improvement strategy.	NHS smoking cessation service/ HI	Ongoing
2	8	Build on the tailored support already in place for those in the care of the prison to manage mental health issues such as high levels of anxiety and stress and be set within a context of throughcare. Utilise the enhanced remote consultations options now available to ensure talking therapies are available, consider applicableness of group Cognitive Behaviour Therapy.	GP; NHS Psychiatry; Psychology	2
2	9	For staff and those in the care of the prison provide training and educational opportunities about how, those in the care of the prison, can access support for financial advice and employment help.	DWP; Educ; NHS; SPS	2
2	10	Investigate the current medication dispensing processes using improvement methodologies (e.g. waste wheel and ideas forms).	NHS; Pharmacy; PH	2
2	11	Review how the existing incident/ complaints data is used in providing feedback to staff and in reviewing the service.	NHS; Pharmacy; PH	2
Engagement				
3.6.1	12	Ensure opportunities for those in the care of the prison, who are vulnerable, to participate in 'self help' programmes.	HCPG; NHS; SPS	2
3.6.1	13	Prioritise the ongoing development of the peer model of support provided by those in the care of the prison to others. Extend this beyond the current model by mapping and utilising (where appropriate) the assets of those in the care of the prison.	HCPG; NHS; SPS	2

3.6.1	14	Develop a framework and action plan (to include all staff groups and those in the care of the prison) to tackle prejudice and stigma directed towards those in the care of the prison.	HCPG; NHS; SPS	2
3.6.1	15	Develop processes/pathways to plug the gap left by the loss of the throughcare officer role.	HCPG; NHS; SPS	2
3.6.1	16	As a principle, the maintenance of family relationships (as defined by the person in the care of the prison), where appropriate, to be at the heart of health and health care prison policies.	HCPG; NHS; SPS; Family Support Groups	Ongoing
3.6.1	17	Continued development of the 'personal officer' role as a standard rather than being prison officer dependant. Introduction of an outcome star/My Compass will provide qualitative and quantitative data as well as being a useful management tool.	HCPG; NHS; SPS	2
3.6.2	18	An increased understanding of the perception of 'management' (both NHS/Prison), for example, the distance those in management are from the front line, and how this can be changed might enhance relationships throughout the prison.	HCPG; NHS; SPS	3
3.6.2	19	The impact of staffing levels on the morale of staff to be constantly reviewed and appropriate mitigations agreed with staff, staff representatives and professional bodies.	HCPG; NHS; SPS	2
3.6.3	20	Consider the expansion of liberation case conference meetings to include organisations such as DWP, housing and APEX.	DWP; HCPG; NHS; SPS; TSP	2
3.6.3	21	Consider the appropriateness and implementation of the 'Do it profiler' global tool to assess social functioning, numeracy, literacy and life skills being considered as a national tool.	Fife College	Ongoing
3.6.3	22	Explore increased involvement with families starting with monthly meetings.	Prison Chaplain	4
3.6.3	23	Provide additional support for those in the care of the prison experiencing bereavement.	Prison Chaplain	4

3.6.3	24	Travelling Communities: promote the E-learning module about raising awareness about working with the travelling community available on NES TURAS (internal learning platform) for NHS staff.	NHS	2
3.6.3	25	Review the processes that result in the waste of tablets that are destroyed because of the continuous turnover of patients.	Pharmacy	2
3.6.3	26	Develop a process to increase self possession of medication because this would decrease the need escorts to the medical centre.	GP; Health care centre; SPS	2
3.6.3	27	Consider increasing practical skills such as cooking and shopping because this would support oral health, money management, maintaining a healthy weight and help build self confidence.	HCPG; SPS life skills officer	3
3.6.3	28	Raise with SPS national procurement the Prison issue toothbrushes are not fit for purpose	Dent; SPS	4
Literature Review				
4.1		Health care and physical health		
4.1	29	Increase level of preventative care through proactive health checks.	NHS	3
4.1	5	Actively encourage participation in access to medical care, art/ education projects with the purpose of encouraging self help and/or peer support programmes to improve general heath and increase wellbeing. (Will include chronic disease management).	NHS	2
4.1	30	Review nursing specialist functions including use of triage and nurse prescribing.	NHS	2
4.1 General	3	Development of / or refresh an existing healthy prison workforce plan; include training needs.	HCPG; HI; SPS	1
4.2		Communicable disease		
4.2	31	Training for SPS staff in Blood Borne Viruses.	NHS; PH; SPS	2
4.2	32	Make condoms, and lubricants available to those in the care of the prison through a number of outlets in addition to the Healthcare Centre and at liberation.	HI; NHS; SPS	2

4.2	33	Introduce tuberculosis screening processes.	HPT; NHS; PH	4
4.3		Mental Health and Wellbeing		
	8	Build on the tailored support already in place for those in the care of the prison to manage mental health issues such as high levels of anxiety and stress and be set within a context of throughcare. Utilise the enhanced remote consultations options now available to ensure talking therapies are available, consider applicableness of group Cognitive Behaviour Therapy.	GP; NHS; SPS	2
	5	Actively encourage participation in access to medical care, art/ education projects with the purpose of encouraging self help and /or peer support programmes to improve general health and increase wellbeing. (For example Listening schemes and buddying programmes).	HCPG; HI; NHS; SPS	2
4.3	34	Embed a trauma informed approach into staff training programmes and in service delivery and planning.	NHS; PH; SPS	Ongoing
4.4		Learning disability and learning difficulty		
4.4	35	Adopt/agree to use a validated learning disability screening tool during the admission process to prison. This might be the 'Do it Profiler' tool if nationally enforced.	Educ; LD service; NHS; SPS	3
4.5		Drugs and Alcohol		
4.5	36	Continued drug and alcohol screening at admission including use of the AUDIT tool. Review pathways following identification of problematic alcohol or drug use.	GP; NHS	Ongoing
4.5	17	Continued development of the 'personal officer' role as a standard rather than being prison officer dependant. Introduction of an outcome star/My Compass will provide qualitative and quantitative data as well as being a useful management tool.	HCPG; NHS; SPS	Ongoing
4.5	37	Continue to offer the choice of recovery groups to those in the care of the prison with a view to extend the choice.	HADP; HCPG; NHS; SPS	2
4.5	38	Enhanced use of peer support and family support.	HADP; HCPG; NHS; SPS and family support groups	2

4.5	39	Continue to provide naloxone upon release and ensure accurate record keeping.	HADP; NHS; SPS	Ongoing
4.5	40	Investigate if alternative opiate substitutes can be dispensed to those in the care of the prison that allow for weekly or monthly treatment.	GP; NHS; Pharmacy service	2
4.5	31	Continue to develop and provide training to enhance the personal officer role so the officer is confident is in supporting those in the care of the prison with alcohol and drug related issues.	HADP; NHS; SPS	2
4.6		Older people in the care of the prison		
4.6	42	Develop a health care plan to meet the needs of older men in the care of the prison; this might include screening for cognition, preventative screening and managing dementia, building links with the third sector and social work. It might also include opportunities for physical activity (not necessarily the gym) peer support/mutual aid and self help.	NHS; SPS named nurse lead from health care centre	3
4.6	43	Develop an end of life pathway for those in the care of the prison	Prison Chaplain; GP; NHS; Local hospice; named lead from health care centre	3
4.7		Oral Health		
4.7	28	Advocate for the review of the national contract with SPS for the purchase of toothbrushes and interdental brushes.	Dent; SPS	3
4.7	44	At the time of liberation, provide those in the care of the prison, the hotline number for advice on how to access dental treatment in the community.	SPS	Ongoing
4.7	45	Provide sweeteners as an alternative to sugar at all times, for those in the care of the prison.	SPS	2
4.7	46	Pilot a triage process for those in the care of the prison requiring dental care; consider costs and benefits against the requirement of the additional staff resource.	Dent; NHS	4

Table 12: Recommendations: acronyms explained

Acronyms		Acronyms	
Dent	Dental Services	HCPG	Health Care Planning Group
DWP	Department of Work and Pensions	HI	Health Improvement
Educ	Education	NHS	National Health Service
GP	General Practice	PH	Public Health
LD	Learning Disabilities	SPS	Scottish Prison Service
HPT	Health Protection Team	TSP	Third Sector Partners
HADP	Highland Alcohol and Drugs Partnership		

Conclusion

The authors have based this report on information gathered during the health and health care needs process and have aimed to provide an independent perspective, but recognise not all partners will agree with some of the findings. The evidence behind most of the recommendations are from a number of sources, for example, reported in the literature and gathered from local data. It should also be noted that many of the issues raised are related to the economic and social determinants of health which the prison health care group has little influence over, and for this reason, the authors focused on potential actions and recommendations.

There are forty six recommendations and these have been prioritised using numbers 1 to 4, where 1 is highest priority. Those prioritised with a number 1 relate to restarting processes within the health care service that will provide some governance and oversight for the other recommendations. In addition, a reflective session is suggested to discuss 'lessons learnt' from the COVID-19 pandemic and impact on prison health care.

The strongest emerging theme from all staff groups and from those in the care of the prison was for more support to manage the mental health of people in the care of the prison. The associated recommendations include the desire for more staff training and support, for example, on trauma informed practice, and those in the care of the prison greater access to specialist mental health services such as talking therapies. Feeling anxious and stressed, for much of the time, was frequently cited in the focus groups as a major issue.

Another strong theme was problematic alcohol and drug use and to note this disproportionately affects those with mental health issues.

The health care centre is a pressurised service because of the volume of work and also staff shortages. A number of recommendations have been made for consideration by the health care prison group that would go some way to alleviate these services pressures, for example, self possession of drugs by those in the care of the prison and a review of the complaints and drug medication processes using improvement methods.

The growing number of older prisoners, with additional needs, was also identified as an area to proactively plan for immediately and for the future.

In relation to the SPS the loss of the throughcare officer role was highlighted by both health care and prison staff and also by those in the care of the prison. Furthermore, the role of the prison personal officer was also highlighted along with the use of an outcome monitoring tool such as My Compass. These are two processes that should increase engagement with those in the care of the prison and therefore should be prioritised. With the delay in this report it might be that the gap left by the role of the throughcare officer and the role of the personal officer have been either resolved or progressed.

The commissioned 'ask' by the Head of the NHS HMP Inverness health care service and the HMP Inverness Prison Governor was made to assist with planning the move into the new prison. The current building, especially the space occupied by the health care centre, is not fit for purpose and the move, when it happens, will immediately enhance the health and wellbeing of those in the care of the prison and also those who work there. Some of the issues, however, will not be solved by a new prison and require organisational change such as tackling stigma; this work is already ongoing and should be sustained. It is encouraging that there are many partners (including those in the care f the prison) willing to engage with the prison health care group and the SPS to ensure those in the care of the prison have the opportunity to recover, desist from crime and lead fulfilling lives.

Finally, a quote from one of the focus groups to describe the health and health care journey demonstrating the difference from the 1990s to present day:

> "The health care service is much improved compared to 30 years ago being three male nurses, paracetamol and a cart".

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Appendices

Appendix 1: Health and health care prison needs assessment Advisory Group members – invited list

Name	Organisation
Catherine Flanigan Co-chair	Public Health Registrar, NHS Highland
Elisabeth Smart Co-chair	Consultant in Public Health, NHS Highland
Susan Birse	Health Improvement, NHS Highland
Suzy Calder	Head of Service - Drug & Alcohol Recovery / Prison & Police Custody Healthcare & SSARC, NHS Highland
Alan Colne	Offender Outcomes HMP Inverness
Helen Eunson	Professional Lead Nurse, Mental Health, NHS Highland
James Fraser	General Practitioner, Southside Practice
Ann Galloway	Consultant Clinical Psychologist/NHS Highland's Professional Lead for Psychological Services, NHS Highland.
Pat Griffin	Governor, HMP Inverness
Sharon Holloway	HADP Development Manager
Sandy Hamilton	Clinical Manager, HMP Inverness, NHS Highland
Jackie Hand	Acting Clinical Manager, HMP Inverness, NHS Highland
Carolyn Hunter-Rowe	Senior Epidemiologist, Public Health, NHS Highland
Arlene Johnshon	Head of Service Learning Disabilities and Autism, Highland Council
Alex Keith	Consultant Psychiatrist, NHS Highland
Siohan Neylon	Hospice
Stewart MacPherson	Associate Medical Director Mental Health, NHS Highland
Thomas Ross	Lead Pharmacist South and Mid, NHS Highland
Dan Sowter	Dentist, tutor and Inverness Dental Centre
Nikki Thomson	Consultant Psychiatrist, NHS Highland

Appendix 2: Inverness Prison Healthcare Needs Assessment Advisory Group Terms of Reference - May 2019

1. General

These terms of reference describe the membership, responsibilities and arrangements of this steering group.

2. Purpose

The purpose of this group is to:

- Provide advice, guidance and constructive challenge to the planning, implementation and recommendations of this HNA
- To draw on their own areas of expertise and experience to inform and support this HNA
- To engage with and promote to relevant colleagues the activities of this HNA
- To consider the findings of this HNA and provide advice on what recommendations should be made as a result.
- To assist in prioritising the areas for focus within recommendations
- To promote, disseminate and action the recommendations of this HNA

3. Responsibilities

All group members are expected to:

- Engage with HNA in so far as is practical and appropriate for their job role
- Promote engaging with the HNA where applicable with other staff members and colleagues
- To provide scrutiny for the plans, activities and recommendations of the HNA
- Make reasonable efforts to attend meetings and send a deputy with suitable authority where it is not possible to do so
- Consider what practical actions can and should be implemented as a result of this HNA and take reasonable steps to achieving these actions as is appropriate for their role.

4. Membership

The core membership is approximately 17 people and it is anticipated that as many people as possible will attend. Where this is not possible members will be able to provide advice virtually (such as email exchange).

Key documents or decisions will be shared and agreed through the group or via a virtual email group.

Other members can be invited to join the advisory group for specialist advice if the need arises.

Core Membership (see appendix 1)

Frequency of Meetings

The core membership will meet quarterly (approximately every 3 months) for the duration of the HNA, which is anticipated to be a year.

At the conclusion of the HNA it will be discussed as a group whether the group will be disbanded or continue as an implementation group until such time as the core recommendations have been actioned or there is no further need to meet

Meeting Description

- Meetings will be scheduled for 90 minutes
- The agenda and meeting papers will be distributed at least a week in advance of the meeting
- Meetings will take place in Prison Service premises.
- The NHS public health department will provide an action note summary within 3 weeks of the meeting.
- Any agenda items will be highlighted to the co-chairs at least 10 days prior to the meeting date.

Reporting

HNA commissioned by HMP Prison Inverness on behalf of Scottish Prison Service and will report back to both services through the advisory group in the first instances then through the most relevant boards and committees as determined by the final scope and focus.

Group Ground Rules

All group members will:

- positively participate and collaborate in group discussions
- will be listened to and considered
- will be respectful of other members ideas, views and cultures
- respect confidentiality where applicable

Review Date

Once the HNA has been concluded and recommendations have been shared the group will decide whether to proceed as an implementation group or monitoring and evaluation group.

If the group decides to do so then these TOR will be reviewed and adapted accordingly.

Document Control

Date	Status	Author
08.04.2019	Draft 1	Catherine Flanigan
10.04.2019	Draft 2	Reviewed Elisabeth Smart, Carolyn Hunter Rowe and Susan Birse
21.05.2019	Approved with agreed ammendments	First advisory group meeting

Appendix 3: Person Centred Planning / Equality and Diversity Impact Assessment

Name of the person completing this assessment: Elisabeth Smart, Catherine Flanigan, Scottish Prison Service rep; NHS Healthcare rep.

Date of assessment: 29/07/2019

Responsible Manager: Scottish Prison Service and NHS Healthcare representatives.

Name of the project/policy/plan you are working on: HMP Inverness Healthcare needs assessment

Preliminary questions

1. Is the project, plan or policy you are working on major in terms of its scale or significance?

Yes.

The prison is facing multiple challenges currently. These include the loss of the Throughcare Support Officer (TSO) role, long term vacancies in the healthcare centre and the anticipated 5 year delay to moving to new premises. This work is of major significance to understanding, protecting and promoting the health and well being of people living in prison.

2. If your work is considered minor in terms of its scale or significance, is it likely to have a major impact on people with protected characteristics or the groups listed in the guide?

See below.

Stage 1 – About your work

Provide a brief overview of the work you are doing:

Consider the following areas:

- Why are you doing this work? Is it to improve a service, to save money? Is it a new piece of work or a review of existing policy or practice

Aim: To recommend how prisoner health and health care could be improved through considering the healthcare needs and provision of the Inverness prison population now and estimating the future healthcare needs for the larger prison population anticipated in the coming years at a new site.

Objectives:

- To understand the current healthcare **needs** of prisoners in Inverness using data, evidence and engagement of prisoners and staff
- To understand the current healthcare **provision** in Inverness prison using data and engagement of prisoners and staff
- To summarise the evidence base for prisoner health and healthcare
- To make evidence based, locally informed recommendations to improve the health and healthcare needs of prisoners now and potentially at a future site

Saving money is not an objective of this work.

- What do you know about the people who might be affected by this work or activity? Consider people with protected characteristics and the disadvantaged groups listed earlier.

We anticipate that people both living and working in prison will be affected by this work.

Protected characteristics:

Age: in the prison the population is aged 21-65. This work will quantify the proportion of older adults with multimorbidity, limited mobility and polypharmacy. The number of older prisoners is increasing nationwide and it is expected that this will be reflected locally. This would increase the number of prisoners with complex health needs, multimorbidity, polypharmacy, physical disability and end of life care. For younger prisoners specifically body image and use of steroids to achieve desired body image were highlighted as issues.

Gender and gender reassignment: this prison has an all male population. This can include transgender male prisoners. Over the past 10 years it is believed that less than 5 transgender male prisoner have been resident at HMP Inverness. There are also staff members who are or who will in the future transition. Transgender prisoners are held in a separate section of the prison with separate physical activity rota and meals are eaten alone. They have regular one to one meetings with a member of the mental health team. The number of transgender prisoners under the care of HMP Inverness will be recorded within this HNA. Staff members who are in the process of transitioning would take up the roles and responsibilities of their identified gender.

Disability: there will be prisoners with both physical and learning disabilities. SPS are currently starting new admission screening which may detect more people with both forms of disability. However this tool has not yet been launched in Inverness prison and is not designed to screen for specific conditions. It is a global assessment of social, psychological and intellectual functioning. The physical space of Inverness prison is not well designed for people will limited mobility or physical disability including wheelchair users. There are no lifts and no baths. The education centre has a stair lift which cannot be used due to fire safety restrictions. People unable to access the centre can have a limited range of activities in other accessible contexts in the prison and each person has tailored support on a one to one basis.

Ethnicity: approximately 5% of the prison population at any one time will have a second language other than English with Polish being the most common.

Religion: there is multifaith chaplaincy, led by a Church of Scotland Minister with a dedicated Iman. Where required other faith leaders can be arranged through the chaplaincy service.

Sexual orientation: there will be both prisoners and staff who are part of the LGBTQI+ community. Sexual orientation is recorded at admission and this HNA will establish the proportion of prisoners who self declare as being part of this community.

Pregnancy and maternity: this is a male prison so this is not applicable to prisoners. It should be acknowledged, however, that some Prisoners may have pregnant partners or partners that give birth and this is likely to be a time of concern and anxiety. There are also female members of staff and there are some restrictions on working in a prison setting in the later stages of pregnancy. This can lead to further reduced staff levels at points.

Other:

Carers: although few prisoners are believed to be primary carers many are parents. SPS have a named families officer and range of activities to support family connection.

Homelessness and poverty will be experienced by some prisoners. This HNA will determine the proportion of patients affected by this through admission recording of housing status and postcode of residence.

SPS also identify veterans as group who experience disadvantage with 5% of the prison population being veterans. SPS have a named veteran and custody officer and Poppy Scotland provide services including some throughcare support.

Finally reduced literacy and numeracy is more common in the prison population, where available data will be collected on this.

Stage 2 – How people might be affected by your work

Consider what information you have found out in Stage 1...

- How might people be impacted by your work?
- Think about both positive and negative impacts on patients, the public and staff and particularly those with protected characteristics or from disadvantaged groups.

It is expected that in the short term there will be an impact on how the healthcare services are delivered. In the long term it is anticipated the information will be useful as a planning tool when the new prison built.

This process will be revisited at the point of making recommendations to ensure the groups of people identified have been given due consideration and will not be further, unfairly disadvantaged as a result of these recommendations.

Positive impacts:

- For both staff and prisoners the process of the HNA should provide an opportunity to have their thoughts, concerns and suggestions heard and to see action as a result.
- For both staff and prisoners there should be positive recommendations and improvements as a result which improve the healthcare and wellbeing of the prison population.
- Staff may report improved job satisfaction if they are better able to meet the needs of the prisoners.
- The partnership approach of the HNA may result in better communication and relationships within the prison and with external services involved in service delivery
- The prison service should have a better understanding of the needs of its population which should provide a framework for future planning of service including the new prison site.

Negative impacts:

- During the engagement process and where changes are suggested there is likely to be accompanying uncertainty which may cause anxiety to staff.
- Where different views are encountered it may be challenging to come to a consensus view on the best course of action and this could cause friction.
- Needs may be identified which may be out with the control of those involved to address fully (including national policy changes) and this may cause frustration through raising expectations that cannot be met.
- Despite the adjustments suggested below some of the above groups may not be fairly represented in the engagement process.
- Depending on the nature of your project you may also want to consider transport issues, physical access, delivery of care; or communicating your work to staff, patients and the public.

Adjustments for prisoner and staff engagement

The prisoner questionnaire has been designed to be short and simple to read. There will also be an option to complete the questionnaire by phone instead, this will be free and can use language line to provide interpretation as well. This should make it more accessible for people with lower literacy, poor vision, English as a second language or physical limitation making writing difficult. This offer is written at the top of the paper questionnaire in large print in both English and Polish. This questionnaire has been reviewed by the advisory group, NHS Highland's accessible information officer and tested with a group of 6 prisoners. It has been reviewed by the Fife college learning and development lead and the British Dyslexia Association Style Guide has been consulted. It will be formally piloted before use.

In addition there will be a focus groups which will use more visual tools and aids to explore some issues in more depth, these groups will be run in the prison in accessible rooms. It is hoped additional people may be accessed through this.

The staff questionnaire will be available online and on paper and there will also be an option to complete by phone. Wednesday afternoons have been recommended as preferred time for staff focus groups and named leads for staff training and communications have been given.

Every effort has been made to avoid stigmatising language and all questionnaires will be completed anonymously. The questionnaires contain no gender specific pronouns.

The findings will be communicated back to staff and prisoners using infographics and plain English summaries.

Stage 3 – Promoting access to services and rights to care and support

Think about your findings from Stages 1 and 2 and consider...

- Have you become aware of any opportunities to promote access for the people affected by your work?
- Have you become aware that some people may find accessing services or support more difficult?
- Are you promoting people's rights to health, care and support?
- Is there any possibility that your work may indirectly discriminate against a group of people who share a protected characteristic/s?
- Are there any other opportunities to promote equality or foster good relations between groups that you have become aware of so far in this assessment?

For the HNA process appropriate adjustments for the identified groups have been described above.

At the point of agreeing recommendations this process will be repeated and will again consider the potential impact on those groups in terms of access and rights.

Stage 4 – Taking Action based on your findings

Think about what you have found out so far...

- If you have become aware of any opportunities to promote equality are you taking further action to ensure this is included within your work going forward?
- If you have become aware of any negative impacts on people with protected characteristics or from disadvantaged groups are you going to address these?

For the HNA process appropriate adjustments for the identified groups have been described above.

At the point of agreeing recommendations this process will be repeated and will again consider the potential impact on those groups in terms of access and right

Select which one of the following steps you are taking following this assessment:

Make sure you have recorded the how you arrived at your decision in the box above.

☐ No major change	☐ Adjust the work
☒ Continue the work	☐ Stop the work

Appendix 4: Working document HMP Inverness Data Map, Dec 2019

With thanks to NHS Lothian for sharing their scoping work of health intelligence in prison.

Key : Green available and valuable Amber either uncertain availability and/or questionable value Red not available and/or valuable

What we want to know?	Local data source? (numerator)	Proxy data national source?	Local data source? (denominator)	Comparison group?	Status	Plan (person)
Demographics : - Age - Gender/ gender identity - Ethnicity - Length of sentence - Remand/convicted - Transfer/local - No of admissions	1) Prison Records 2 (PR2)	n/a	PR2	Population statistics	Received 2014-2019	Prepare spreadsheets – done. Analysis to follow.
Prevalence of common physical health conditions: - Asthma - Diabetes - Epilepsy - Hypertension - Chronic obstructive pulmonary disease (COPD) - CHD (heart attack or angina) - Heart disease/ heart failure - Stroke - Deep vein thrombosis - H/O head injury - Previous operations - Skin condition/wound care / injuries - Dementia - Chronic Kidney Disease (CKD) - Cancer - Notifiable conditions - Sexually transmitted infection - Vaccination rates - Oral Health	1) All in bold in new admissions guidance from July 2019. Plan to review data completeness in Oct/Nov 2019. 2) Nil data on CKD, dementia or cancer 3) Health Protection Zone (HPZ) query for notifiable (e.g. Tuberculosis) 4) National Sexual Health System (NASH) will provide sexual health summary 5) See below for Hepatitis B vaccination, unclear regarding other vaccines. Possible data linkage but proportionality	Local extract from prisoner survey Possible cancer registry	PR2	Scottish Public Health Observatory (ScotPHO) Burden of Disease study Quality and Outcomes Framework (QoF) 2015/2016 Scottish Diabetes Survey ScotPHO prisoner health profiles 2007	1) To discuss GP patient record system 2) N/A 3) No too small to report 4) 1 year received, request for further submitted 5) Not proportionate.	Prepare spreadsheets

Prevalence of mental health conditions and learning disability: - Depression and anxiety - Bipolar disorder - Schizophrenia - Self harm - Personality disorder - autism - Suicidal behaviour - Completed suicide	1) Self declaration on admission form 2) PR2 Talk to Me Status	Education service literacy	PR2	QoF Modelled estimates for local prevalence of common mental disorders (CMD) from 2015 Mental Health needs assessment ScotPHO/ National Records of Scotland (NRS) suicide rates ScotPHO prisoner health profiles 2007 National Scottish Prison Service (SPS) deaths in prison, advised local identifiable due to small numbers.	1) Vision 2) TTM recorded as indicator act on PR2, basic stats spreadsheets	As above
Learning disability: - Intellectual/learning disability	No local data sources Do It Profiler tool once in operation will provide a range of data on global psychosocial functioning and includes statement of previous learning disability contact and any learning difficulty. Time frame unclear	Estimated prevalence rates			Nil	
Previous contact with services: - General Practitioner (GP) - Hospital (operation/ Outpatient Department) - Psychologist - Psychiatrist - Community mental health team - Drug and alcohol services	Advised no single point of access for drug and alcohol recovery services, variable local systems, not aggregated. Mental health recording	in Vision template	PR2	ScotPHO prisoner health profiles 2007	Some self declaration in prisoner questionnaire	

Contact with and waiting times services in prison: - Nurse - Doctor - Dentist - Mental health team - Sexual health - Drug and alcohol recovery services - Podiatrist - Physical educations - No. transferred to hospital - Escorted appointments - Social care - Sexual health screening - Pastoral/listening services	1) GP activity available through Vision 2) Dental R4 (dental information system) for number and type of appointments. Nil for Waiting Times. 3) Waiting list Opticians 4) Podiatry ad hoc 5) PR2 escorts contract service (excl. emergency) 6) New social care recording at admission 7) NASH can provide number of contacts but not waiting times	Data linkage to recover services waiting times National prisoner survey question about assistance with Activities of Daily Living (ADLs) Chaplaincy re listening services Scottish Prisoner Survey NASH Drug and Alcohol Information System (DAISy)(end of 2019) Recovery Drug Alcohol Treatment Waiting Times (DATWT)	PR2	Information Services Division (ISD) QoF ISD waiting times Psychological therapies	1) Vision data to discuss 2) R4 data requested 3) Nil 4) Nil 5) PR2 hospital visits received 6) Vision data to discuss 7) NASH as above	To clarify staff role field Follow up Dec 2019. Expected Jan. in PR2 data
Blood borne viruses: - Risk factors - Screening - Prevalence - Starting treatment - Partial or full Hepatitis B vaccine	1) Vision 2) Exclude NASH data as risk of double counting	NASH For starting treatment/ vaccination Pharmacy orders National prisoner survey	PR2	Scottish Burden of Disease Historic Bllod Borne Virus (BBV) network numbers (prison extract available) Taylor et al 2011 prison prevalence estimate for BBV	1) To discuss Vision and BBV network record request	Followed up in December, response awaited.

Prescribing data: - prevalence - polypharmacy - Opioid Substitution Therapy (OST) - DETOX medications	1) Lloyds management report and bespoke requests possible	Prescribing Information System (PIS)	PR2	Pharmacy can access Highland comparison May also be possible through Prescribing Information System for Scotland (PRISM)	2017-2019 management reports received	Dataset and analysis plan prepared. Sent for comment.
Substance use : - Smoking status - Alcohol use - Drug use at admission/ liberation - New Psychoactive Substance (NPS) - Drug related death - Naloxone kits distributed	1) Admission, include ADUIT screen 2) SPS report of no of smokers/vapers, no of devices and refills purchased from Electronic Point of Sales (EPoS) 3) Uptake of naloxone discharge data 4) Drugs related deaths within X number of months	Scottish Prisoner Survey Possible local raw data for AUDIT tool? APT from SPS (Available from ScotPHO/ ISD NHS smoking cessation services - nos seen refill, Nicotine Replacement Therapy (NRT) purchased National drug related deaths database	PR2	Scottish health survey ScotPHO wellbeing profiles ISD waiting times	1) Vision data to discuss 2) Same as previous 3) Received 4) Need to request	(NRT from pharmacy) And vape sales received from SPS
Health behaviours: - Body Mass Index (BMI) - Healthy eating - Physical activity	1) BMI admission 2) Prisoner report and menu available 3) Prisoner self report and PE classes schedule	Prisoner survey	PR2	Scottish health survey ScotPHO wellbeing profiles AUDIT Scottish prisoner survey	1) Vision data to discuss	

Screening programme uptake: - AAA screening - Bowel cancer screening - Diabetic retinopathy screening	1) Bowel and Abdominal Aortic Aneurysm (AAA) uptake extract requested from ISD 2) Diabetic Retinopathy System (DRS) data not extractable a local level				1) Screening data to discuss 2) N/A	Data awaited
Socioeconomic factors: - Previous employment - Housing status on admission/ liberation - Access to welfare/ employment advice? - Access to life skills/ educational attainments? - Purposeful activity	Local recording? Links centre Key Performance Indicators 3a -5b	Self report questionnaire. SMART recovery. Apex Highland Job centre Samaritans Poppy Scotland [education]	PR2	Local government benchmarking framework/ other local authority data sources	Nil housing or employment referrals data. Housing at admission from PR2, housing at liberation awaited.	Followed up December. SPS statement shared.

Protected characteristics and vulnerabilities: - Sexuality - Gender (inc transgender) - Religion - Registered disabled - Veterans - Housing status prior to admission and liberation from prison - Postcode of residence prior - No. of children/dependants - Experience of trauma - Social care requirement - Literacy and numeracy	1) PR2 primarily 2) No of dependant from self report survey 3) Limited trauma screening through h/o head injury and NASH screening for violence at home 4) Social care as above and community justice social work risk assessment (responses awaited) 5) Literacy/numeracy amongst those involved in education	PR2 Scottish Prisoner Survey Vision Self report Care First Criminal Justice Social Work			1) PR2 gender transition (too small to report), self report disability, veteran status, housing at admission 2) Nil sexuality, religion, postcode of residence 3) Questionnaire number of dependent 4) Limited NASH trauma screening 5) Literature prevalence estimate of literacy.	Check postcode data from PR2. Followed up Dec 2019, agreed to towns and cities. Data awaited.
Other: - Complaints	1) Local spreadsheet for healthcare separate for SPS 2) DATIX (electronic incident reporting) from Information Governance team				Datix spreadsheet received	

Qualitative Data/wellbeing measures

What we want to know?	Local data source? (numerator)	Local data source? (denominator)	Comparison group?	Data received	Plan (person)
Prisoner self reported health and wellbeing: - Warwickshire Edinburgh Wellbeing Scale (WEMWEBS)/other - Comparative health pre and in prison - Priorities	Questionnaire Follow up focus groups	No. of completed questionnaires	Local historic Tweed et al Scottish prison average Scottish health survey pop	Abbreviated WEMWEBS and no of self reported conditions	
People living in prison perspectives and priorities: - Knowledge about available services - Confidence in services - Opportunities to improve health	Questionnaire Follow up focus groups	No. of completed questionnaires	Some historic	Qualitative	
People working in prison perspectives and priorities: - Impressions of main health issues for prisoners - Knowledge about and connection to community services - Opportunities for development and training - Priorities - Scope for improvement and barriers	Questionnaire Follow up focus groups	No. of completed questionnaires		Qualitative	

Appendix 5: HMP Inverness Healthcare Questionnaire for People in the care of the in Prison

This is voluntary! Thank you for your time.

Is this hard to read? Tell a staff member.
We can ask these questions in person or by phone instead.
We would pay for the phone call. We can also arrange a translator.

Zapewnimy wszelką pomoc, której możesz potrzebować, aby zrozumieć niniejsze informacje lub dostarczymy je w innym języku lub formacie. W celu uzyskania dalszych informacji, prosimy skontaktować się z the galley officer.

What is this questionnaire for?

The NHS and the prison want to learn more about your health and wellbeing.

Your answers to this questionnaire will tell us more about your health and healthcare in prison.

We will use this information to inform and plan services.

We will also have focus groups. In the focus groups we will have more conversations about this.

We will write a report on the health of people living in Inverness prison.

Dont know a word? There is a word list on the last page. Please check this. Or ask a staff member.

1) Over the last month my health in general has been:

Very Good Good Fair Bad Very Bad

2) Before coming into prison my health was:

Much better Better The same Worse Much worse Don't know

3) I find accessing healthcare in prison:

Easier than outside The same as outside Harder than outside Don't know

4) Think about the last 2 weeks. Then circle your answer:

Over the last 2 weeks I've been...					
Feeling optimistic about the future	None of the time	Rarely	Sometimes	Often	All of the time
Feeling useful	None of the time	Rarely	Sometimes	Often	All of the time
Feeling relaxed	None of the time	Rarely	Sometimes	Often	All of the time
Dealing with problems well	None of the time	Rarely	Sometimes	Often	All of the time
Thinking clearly	None of the time	Rarely	Sometimes	Often	All of the time
Feeling close to other people	None of the time	Rarely	Sometimes	Often	All of the time
Able to make up my own mind about things	None of the time	Rarely	Sometimes	Often	All of the time

5) Tick (✓) all that apply.

	Before coming in to prison I used these services:	**After leaving prison I plan to use these services:**
My local GP		
The community mental health team		
Other mental health services		
Sexual health services		
My dentist		
Drug or alcohol recovery services		
A&E (emergency department)		
Other:		

6) Read the following statements. Then tick (✓) how much you agree.

In prison I can access support to:	Yes	No	Don't Need	Don't Know
Improve my mental wellbeing	☐	☐	☐	☐
Stop smoking	☐	☐	☐	☐
Recover from drug use	☐	☐	☐	☐
Recover from alcohol use	☐	☐	☐	☐
Exercise regularly	☐	☐	☐	☐
Eat healthy food	☐	☐	☐	☐
For housing advice	☐	☐	☐	☐
For employment advice	☐	☐	☐	☐
For financial advice	☐	☐	☐	☐
Connect with friends and family	☐	☐	☐	☐
Other:	☐	☐	☐	☐

7) How many medical conditions do you have?

None 1-2 3-5 6-10 >10 Don't know

8) Please circle all that apply. Before coming in to prison I:

Smoked Used drugs Injected steroids Gambled Drank alcohol regularly

9) Please read the following statements. Then tick (✓) how much you agree.

In prison these services meet my needs	Yes	No	Don't need	Don't know
Induction information about what services there are	☐	☐	☐	☐
Seeing a nurse	☐	☐	☐	☐
Seeing a GP	☐	☐	☐	☐
Seeing a dentist	☐	☐	☐	☐
Getting my usual medication	☐	☐	☐	☐
Detoxing from alcohol	☐	☐	☐	☐
Detoxing from drugs	☐	☐	☐	☐
Mental health services	☐	☐	☐	☐
Sexual health services	☐	☐	☐	☐
Getting to hospital appointments	☐	☐	☐	☐
Being able to get fresh air and sunlight	☐	☐	☐	☐
Other:	☐	☐	☐	☐

10) My biggest worry about my health and wellbeing is:

_____

11) The thing that would most improve my health and wellbeing is:

_____

12) About Me

I am aged: <18 18-25 26-40 41-60 61-70 70+

I am: White Scottish White British Asian Asian Scottish Asian British Black Black Scottish Black British Mixed or multiple ethnic group Other: ☐

I have ____ number of children and their ages are_____

I am in prison: On Remand Serving Time

I have been living in Inverness prison for:

____ Years ____ Months ____ Weeks ___Days

I have been to prison before:

Never Once before 2-5 times >5 times

My prison sentence is this long:

<6 months 6-12 months 1-5 years >5 years On Remand

13) Is there anything else you think we should know about your health and healthcare?

What next?

Please put this in the envelope and give it to the galley officer.

What do these words mean?

Optimistic: means feeling hopeful or positive.

Feeling close to other people: this means feeling like you can talk to and trust other people.

Able to make up my own mind about things: this means being able to make decisions. Decisions include thinking about the information and weighing it up. Then choosing what you want to do or what you think about a topic.

Wellbeing: means feeling good in yourself.

Healthcare: NHS services you receive during the time you spend in the Prison.

Induction: this is when you are told about a new system and how it works. In a prison induction staff will tell you about how the prison works. This will include what the rules are, what activities and services are available and how to access them.

Recovery: this is the steps someone takes, when they have a problem with alcohol or drugs, to either use less or to stop.

Medical Condition: this includes both mental health and physical health problems.

Detoxing: if you usually drink a lot of alcohol or regularly take drugs and then suddenly stop you are likely to have symptoms and feel unwell. This is called detoxing. Or sometimes withdrawal. There is support and treatment which can help these symptoms and make this easier.

Appendix 6 Inverness Prison staff questionnaire

Who would this questionnaire be circulated to:

- All members of the advisory group
- All staff who work in the healthcare centre in the prison
- All staff who offer in reach services to the prison (including but not limited to mental health, substance recovery, physiotherapy, end of life care, dental, optical and educational services)
- Prison officers
- Through care support officers (former)
- Link workers
- Cascade to others as appropriate

Landing Page

This questionnaire will help us to understand the health and wellbeing needs and provision for the people living in HMP Inverness. For the purposes of this questionnaire "those in our care" means people living in HMP Inverness.

This questionnaire will be summarised anonymously, shared with a multidisciplinary steering group and the findings will help us make recommendations for improving health and healthcare in Inverness prison

This questionnaire will take approximately 15-20 minutes.

Thank you for your time.

Section 1: The health of people living in Inverness Prison

1. **Would you say the health of the local prison population is:**

   Very Good Good Fair Bad Very Bad

2. **Wellbeing mean feeling good in yourself. I think the wellbeing of the local prison population is:**

   Very Good Good Fair Bad Very Bad

3. **Compared to healthcare in the community I think the healthcare provision in prison is:**

   Better The same Worse Don't Know

I think the main healthcare needs of those in our care in this prison are:

1)
2)
3)

I think the main *unmet* healthcare needs for those in our care in this prison are:

1)
2)
3)

Section 2: staff perceptions

I see supporting the health and wellbeing of those in my care as part of my job :

Strongly disagree Somewhat disagree Neither agree nor Disagree Somewhat agree Strongly agree

I am confident I know how to use a trauma informed approach in my work in prison:

Strongly disagree Somewhat disagree Neither agree nor Disagree Somewhat agree Strongly agree

I am confident that when a person is imprisoned that I can provide them with all the relevant information they require about health services in prison:

Strongly disagree Somewhat disagree Neither agree nor Disagree Somewhat agree Strongly agree

I think the admission to prison process could be improved by:

I think release from prison could be improved by:

Please read the following statements. Then tick (✓) how much you agree with it.

I am confident that if I needed to I could help a person in my care in prison to access support to:

	Yes	No	Don't need	Don't know
Improve their mental wellbeing	☐	☐	☐	☐

Stop smoking	☐	☐	☐	☐
Recover from drug use	☐	☐	☐	☐
Recover from alcohol use	☐	☐	☐	☐
Exercise regularly	☐	☐	☐	☐
Eat healthy food	☐	☐	☐	☐
For housing advice	☐	☐	☐	☐
For employment advice	☐	☐	☐	☐
For financial advice	☐	☐	☐	☐
To connect with friends and family	☐	☐	☐	☐
Other **If other, please specifiy [insert box]**	☐	☐	☐	☐

What would help you to support those in your care to access any of these services more easily?

Section 4: staff training and development

I can access development opportunities to support my role in those is our care's prisoner health and wellbeing:

Strongly disagree Somewhat disagree Neither agree nor Disagree Somewhat agree Strongly agree

I can access training opportunities to support my role in those in our care's health and wellbeing

Strongly disagree Somewhat disagree Neither agree nor Disagree Somewhat agree Strongly agree

I would welcome additional training to support my role in (tick all that apply):

Supporting people:

- Experiencing acute anxiety, distress or low mood ☐
- Experiencing thoughts of suicide or self harm ☐
- Living with a mental health condition ☐
- Who use drugs ☐
- Who use alcohol to excess ☐
- Who smoke tobacco ☐
- Living with a physical disability ☐
- Living with an intellectual/learning disability ☐
- Receiving end of life care ☐

Learning more about:

- Recovery from drugs ☐
- Recovery from alcohol ☐
- Motivational interviewing ☐
- Working with interpreters ☐
- Person centred approaches to behaviour change ☐
- Understanding heath inequality ☐
- Blood borne viruses (eg HIV and hepatitis) ☐
- The impact of trauma on health ☐
- Alcohol brief interventions ☐

Other training:

I would welcome more joint learning and knowledge exchange opportunities between Scottish Prison Service (SPS) and National Health Service (NHS) staff:

Agree Neither agree nor disagree Disagreee

I think I have sufficient personal (eg pastoral) support to perform my role? Agree Neither agree nor disagree Disagree

Optional comments box:

Do you have anything else you would like to say about training and or support opportunities in relation to prisoner health and wellbeing?

The following questions are for people working in direct healthcare delivery only .

If you do not consider yourself to be a member of the healthcare team please tick here to skip this section

For prison healthcare staff only

I think prison healthcare has improved since moving to the NHS in 2011:

Disagree Neither agree nor Disagree Agree

I am confident that when a new person is imprisoned I know how I can access reliable community health information about them:

Strongly disagree Somewhat disagree Neither agree nor Disagree Somewhat agree Strongly agree

I am confident that when a person is released from prison I know what local community services I can refer them to:

Strongly disagree Somewhat disagree Neither agree nor Disagree Somewhat agree Strongly agree

I am confident that when a person is released from prison I know how to refer them on to local services:

Strongly disagree Somewhat disagree Neither agree nor Disagree Somewhat agree Strongly agree

I am confident that the following services meet the health care needs of people living in prison:

	Yes	No	Don't Need	Dont Know
Induction information about available services	☐	☐	☐	☐
Seeing a nurse	☐	☐	☐	☐
Seeing a GP	☐	☐	☐	☐
Seeing a dentist	☐	☐	☐	☐
Dispensing usual medications	☐	☐	☐	☐
Detoxing from alcohol	☐	☐	☐	☐
Detoxing from drugs	☐	☐	☐	☐
Mental health services	☐	☐	☐	☐

Sexual health advice	☐	☐	☐	☐
Accessing outpatients appointments	☐	☐	☐	☐
Being able to get fresh air and sunlight	☐	☐	☐	☐
Other _____	☐	☐	☐	☐

About my job

The single thing I think would most improve healthcare in prison is _____

The single biggest barrier to improving health and wellbeing in prison is _____

All staff again

What aspects of the health care service in prison do you think work particularly well?

1.

2.

3.

What aspects of the healthcare service in this prison do you think could be most improved?

1.

2.

3.

How could those aspects of the healthcare service in this prison be improved?

1.

2.

3.

What do you see as the barriers to improving the healthcare service in this prison?

1.

2.

3.

How could these barriers be overcome?

1.

2.

3.

Is there anything else you would like to say about health and health care in Inverness prison?

About Me

Organisation: [insert drop down list SPS, NHS etc, include other -> triggers free text box]

I work in Inverness prison: [insert drop down: full time, part time, once a week, once a month etc]

I also work in other settings except from the prison: yes/ no /sometimes

Last Page

What next?

All questionnaire responses will be summarised anonymously. We may use some anonymous quotations in our final report.

We will use your answers to learn more health and health care in Inverness prison.

We will use this information, conversations with prisoners and health care staff and learning from the literature to understand what's working well, not so well and to make recommendations for change.

The final report will be circulated through normal staff routes and will be available to everyone.

Thank you for your time!

Appendix 7: Focus Group on Health and Healthcare

Consent form

Purpose

The purpose of this focus group is to hear from people working in Inverness prison about their perspectives on health and healthcare in the prison.

What will happen?

A focus group is like a group conversation. People will be asked questions about their opinions on health and wellbeing in prison. This will include questions about services, priorities and suggestions for improvements.

Notes will be made on flip charts and post it notes during the conversation. The conversation will not be recorded.

The conversation will take about an hour.

Who is collecting this information?

Catherine Flanigan and Elisabeth Smart from the public health team at NHS Highland. They are asking these questions as part of a joint Healthcare Needs Assessment between SPS and NHS.

Your rights as a participant

- Your participation in this focus group is voluntary.
- You may refuse to take part at any time.
- You can leave at any time
- You may ask questions at any time.
- We can decide as a group to have a short break if needed

What will my information be used for and who will see it?

Your name will not be put on any of the work we are doing. What you say will normally be strictly confidential but if you tell us something that makes us think you or someone else is at serious risk of harm we may have to escalate it.

After we have seen all the people we need to talk to we will write a report. The report will include these findings and findings from the data and literature. In the report no-one will know who has said what. This report will be used to plan healthcare for the future. The report or a summary sheet will be made accessible to people living in prison and to staff working in it.

How will my information be recorded, stored, and for how long?

Only the NHS staff working on this project will be able to see what you have said. The notes from our talk will be kept securely in a locked drawer at NHS Highland Public Health Department. They will not have any names on them.

Copies or pictures of these notes will also be on a secure part of a computer system. Only NHS staff working on this project can get into this system.

Once we have written and shared our final report we will delete them. All information collected is being treated in line with NHS Highland information governance policy and GDPR regulations.

Your agreement

We will answer any questions you have.

If you are happy to join this conversation please sign below.

Thank You.

Date:

Signature:

Appendix 8

Focus Group - Paul

Discussion point

I would like to introduce you to Paul who comes from a small city.

Paul is 33 years old and has two younger siblings. His parents both had long term problems with drug misuse and because of this his life was chaotic. Paul didn't attend school and if he did his behaviour was disruptive to the rest of the class. Paul recounts stories from his early years when his father told him about his grandfather drinking alcohol and how his father was subjected to violence and locked in the garden shed.

Paul, aged 10, at a very low point of his life tried to slit his wrists and ended up in hospital. For most of his youth, Paul was part of a local gang and got involved in a culture of selling illegal drugs. He eventually got caught and this resulted in a prison sentence in HMP Young Offenders Institute, Polmont. In his middle twenties, Paul was heavily in debt and homeless.

At end of focus group

So what happened?

Paul was linked up with a mentor through an offending programme.

This mentor helped build his confidence and self-esteem and helped him become the actor Paul Brannigan.

Paul is best known for his roles as Gareth O'Connor in Scottish soap opera River City and as Robbie in the film The Angels' Share (2012). Brannigan also appeared in the 2013 movie Under the Skin.

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