

Integrated health and social care in prisons

Tests of change:

workstream findings

and recommendations

Alison Bavidge

Social Work Scotland

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Glossary and acronyms

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| Term | Meaning |
| ADP | Alcohol and Drug Partnership.  A multi-agency group tasked by the Scottish Government with tackling alcohol and drug issues through partnership working. Members in each local partnership usually include the local authority, NHS board, Police Scotland, Scottish Fire and Rescue, Third Sector Alcohol and Drug Agencies amongst others. |
| CBSW | Community Based Social Work. Social work services for adults that are based in the community as opposed to those based in prison.  |
| CJP | Community Justice Partnership.  A local partnership made up of a **group of agencies with the remit of reducing re-offending and improving outcomes for people who have been involved in the justice system.** The partnerships were set up under Scottish Government legislation, passed in 2016, The Community Justice (Scotland) Act 2016 which put a legal duty on a set of statutory partners in each local authority area to engage in a planning process.  |
| CJS | Community Justice Scotland. A national body whose role includes supporting the CJPs and identifying improvements and challenges in the community justice system. |
| CJSWR | Criminal Justice Social Work Report: a report requested of social work by the Courts before sentencing. Any person who is under 21 or who is over 21 and facing the possibility of a first custodial sentence must have a report.  |
| GIC | Governor (in Charge)The most senior manager at each prison |
| HB | Health Board |
| HSCP | Health and Social Care Partnership: a partnership between a health board and local authority through an integration authority to deliver integrated health and social care. |
| IA | Integration Authority – the name encompasses both models of integration; the body corporate (IJB) and lead agency model. Of the 31 Integration Authorities, 30 use the body corporate model of an IJB.  |
| IJB | Integration Joint Boards. See IAs |
| LA | Local Authority |
| LS/CMI | Level of Service \ Case Management Inventory |
| NHS | National Health Service |
| Ordinary residence | Ordinary residence is used by local authorities to determine which local authority is responsible for delivering services. More information can be found at: <https://www.gov.scot/publications/community-care-ordinary-residence-determinations/> |
| PBSW | Prison Based Social Work. Social work services that are based in the prison as opposed to those based in the community. |
| Personal care | Intimate physical care including help to wash, eat, use the toilet and dress |
| SDS | Self-directed support. Self-directed support can help people have better lives by making sure that:* Disabled people have the same freedom and choices as others at home, at work or in the community.
* People get the kind of support they want, and where and when they want it.
* People get support at the right time, before a crisis or emergency happens.[[1]](#footnote-2)

SDS has 4 options:* Option 1 - a direct payment, which is a payment to a person or third party to purchase their own support
* Option 2 - the person directs the available support and the financial aspects are handled by the local authority.
* Option 3 - the local council arranges the service and handles the finances for the support
* Option 4 - a mix of the above
 |
| SG | Scottish Government |
| SIMD | Scottish Index of Multiple Deprivation. SIMD looks at the extent to which an area is deprived across seven domains: income, employment, education, health, access to services, crime and housing. |
| Social care | Support to help people live full lives. Encompasses, daily living tasks, housing support, support to work and take part in leisure activities, relationship and connections to community. The Dilnot Commission 2011 defined social care as follows:*Social care supports people of all ages with certain physical, cognitive or age-related conditions in carrying out personal care or domestic routines. It helps people to sustain employment in paid or unpaid work, education, learning, leisure and other social support systems. It supports people in building social relationships and participating fully in society.* (Commission on Funding of Care and Support, 2011) |
| Social work | The practice of assessing and delivering support for people facing significant life challenges in order to promote wellbeing and independence. Based in a human rights approach, it considers individual, family, community and socio-economic circumstances and works within legal frameworks particularly around protection and capacity. The assessment is the statutory route to formal services and support plans that may include social support and personal care. Social work is a reserved profession (a person must be qualified and registered to practice) and academic subject in its own right whilst drawing on the evidence base of a range of social sciences.  |
| SPS | Scottish Prison Service |
| SSSC | Scottish Social Services Council: Regulator for the social work and social care workforce. Registers social service workers, sets standards for their practice, conduct, training and education and supports their professional development. |
| SWS | Social Work Scotland: the membership organisation for social work leadership in Scotland |
| WSA | Whole systems approach:  A strategic integrated approach to planning and delivering services  and supports that encompasses every element of service that a person might come into contact with in their involvement in that areas. So, a WSA for people in prison requires consideration of the courts, prisons, health and social service provision. It should also include strong representation from people with lived experience who can contribute real perspectives on the impact of the system overall. |

# Summary and recommendations

This report results from more than 2 years of intensive exploration of the rationale for and the challenges of delivering integrated health, social work and social care services and support in Scottish prisons. Seven individual prison sites across five HSCPs undertook tests of change for up to six months, working with the Scottish Prison Service, Scottish Government, Social Work Scotland, IJBs and other stakeholders to provide evidence and learning about what is required for the future. As this report was written in September 2020, it, and the tests of change earlier in 2020, were not in a position to consider the recommendations from the Independent Review of Adult Social Care[[2]](#footnote-3) which reported in February 2021. Some amendments have been made to this latest version of our report to incorporate the policy directions from the Independent Review.

This report recognises the positive work already happening in our prisons and HSCPs that supports people in prison and those liberated. It also identifies some key areas where there are opportunities to improve and strengthen the multi-disciplinary approaches that respond to the complex needs of many people in our prisons; to support them lead positive lives within the prison and then to move on and seek employment, support their families and contribute positively to their communities. These key areas include:

**Integrated services:** People in prison with physical needs already receive personal care arranged directly by the SPS. However, they currently are not getting access to integrated services that encompass health, social work and social care and include the opportunity for an holistic assessment of need. This report explores some of the issues around “personal care”, “social care”, “support” and “social work” and illustrates some potential benefits of shifting some of the traditional boundaries between social work specialisms. Equivalence of access to health and social work and care assessment and provision in prison is a human rights issue. This report finds that better access would bring with it the potential for support for the SPS (who design the daily experience for people in their prisons) from health and social services professionals to improve accessibility to work, education and leisure activities. This is equally important for people with poor mobility and for those with needs that may not be visible such as learning disability, mental health, substance use and autism, all of which affect the person’s capacity to manage daily life.

**Transitions:** Admission to prison, moving across the prison estate and liberation are all significant events that currently carry a risk that people with support needs (particularly those that are not physical) are not identified early on and that continuity of care and support is jeopardised. The current system of voluntary Throughcare (for those not subject to statutory supervision upon release) requires the person in prison to understand the supports available and choose whether to engage or not when a service is offered, or to actively request available support from local authorities after release. People in prison may have a range of difficulties engaging with services, for example, remembering appointments and developing relationships and may have had little opportunity to control their daily life whilst in prison. This report recommends a whole system approach to transitions including a development of existing Throughcare and pre-release approaches to ensure that each person’s circumstances and needs are assessed, extending the current considerations of housing and benefits to encompass wider aspects of health and social care. With greater support on their return to the community, the likelihood of crisis and thereby return into the justice system can be reduced.

**Early intervention, prevention and eligibility for services**: In the community there are a variety of Third Sector organisations who offer support to people both on a self- or formal-referral basis; drop in cafes, support groups and so on. If people can access the internet in the community, there is advice and information for issues of well-being. Friends and family are also a source of informal support and services within the community. These community supports reduce the need for formal professional assessment by enabling people to successfully manage their health and well-being needs themselves and with their network of friends and family. Whilst there are a number of well-being services in prison, these have generally grown up organically rather than being based on strategic needs assessment and a commissioning plan. In the community, if needs cannot be met through these informal supports, people are entitled to ask for an assessment as the gateway to formal services. Currently only needs deemed sufficiently critical are eligible for formal support through care packages. This high threshold of eligibility, when applied to the prison setting, excludes people in prison from the support they need for reason of learning disability, mental health and so on, which are very often related, directly and indirectly, to criminogenic need. For example 20% of the prison population in NHS Greater Glasgow and Clyde (NHSGGC) were alcohol dependent and over half of NHSGGC people in custody were under the influence of alcohol when committing their offence (NHS Greater Glasgow and Clyde, 2012).

The people involved in delivering the tests of change from the SPS, health and social work teams undertook a mammoth task in aiming to deliver an integrated service across not only health and social care but including the prison service and justice social work. They did this within a six month timeframe. All the test sites were affected by the COVID-19 pandemic and at the time of writing, there is still some data outstanding that once analysed will offer further useful learning for the future.

Some of the recommendations in this report are ambitious; some will require further development and some are likely to have some resource implication. What this reports illustrates is that there are significant opportunities to improve the well-being of people in prison through access to integrated health, social work and social care support which will not only ensure their rights are addressed but will contribute to better engagement within the prison and more positive lives on the outside. These recommendations promote Scotland’s National Outcomes[[3]](#footnote-4) particularly in the areas of strong and safe communities, health, human rights and poverty.

**Table of recommendations**

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| --- | --- |
| 1 | People in prison should be taken into account in all areas of health and social care improvement. Future Government policy development should treat prisons as an additional setting in which health and social care is delivered. |
| 2 | In order to ensure that all elements of the system can deliver a more cohesive and effective model of support for people in prison, the interdependencies between those responsible for integrated health and social care in prisons (currently HSCPs) and the SPS must be acknowledged and each organisation‘s strategies must dovetail.  |
| 3 | Expectations around the duty for a holistic and integrated health and social work and social care service encompassing assessment and the commissioning of services for people in prison should be clearly incorporated into local IJB arrangements and take into account the potential for national oversight through the proposed National Care Service.  |
| 4 | The Workstream found a lack of robust information about the ongoing health and care needs of people in prison which resulted in the social care needs assessment modelling project. Further work by Government, the SPS, LAs and HBs is required to improve the range and quality of data to identify levels of need and monitor outcomes. |
| 5 | Self-directed support guidance should clarify the expectations for people in the justice system. |
| 6 | Future commissioning must explicitly recognise the impact of the prison environment on the availability of informal and third sector support and take into account the capacity of individuals in prison to access such supports. |
| 7 | Existing Throughcare and release planning should be enhanced to include a greater focus on health and social care needs at transition alongside the existing considerations around housing, benefits etc.  |
| 8 | The Memorandum of Understanding between SPS and the LAs on PBSW and the connections with the IA, as well as the role of social work within prisons more widely, should be reviewed to establish and promote a more cohesive approach to social work in prisons in the future. |
| 9 | To enable workers in prison to gain access to LA IT systems, the Scottish Government should review current progress and direction of travel on commissioned work to date. This review should focus on access to systems in prisons, ensuring that this is aligned to SPS digital strategies and the refresh of Scotland’s Digital Health and Care Strategy*.*  |
| 10 | Given the range of potential governance and management structures, a national implementation support structure is recommended which would:* + Communicate consistently about the change in responsibility and coach local stakeholder groups around each prison in taking up this new role.
	+ Support consistent data collection to inform future decisions.
	+ Disseminate learning from the tests of change and early implementers to support quicker and more robust implementation.
	+ Escalate issues requiring national resolution.
 |
| 11 | Scrutiny and Improvement bodies should work together to ascertain roles and clarify inspection regimes of integrated health and social care in prisons. |
| 12 | Scottish Government should link with the Scottish Health in Custody Network to clarify the Network's role in supporting the implementation of integrated health and social care in prisons.   |

Figure : Summary table of recommendations

# 1 Purpose of this report

This report sets out the findings from a three-phase project that tested out the delivery of integrated health and social care in prison in 2019-2020. It makes recommendations to the Scottish Government Workstream about areas that need a national proactive approach before the model is mainstreamed across the prison estate and the Health and Social Care Partnerships (HSCPs). It also looks ahead and takes the learning from the tests that were carried out and, in the appendices, makes recommendations to support local teams who are likely to be implementing the approach in the future.

# 2 Background

## 2.1 Legal status of social care in prisons

Healthcare in Scotland’s prisons was transferred from the Scottish Prison Service (SPS) to the National Health Service (NHS) in 2011. The Memorandum of Understanding specifically excluded social care which by default remains the responsibility of the SPS. The subsequent integration of health and social care in 2016 did not in practice extend adults social work and social care services to prisons as there was no explicit reference to prisons in the Public Bodies (Joint Working) (Scotland) Act 2014 which moved the responsibility for all adult health, social work and social care to the Integration Authorities (IAs) . This has resulted in legal, financial and operational ambiguity about responsibility.

## 2.2 Increasing levels of need

The SPS has seen a significant increase in the amount and cost of personal care it purchases from care at home agencies due to the increased number of older people in prison. The percentage of people over 55 in prison has doubled over the last 10 years[[4]](#footnote-5) resulting in significant challenges in providing appropriate personal and social care for them. The issue was highlighted by the Health and Sport Committee on Prisoner Healthcare in May 2017 and HM Inspectorate of Prisons Scotland (HMIPS)’s report *‘Who Cares? The Lived Experience of Older Prisoners in Scotland’s Prisons[[5]](#footnote-6)’* in July 2017. The Health and Justice Collaboration Board (Appendix 1) was formed to be responsible for a range of programmes including one on Health and Social Care in Prisons. The Integrated Health and Social Care Workstream was tasked with looking at models of delivery and making recommendations about the potential for Ministers to clarify health and social care responsibilities. The Workstream agreed early on that the most effective place for the duties and powers for integrated health and social care in prisons to lie would be with the Health and Social Care Partnerships (HSCPs) and proceeded to test this out.

£s

Figure : SPS spend on personal care.

In 2019-2020, SPS spend on personal care reached nearly £960,000 in the 13 establishments run directly by them. One of the two private prisons reported a spend of £6,500. Notably the main women’s prison in Scotland did not purchase personal care in 2019-20 but reports that, when care is needed, which is rarely, the NHS and SPS staff group will provide it.

Before the Workstream began to examine the issue more thoroughly, the discourse around social care in prisons was focussed on the physical needs of mainly older people in prison. However, the commitment in the Workstream to holistic assessment quickly meant that the scope of our understanding of the needs of people in prison extended to include younger people and people with disabilities that are not physical and which may include learning disability, cognitive function (eg brain injury[[6]](#footnote-7) or dementia) neuro non-typical presentations, mental health[[7]](#footnote-8) and substance use[[8]](#footnote-9) needs (often related to deprivation and trauma) experienced by a large proportion[[9]](#footnote-10) of the prison population. A University of Dundee report undertaken in Phase 1 of the project recommended the adoption of the Dilnot Commission’s definition of social care to help define the scope of this work:

*Social care supports people of all ages with certain physical, cognitive or age-related conditions in carrying out personal care or domestic routines. It helps people to sustain employment in paid or unpaid work, education, learning, leisure and other social support systems. It supports people in building social relationships and participating fully in society.*

 (Commission on Funding of Care and Support, 2011)

## 2.3 Social care and offending

*“The Scottish prison population reflects our most socially deprived communities.”**[[10]](#footnote-11)*

The Reducing Offending, Reducing Inequalities report10 from NHS Health Scotland identified clear inter-relationships between poverty, social exclusion and offending. It reported that 20% of people in prison have a physical disability, that 20–30% have a learning disability that affects their ability to cope with the justice system and called for this to be addressed through improved access to quality housing, work, education cultural opportunities and support services.

The Scottish Government’s National Strategy for Community Justice[[11]](#footnote-12) recognised the connections between deprivation, poor educational outcomes, mental health, substance use and the likelihood of offending:

*“An individual's likelihood of desistance can be significantly affected by structural factors such as timely access to housing, health and wellbeing, financial inclusion and employability. Furthermore, people who have committed offences may present complex and multiple needs* (see figure 3 below) *or require support in order to engage effectively with necessary services.”*



Figure : From the National Strategy for Community Justice 2016

So, in addition to the better understood support needs of ill-health and disability, Scotland has already committed to improving the holistic model of support to people who are or who might enter our justice systems.

The complexities of need experienced by people in prison has been further evidenced by the [Hard Edges Scotland](https://lankellychase.org.uk/resources/publications/hard-edges-scotland/)[[12]](#footnote-13) report (2019). This found that 5,700 adults in Scotland experience three ‘core’ forms of severe and multiple disadvantage (homelessness, offending and substance dependency). Many of these people will be in our prisons, meaning that in order to be effective, integrated health and social care has to work within prisons, across transitions into and out of prison, and with community-based supports and services.

## 2.4 Existing services in prison

|  |  |
| --- | --- |
| SPS | Responsible for protection of public safety, focusing on recovery and reintegration. Responsibilities encompass security, programme delivery, general wellbeing, education and employment within the prison. Plays a pivotal role in identifying the needs of people in prison and enabling access by health and other professions to deliver care and support. |
| NHS prison-based healthcare | Access to GP, dentist and other primary healthcare services is delivered through healthcare centres in each prison. Access to specialist services by onward referral as it is in the community. Prisons do not have hospital type services based within them. Acute care is delivered not in the prison but in a hospital as it would be in the community.  |
| Prison based social work (PBSW) | Paid for by the SPS. Delivered by local authority justice services that may or may not be delegated to the Integration Authority (IA). Delivers assessment of risk of re-offending and harm, reports for the Parole Board/Tribunals and statutory Throughcare planning for those subject to statutory supervision upon release. Is not funded to deliver adults’ social work and social care services. |
| Third Sector | There are many Third Sector organisations providing a variety of arts and informal therapeutic supports in prisons. This is different in every prison and there has not historically been any consistent strategic planning for commissioning these services and supports. |
| Voluntary throughcare | People who will not be released on statutory supervision under Licence can ask for support (Voluntary Throughcare) before liberation and for up to a year following release which Local Authorities have a statutory duty to provide. The uptake of this overall is low. For example in 2017-18, 1,948 people asked for assistance[[13]](#footnote-14) from an average daily prison population of 7,646[[14]](#footnote-15) and an annual number of liberations of around 18,000[[15]](#footnote-16). Nationally, two public social partnerships (PSPs), New Routes for men and Shine for women offer a mentoring service. The SG funds these national voluntary throughcare services directly, and the services are delivered by partnerships of third sector organisations who co-ordinate activities to offer a standard service in all areas. Eligible prisoners are offered the chance to sign up to the PSP services in prison, and are then lined with a third sector worker to assist them for around six months after their release. There are also a range of other third sector services offering voluntary support to prison leavers, commonly serving specific regions, or particular prisoner groups.The SPS had developed the role of a Throughcare Support Officer which focussed on supporting people before and for up to three months after liberation. Whilst this role was viewed as a very significant enabler for people likely to struggle on release, it was temporarily removed on 2019 due to pressure on the prison officer workforce. |

Figure : Existing services in prisons

In effect, this has meant that people in prison do not access anything similar to the adults’ services (community care) social work assessments or the range of formal and informal integrated care and support that people in the community can access.

## 2.5 Integrated Health and Social Care in Prisons Project

Scottish Government commissioned Social Work Scotland to deliver the project in three phases (Appendix 3). Early on in the project, the Scottish Government Workstream and its key stakeholders agreed on a direction of travel that would see the responsibility for integrated health and social care placed clearly with local HSCPs. The tests of change trialled this concept. The staffing elements that were funded in each test site are included at Appendix 4. This helps to illustrate the model of delivery at each site.

This report is based on:

* the evaluation reports from each of the test sites (Glasgow delivered an interim report which informed this report),
* any questionnaires that were completed by staff
* information and views collected throughout the project from Workstream members, tests of change teams and other stakeholders. These were mainly expressed through meetings, emails and the series of Workshops that were held for the test of change multi-agency teams.

## 2.6 Wider policy connections

Within Scottish Government, there are a number of policy areas for which the learning from the tests of change will be relevant and should be taken into account in order to deliver improved support to people in prison. These include: self-directed support, health and social care integration, prisons and community justice including Throughcare, the development of the Throughcare Assessment for Release on Licence (TARL) and the development of the custodial estate for women. Government officers from relevant policy teams have been involved throughout the work of the Workstream and contributed to the development of this report to ensure that integrated health and social care in prisons becomes an integrated element of wider policy development and implementation, namely that prisons are considered another setting where health and social care is delivered.

The work of the Drugs Death Taskforce[[16]](#footnote-17) will also offer opportunities to further develop the range of supports to people in prisons and as they return to the community to reduce the risk of harm through programmes of support. Other policy areas that should be specifically connected into the work of integrated services in prisons include: mental health, learning disability, autism and dementia.

The Scotland Prevention Review Group[[17]](#footnote-18) convened by Crisis is reviewing the role of public bodies in preventing homelessness and the Homelessness and Rough Sleeping Action Group[[18]](#footnote-19) report of 2018 notes the high risk of homeless for people leaving prison.

The Social Renewal Advisory Board[[19]](#footnote-20) was set up in June 2020 to respond to the learning and innovation arising from the coronavirus pandemic through a focus on reducing poverty and disadvantage, embedding a human-rights based approach and advancing equality.

In addition to these existing policy connections, the Independent Review of Adult Social Care[[20]](#footnote-21) reported in February 2021 and Ministers have accepted its recommendations.

The Independent Review, chaired by Derek Feeley, argued for a new narrative on social care; one in which it should be seen as an investment not a burden and focussed on prevention not crisis.

The report took into account different types of support and care that are provided in a range of settings, including residential settings such as care homes and in people’s own homes. It covered care and support for a broad range of people with long-term conditions, older people, people with physical disabilities, people with learning disabilities, people with mental health problems, people with addictions, and people with experience of the criminal justice system.

The report said human rights, equity and equality must be placed at the heart of social care and mainstreamed and embedded. It recommended a new social covenant should be established to rebuild trust between those who rely on support, and the system that delivers it. This system must become consistent, intentional and evident in the everyday experience of everyone using social care support including unpaid carers, families and people working in the social care support and social work sector.

The Review recommended the formulation of a National Care Service which includes workforce planning and development, data and research, IT and, as appropriate, national and regional service planning. A National Care Service would be able to manage services that are better organised on a once-for-Scotland basis. The report suggests such services might include support for people with complex and specialist needs and provision in custodial settings including prisons.

It is encouraging that the Independent Review of Adult Social Care and this report concur entirely on the centrality of a human rights approach enhancing independent living, early intervention and prevention, successful rehabilitation into community life and focussing on helping *people achieve their goals and desired outcomes: to live their best lives and maximise their wellbeing, as equal citizens.*

As such this strengthens Recommendation 1 of this report.

**Recommendation 1**: People in prison should be taken into account in all areas of health and social care improvement. Future Government policy development should treat prisons as an additional setting in which health and social care is delivered.

2.7 Concurrent SPS strategies

The capacity to deliver integrated health and social care in prisons is interdependent on some key SPS policies:

* **Estates**: The SPS has been working on making the prison estate more accessible. This has included creating accessible cells, widening doorways to allow access with aids such as wheelchairs, handrails and shower equipment.
* **Population Management**: There is often a significant amount of movement of people between prisons. There are a range of reasons for this, including managing operational capacities, and working with risks to people in prisons who are identified as vulnerable either due to the nature of their offence or because they are known to be at risk from others and are moved in order to reduce that risk. People on long sentences need to complete specified programmes that look at their offences before they can progress to the open estate or apply for parole.  The women’s estate covers fewer sites and is in the process of a significant improvement programme resulting in altered capacity arrangements, where possible women are transferred to establishments nearest their home address.
* **Digital strategy**: Access to technology in prisons has, to date, been minimal for people in prisons and for visiting professionals. A digital strategy has begun to address this. Developments may include in-cell phones and video conferencing within and outwith the prisons to facilitate professional and family visits. Virtual visits started during the COVID crisis which were viewed as successful with a blended approach of in-person and virtual visits is intended going forward. During the lockdown period of the pandemic, the NHS Near Me video conferencing application has been used in prisons and its capacity for connecting people in prisons with a wide range of professional support is being further developed. NHS Near Me is now available in all 15 establishments across the prison estate.

**Recommendation 2:** In order to ensure that all elements of the system can deliver a more cohesive and effective model of support for people in prison, the interdependencies between those responsible for integrated health and social care in prisons (currently HSCPs) and the SPS must be acknowledged and each organisation‘s strategies must dovetail.

## 2.8 National governance for health, social work and social care in Scotland

The primary legal responsibilities for health service delivery fall to the NHS (14 local boards) and for social work and social care, to the 32 local authorities. Local Authorities and Health Boards are required by law to work together to plan and deliver, as a minimum, adult social care services, adult community health services and a proportion of adult acute services. These services are delegated to the 31 Health and Social Care Partnerships (HSCPs) (30 Integration Joint Boards (IJBs) and one lead agency model[[21]](#footnote-22)) to be delivered in an integrated model. Justice Social Work is included in some schemes of integration but retained by the local authority in others[[22]](#footnote-23). All Health Boards have delegated prison health care to their respective Integration Authorities except NHS Forth Valley and NHS Lothian. These Boards have retained responsibility for planning and delivering of health provision in prisons within their areas. This creates a highly complex landscape for integrated service development in prisons and contributed to the difficulties in those two NHS regions in being able to get the right people engaged to submit a test of change proposal that met the criteria. There are high numbers of young people, women and people with higher levels of frailty in these Board areas. This was unfortunate as we had hoped to include at least some of these particularly vulnerable populations in the tests of change.

Multi-agency structures such as the Community Justice and Alcohol and Drug Partnerships need to be taken into account in engaging with key partners and ensuring best use of resource.

In every prison in Scotland, there are likely to be people from every local authority area. Because of the lack of clarity about responsibility for the “community care” provision in prisons, this has sometimes led to a focus on the ordinary residence status of a person. This has the potential to cause inter-agency disagreement and can result in delayed services for people whilst they are in prison. It has also the potential to mean that some people in prison who are ordinarily resident in the local area can receive services funded for local residents only, leaving people in prison form other LA areas in a position where they are not entitled to the same services. In the prison health services this is managed through an agreement that people in prison get their healthcare from the health board in which the prison is sited. This approach, if mirrored in integrated health and social care will improve clarity of access to services while people are in prison, However, it will not resolve the issue of ordinary residence when planning for liberation unless attention is given to the issues described later regarding Throughcare and planning for release. However, by making the IA to the prison responsible, this will begin to support better continuity of services on admission and release.

**Recommendation 3**: Expectations around the duty for a holistic and integrated health and social work and social care service encompassing assessment and the commissioning of services for people in prison should be clearly incorporated into local IJB arrangements and take into account the potential for national oversight through the proposed National Care Service.

## 2.9 Challenges for the project

At the beginning of this project, it was intended to fund two or perhaps three tests of change. However, when the proposals for the tests of change were analysed, it became clear that most of the applicants wanted to take a particular focus rather than try to deliver all aspects of social care at once. The Workstream decided to use the available budget across seven test sites to maximise learning. Six of these were to deliver an integrated referral and assessment service, the other looked at improving information about people arriving to prison and resolving local access to personal care delivery.

The six test sites that were chosen to trial integrated health and social care represent around 40% of the prison estate and overall achieved their goals in setting up referral and assessment processes in their prisons. This evidences the ability of the HSCPs to deliver successful referral and assessment services within the environment.

The agreed timescale for the tests of 6 months was a very tight window to deliver an integrated team, the necessary training to access the prison environment and to fully develop and test new referral, assessment and service delivery pathways. As a result, none of the test areas were able to get to any analysis of the Third Sector services already in the prisons or to start any strategic planning around future commissioning of either personal care or wider supports. Their development plans recognise this as an area they need to address going forward.

This report must be considered with the following:

* Any notion of consistency refers to consistency of outcomes or access to services within an HSCP area. There was no intention of the tests of change offering consistency across the prison estate.
* It has proved extremely challenging to work through the data sharing agreements for the small amount of data (Appendix 6) that was necessary for this project. This impacted on the social care needs assessment modelling study commissioned from Alma Economics by Scottish Government delaying the final report from that project and has limited the availability of data for this report.

The impact of the COVID-19 pandemic was significant.

* Only two sites completed their tests of change before team members were pulled back into community teams at the end of March 2020. This could be interpreted as people in the community were deemed in greater need than people in prison. Access to and within prisons became more challenging due to the need to reduce footfall and maintain physical distancing. The SPS also experienced a significant number of staff being off sick or shielding which reduced capacity to support access to people in prison. The impact of this was that two sites withdrew from the tests early. Two in Glasgow that had only just started in March have since restarted in July 2020.
* There has not been the opportunity to critically support and develop the evaluations at each site in the way originally planned. It has only been since July that the test teams have had any capacity to return to work on their local evaluations and to try to get responses to the questionnaire from people who used the service and staff members across the multi-disciplinary team.

The Glasgow tests continue and are evidencing where the pandemic and physical distancing may impact service delivery. Glasgow delivered an interim report that has informed this report and further learning from the Glasgow tests will be vital to ensure effective implementation.

# 3 Tests of change

## 3.1 Purpose of the tests of changes

The purpose of the tests was to explore approaches to bring in the element of adult social work assessment and social care delivery to the existing services in the prisons (fig. 3). They worked towards anticipated outcomes based on existing outcomes and standards (Appendix 4) and summarised at the start of section 5 of this report. The test sites were to identify the challenges in assessing and arranging services for people in prison in a way that could be deemed equitable with community based assessment. All the test sites worked on the principle that people resident in their prison should be treated for social work and social care services in the same way as they are for their health services; if a person is in HMP Perth, Perth and Kinross Local Authority has the duty of assessment and service delivery under the Social Work (Scotland) Act 1968 and other relevant legislation.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Prison** | **HSCP** | **Start date** | **Expected end date** | **Impact of COVID-19** |
| HMP Perth | Perth and Kinross | 1/10/19 | Completed 31/3/20 | Only impacted on the evaluation phase. |
| HMP Castle Huntly |
| HMP Shotts | North Lanarkshire | 1/11/19 | Due 30/4/20 | Withdrew six weeks early |
| HMP Grampian | Aberdeenshire  | 1/12/19 | Due 31/5/20 | Withdrew two months early |
| HMP Greenock | Hosted by Glasgow City | 1/3/20 | Due 31/8/20 | Withdrew in March and restarted July |
| HMP Low Moss |
| HMP Kilmarnock | East Ayrshire | Two small tests of change were planned but not implemented. Local COVID-19 remobilisation plans will include the elements as services restart.  |

Figure : Tests of change

## 3.2 Governance structures of the tests

Each test of change was responsible for working with stakeholders to create appropriate governance and operational structures. The Aberdeenshire governance model was the most simple as within the prison there was already a Health and Wellbeing Board connecting the HSCP which includes Justice Social Work into HMP Grampian. Perth and Kinross HSCP hosts the prison healthcare function across Tayside but justice social work is not in their integration scheme. The Glasgow model was the most complex as Glasgow City IJB hosts prison healthcare for the three prisons in the Greater Glasgow Health Board area: HMP Greenock in Inverclyde IJB, HMP Barlinnie in Glasgow City IJB (not part of the test of change) and HMP Low Moss in East Dunbartonshire IJB. Justice social work in each of the three areas is delegated to the HSCP but the Glasgow test of change leadership team had to build relationships and liaise with both test of change HSCPs to agree a model to enable Glasgow to host an integrated adults’ service.

## 3.3 Deliverables

The major deliverable at the integrated test sites was a referral, assessment and care and support delivery model. In addition, each test of change area agreed to:

* Collect a consistent set of anonymised data.
* Send out an agreed questionnaire to people who had an assessment as part of the test.
* Distribute an electronic questionnaire, consistent across the tests, to local SPS and HSCP staff members who had any involvement with the test.
* Use the above to write an evaluation report on a set of qualitative themes based on the Dundee University report and the Standards and Outcomes Matrix (Appendix 5).

All of these elements were used to inform this report and to draw together themes and issues and recommend future steps.

During the tests, the financial responsibility for the delivery of any personal care remained with the SPS.

## 3.4 Local evaluations

The local evaluations from the tests of change evidence the shared goal within the multi-disciplinary teams of improving outcomes for people in prison. Teams reported positive responses from people who used the services and from SPS colleagues. Key barriers to reaching more people in the prisons appears to be the need for people not to appear vulnerable in the prison setting and people’s capacity to manage and maintain engagement with services. This can also be looked at from the opposite perspective as being the ability of services to be “sticky”, that is, to stick with and be flexible in service approaches towards people who appear to choose not to engage.

The tests were initiated for only six months to deliver evidence to the Scottish Government Workstream for the direction of travel and policy decisions. In conversations with tests of change leads, they would have preferred to be able to continue as pathfinder sites, improving their services and sharing learning to help other HSCPs yet to take on this role.

The Glasgow test of change of change in HMPs Greenock and Low Moss offers an important opportunity to test out services within a pandemic context. Only part of this learning was available for this report but will be extremely important in moving towards implementation

# 4 Key data from tests of change

4.1 From the data set

The intention had been to use the tests of change as an opportunity to collect data which would increase our understanding of the level of social care need in prisons. However, due to challenges around data sharing, and pressures resulting from responding to the Covid-19 pandemic, it has not been possible to obtain sufficient data for analysis.

## 4.2 Data, modelling need and funding

One of the challenges in this project was the lack of quality data on the level and type of health and social care needs of people in prison. The last health needs assessment for the population in prison in 2007 did not include social care needs. Whilst each health board that has a prison within it is charged with delivering a local needs’ assessment, this does not reflect social care needs. Therefore, the Scottish Government commissioned a social care needs assessment modelling study to estimate the prevalence of social care needs in the prison population, as a first contribution towards a new comprehensive, national assessment of health and social care needs in prisons. A report on Understanding the social care support needs of Scotland’s prison population[[23]](#footnote-24) provides additional analysis and context to the Workstream to support decisions for further action. The central estimate produced by this study is that 7-10% of the prison population in Scotland have social care needs. This is based on extrapolating from the non-prison population based on characteristics including age, deprivation levels, gender and the premature ageing of the prison population. It should be noted that there are a wide range of estimates available outside of the central estimate. Extrapolating from the non-prison population receiving social care produces an estimate that around 3% of the Scottish prison population would have met eligibility criteria thresholds for support outside of prison. Focusing on social care data recorded in the SPS prison records system, PR2, provides the highest estimate in the range, with a result of 13%. All of these estimates apply to the same definition of social care, although the lowest estimate also factors in eligibility criteria.  As a baseline estimate, this figure reflects the poor quality of social care data for prisons as it currently stands. There is an issue in using existing community eligibility criteria in that it explicitly excludes needs that are psycho-social and focusses on physical care needs.

Local authorities and HSCPs have little data on people in prison as they do not yet have clarity of their duties in this regard and national social care datasets do not relate directly to people in prison.

One of the other Workstreams in the Health and Social Care in Prisons Programme is Clinical IT. As this and integrated provision in prisons moves forward, the need for improved data should be recognised and incorporated into local and national data strategies

**Recommendation 4**: The Workstream found a lack of robust information about the ongoing health and care needs of people in prison which resulted in the social needs assessment modelling project. Further work by Government, the SPS, LAs and HBs is required to improve the range and quality of data to identify levels of need and monitor outcomes

## 4.3 Findings from questionnaires

At the time of writing: no questionnaires from people using the service had been returned from any of the test of change sites. The methodology for these required a wait after assessment and/or delivery of any service to enable the person to comment on their experiences. A paper format was used and then converted into an electronic reporting system. The pandemic, unfortunately, resulted in lockdown and staff were not able to distribute the paper questionnaires to people in prison at any of the test sites.

Staff members from three sites returned questionnaires; a total of 24 people of whom 17 were SPS, 5 health and 2 adults’ social work staff. Some of the issues arising included:

* The ease of making referrals was different across sites. At one site, there were no negative responses whilst another showed that some reported difficulties.
* In terms of seeing positive impacts for people using services, around a third of respondents said yes, a tenth said no, however most said they weren’t sure. This may be an effect of the short timescale of the tests; the benefits of good social care take time to realise and the performance feedback loops in the test sites were not yet mature.
* We asked how easy it was to raise and to resolve barriers and issues during the tests. Two thirds of staff said it was easy or ok, one third said it was not. In terms of resolving those barriers, there was an almost equal split between those who said it was at least “ok” to resolve barriers or “not easy” or “difficult”. This indicates a need for greater communication across professional groups and for clear access to managers and forums that can quickly resolve issues.
* Nearly half of staff respondents thought that appropriate services (albeit a large proportion reported no choice in the services) were available. Likely reasons for this may include the challenges of delivering services in the prison environment and the absence of a strategic commissioning approach to enable easy access.
* There was a fairly even split between those who responded that they did or did not feel part of a multi-disciplinary team working together.

Responses noted confusion in both staff and users’ expectations of the roles of social work (usually meaning PBSW) and adults’ services (integrated health and social care) social workers. Staff stated it was difficult to know when a person was working with the health and social care team. There was recognition of the difficulties in getting access to people when SPS staff were busy. There were also many positive comments about how well all the organisations involved in the prison worked together during the pandemic.

# 5 Findings from the tests of change

## 5.1 Outcomes

The outcomes that are desired and anticipated from delivering integrated health and social care in prisons distilled from the detailed matrix at Appendix 5 can be expressed in the following way:

|  |  |  |
| --- | --- | --- |
|  | Short term | Long term |
| Prison | Equivalence of access to integrated professional assessment, meeting human rights and equalities duties. This needs to recognise that this may need different approaches and resources in prison compared to the community.Improved rehabilitation and independence. Early intervention and prevention reduces the need for crisis interventions.Access to personalised care and support improves relationships within the prison and with friends and family outside.  | Improved quality of life.People live in good health and have better well-being for longer. Reduction in health inequalities.Enhanced supports for the SPS policies of improving access to education, work and positive activity in prison.Improved infrastructure for a particularly vulnerable population.Risk management and vulnerability are dealt with by a full multidisciplinary team.People serving long sentences can be more actively involved in prison life for longer. |
| Community | Better transitions from prison to community.Improved continuity of care and support.Smoother access to support services. Greater use of voluntary Throughcare especially for housing, benefits, primary health and social care and support.  | Reduction in health inequalities.People are able to lead more stable lives and get the support they need. Reduced crises such as mental health and drug deaths on liberation.Better integration into the community promotes restoration to positive citizenship. Reduced reoffending.Reduce number of people returning to prison.Reduced rates of re-incarceration. |

Figure : Condensed Outcomes

With only a six-month test of change, there can be no conclusive evidence of anything other than some of the short-term outcomes in the prison. The tests demonstrated some positive processes and structures that are more likely to support the delivery of integrated health, social work and social care in prisons which will be useful learning for implementation.

Some of the immediate effects across the tests reported by the sites teams included people in prison reporting they felt listened to and that requests for support were being followed up. However, several of the test sites reported that people in prison are often unwilling to seek help for fear of appearing vulnerable. There was some evidence that as people began to connect with services, their concerns reduced but this is likely to be a continuing factor in being able to identify people and offer support.

In HMP Shotts where the service had a significant focus on rehabilitation, the support that people received meant they were more able to take part in activities and move around more independently. One person was able to receive a visit for the first time in years and another was able to get to the dining room independently. At HMP Grampian, it was acknowledged that a rehabilitation service would be an important element of future provision and that support to help people remember appointments and take medication would improve the quality of life for many. These needs, which appear low level but are about everyday routine, can make enormous differences to the quality of life for people.

At HMP Grampian, the test found a high incidence of falls and started to look at mirroring the falls pathway in the community.

One of the limitations to longer term outcomes may be that the prison regime offers a particularly structured environment which, on the one hand, many find valuable for structuring their days but which may also effectively hide the difficulties that some people experience when they return to the community. The structure of the day, clear expectations and rules with few expectations of many of the daily living tasks of time and diary management, budgeting, household chores and so on mean that assessments in prison may not always pick up these issues.

## 5.2 Pathways, links to community teams and self-directed support (SDS)

Self-directed support is the means of social care and support delivery in Scotland and comprises the person deciding the level of direct control and choice they want to have in arranging and managing their own services and support. Before and during the tests, the focus was on enabling good quality services to be delivered in an environment where it would not be safe to have a large number of providers going into and coming out of the estate. There was limited choice about the timings and delivery of personal care, but information from the tests showed that everyone clearly tried to engage people in making decisions about their care and support as much as possible. All the services delivered were, in effect, delivered as Option Three; the provider was decided by the local authority or the Scottish Prison Service and paid for by them.

All the tests of change linked into community based teams in one form or another. In HMP Grampian the local care management team was involved. At HMP Shotts, the local rehabilitation service undertook assessments. At HMPs Perth and Castle Huntly the test brought together a small seconded team who based themselves as much as possible within the prisons. The advantages this brought were that the workers coming into the prison setting were already very familiar with their local authority policies and procedures. Where these related to physical need, it seemed to be fairly easy to translate into the prison environment. However, the frailty care management or rehabilitation approach used in several of the tests, did not translate easily into support for the non-acute poor mental health, substance use and other invisible disabilities and needs. This means that approaches to support these needs were not fully tested within the short test timeframe.

For information, this table illustrates the range of needs of the 192 people screened and/or assessed during the Perth HSCP tests:

|  |  |
| --- | --- |
| **Condition** |   |
| Alcohol dependency | 27 |
| Alcohol related brain injury | 0 |
| Autism/Aspergers | 4 |
| Blood borne virus | 1 |
| Dementia, memory, incapacity | 4 |
| Drug dependency | 55 |
| Hearing impairment/deaf | 2 |
| Learning difficulties | 4 |
| Mental health | 78 |
| Neurological condition (not dementia) | 3 |
| Frailty | 5 |
| Physical disability or long term condition | 45 |
| Visual impairment | 0 |
| Other | 4 |

Figure : HMPs Perth and Castle Huntly range of needs

Whilst the principles of choice and control for people supported by services clearly guided staff in the tests of change, there was not the time to fully examine what self-directed support (SDS) and the use of the options[[24]](#footnote-25) might look like in a prison setting.

Recommendation 5: Self-directed support guidance should clarify the expectations for people in the justice system.

Everybody who arrives at a prison has a health screening on admission. The test of change sites linked in with their health colleagues to improve early identification of issues and it was recognised that admission is an opportunity to identify needs and to liaise with other HSCPs to try to promote continuity of care and support. At one site, a person with mental health needs who had been getting almost daily social support in the community arrived at the prison. The support was not able to follow him and his needs are recorded as unmet at that test site. Criminal Justice Social Work Reports for the Courts include information about health and social care needs and the Courts send these to the SPS if someone receives a custodial sentence. However, there is still inconsistency in staff in prisons getting access to this information.

## 5.3 Early Intervention and Prevention

Several of the test sites noted the importance of early intervention and prevention work particularly around mental health and substance use. Whilst health provision for such needs in the prisons is often better in terms of referral times than in the community, the prevalence of these needs in all prisons, demonstrates a need for a proactive service. This should also encompass the social model of care and support including personal capacity and strengths, community support and daily structure. This might then enable people to leave the prison with improved daily living skills and connections into local resource and support.

If early intervention and prevention is not developed, there is a risk to future integrated services operating in prisons being overwhelmed with referrals for professional assessment that, were they in the community, would be quickly signposted to Third Sector support. The need to improve access to services that aim to support well-being should be part of strategic planning in each prison area.

## 5.4 Eligibility criteria for care and support

What became clear early on in several of the tests areas was the impact that importing standard community eligibility thresholds had on the ability of workers to create effective care and support plans. Local authorities use a [national framework of eligibility](https://www.gov.scot/publications/self-directed-support-practitioners-guidance/pages/6/)[[25]](#footnote-26) to prioritise spending on services. As local government budget pressures and levels of health and social care need have increased over the last decade, all areas now only arrange formal support and services based on substantial or critical risk, that is, a very high threshold. As eligibility criteria are designed to be applied in the community and are heavily weighted towards physical need, their use in prisons means that someone with complex needs including chronic but low-level mental health and substance use, or with cognitive decline who is unable to work, attend education or maintain relationships in prison may not be able to access support. This applies to many in the community but there are infrastructure limitations in prisons in terms of accessing informal support that is available in many communities, for example, in the community many people are able get support from families, friends, libraries and churches etc, and can get a lot of information and support from the internet. Although there are some peer support opportunities and listening services, similar opportunities in prison are much reduced.

To improve options for people, the test team at HMP Castle Huntly with a local employability enterprise developed a small group work service for men with a range of additional physical and mental wellbeing needs that enabled them to learn new skills and develop their interests. This service had hoped to continue beyond the tests of change timescale but lockdown measures meant it stopped at this time.

**Recommendation 6:** Future commissioning must explicitly recognise the impact of the prison environment on the availability of informal and third sector support and take into account the capacity of individuals in prison to access such supports.

## 5.5 Models of personal care provision

The models paper[[26]](#footnote-27) delivered in Phase 2 of this project examined some of the options for commissioning social care in prisons. This recommended that, where there are significant levels of need in a prison, a team operating within the prison is likely to be both cheaper than time limited agency visits and can deliver additional benefits in being able to support daily activities and deliver elements of social support as well as personal care.

Prisons are not open 24 hours a day and this can present further barriers to the delivery of care at night and at weekends. The models used in each area need to be planned to meet the types of needs that can be anticipated and to recognise that emergency support may also be necessary on occasion. Across the estate, prisons have had different exposure to this issue but there have been local examples led by the Governors and those providing the care, to find solutions to ensure appropriate care is provided when it is needed.

One of the tests of change used healthcare assistants already in the prison to deliver personal care for 29 hours per week to 6 people. As the healthcare assistants were already part of the health team, this delivery pathway promoted cohesion, information sharing and joint care planning. This model was useful in supporting someone with an acute illness who needed high levels of support for a short time. It also meant that the time it would take for agency staff to get into and out of the prison was minimised. This test site found that where they also tried to use an external provider for personal care, this caused some confusion for the assessment team who were trying to arrange care. This experience would probably resolve over time as those working in the system would grow accustomed to the possibilities of alternative arrangements.

There is a current anomaly in the integrated health and social care landscape which is that healthcare assistants who are employed by the NHS do not need to be registered whereas social care workers employed by local authorities or the independent sector must register with the Scottish Social Services Council (SSSC). The SSSC is working with stakeholders to resolve this issue which is pertinent to all integrated services and which may mean that it is seen as easier to design services around the health rather than a social model.

The tests offered the opportunity to review some of the care packages already in place and bring their professional assessment and care planning skills to bear. This helped promote planning for re-ablement to improve independence where personal care provision itself might not do this.

## 5.6 Access to aids and equipment

Aids and equipment (such as walking aids, hand rails, wheel chairs, specialist beds) can help people maintain or improve mobility, support independence in daily living tasks and significantly improve comfort and wellbeing. Before the tests of change took place, it was recognised that there was no clear national protocol about the responsibility for paying for aids and equipment for people in prison. Scottish Government supported the drafting of a protocol laying out responsibilities and the tests of change were offered this resource (Appendix 7) for support should they encounter any issues.

There were some instances of difficulty in the delivery and installation of equipment in the test sites that delayed equipment reaching people quickly. One test site commented on the need for appropriate structures to be put in place to ensure that people using aids and equipment could have reviews at regular intervals and noted that there would need to be future work across the HSCP and the SPS to ensure proper delivery, maintenance and installation of specialist equipment.

## 5.7 Family and friends’ involvement

There appears to have been limited involvement of loved ones in assessments and care planning during the tests of change. One test noted this challenge, “who picks up the informal stuff – the sons/daughters who note a cognitive decline ... (This is) a barrier within the prison setting as often family are distant.” This is an area that will need further development during any implementation and should be linked in with the SPS’s Family Strategy which addresses the participation and involvement of loved ones during a person’s time in custody.

## 5.8 Adults with Incapacity (AWI)

Adults with Incapacity (AWI) proved to be a difficult pathway in the prison. One test site reported that the only way to get an assessment of capacity required for a Parole Board dossier was to pay for it privately and they were not clear who was responsible. This area had been picked up before the tests as a particular issue in navigating old age and forensic psychiatry. Lack of capacity appears to have contributed to delays to, and impacted on, the Parole processes for reasons including the capacity of someone to understand their licence conditions and the impact of their capacity on the management of risk and the level of supervision and care they might need if released on licence. People in prison should be able to get capacity assessments through their primary health service which should then flag the need for decisions around legal powers and daily social support. In at least two test sites, people in prison reflected that they would like to have more dementia friendly areas to support people with cognitive decline.

## 5.9 Adult Support and Protection (ASP)

Adult support and protection legislation does not apply in prisons. During the tests of change we expected the teams might come across some people in situations that would be comparable to ASP in the community. A draft ASP policy from SPS was issued to the tests before they started with the intention of testing the policy. None of the tests have reported coming into contact with people whose vulnerability and ability to protect themselves met ASP criteria. SPS will be reviewing the draft policy in the coming year.

## 5.10 Use of peer carers and peer support groups

The tests of change were aware of some instances of peer carers in the prisons. One test site found two people who refused formal services and chose personal care from a close relative or friend also in the prison. Mostly this support was around bringing people meals, helping to clean cells, writing letters and social support. The SPS has a clear policy on the types of support one person may give another in prison. It generally precludes personal and intimate care and promotes risk assessment to ensure that both parties in the caring arrangement are fully considered. The international literature on peer caring in prisons (see the Dundee Report) suggests that it can be a very positive experience for the cared for person and the carer. Certainly, it can be likened to the support that someone in the community might receive from friends or family and is something that with good selection, training and support can be beneficial. However, given the additional vulnerabilities of people in prison and the high instances of invisible or hidden need, peer carers will need good support structures. In prison, some peer carers are paid a prison working wage. If caring is, in effect, a job, this needs some thought as to the formal support, training, supervision structures and any potential workforce registration issues. Where peer carers are not being paid to undertake this work, they may need to be seen as carers who are entitled to a carer’s assessment under the Carers Act (Scotland) 2016 and to be considered for their own support needs including breaks from caring.

The University of Dundee report recommended that people in prison should have access to groups run by peers to offer support for people with disabilities. There may be opportunity to consider this in terms of Third Sector contributions in prisons in the future, but the tests of change did not have the time or capacity to address this element.

## 5.11 Diversity

There is little information on diversity in prisons other than race and sex. In Scotland around 2% of the population of the prisons is of a BAME background and around 5% are women[[27]](#footnote-28). Two of the test sites have women in the prison population but to date only HMP Grampian has been able to report. One of the key issues around diversity is that information systems are limited in what they can provide as regards wider diversity information. The tests of change were limited by this and also by their timescales in being able to get to grips with the range of intersectionality, for example, women from BAME backgrounds with mental health problems. As the three main IT systems (SPS, Health and LA) develop, more thought about being able to view diversity, including where invisible disabilities are known, for better service design and more appropriate services will be important.

## 5.12 Accessibility

Where prisons had more modern facilities and some accessible cells, there were significantly fewer environmental barriers to care and support. However, there were still challenges when people needed wheelchairs, specialist beds and hoist equipment. People who use wheelchairs are, in general, reliant on peers if they cannot propel themselves. The University of Dundee report referenced the challenges that long corridors present to people with mobility issues. Where people have cognitive or hearing problems, these areas can be particularly confusing and uncomfortable. The HMP Perth test steering group has a member in custody who proposed that a specific separated space for people with purely physical or cognitive needs would provide a greater feeling of security and enable a more flexible regime.

Access to education, employment and other meaningful activity in prisons remains a challenge for people both with physical and invisible disability but especially for people with mental health and substance use needs. One test reported that people withdraw from work because they cannot keep up with the “route” (the movement of people between residential halls, work stations and exercise space) or because their anxiety about pressure of keeping up so as not to appear weak precluded them from participation. Some of the tests noted the very positive impact that the work that the SPS has done to integrate people who may have mild learning disabilities or other characteristics to make work, education and social activities accessible to them. However, they felt that this is an area that health and social care provision could be well placed to support and promote further.

Of significant concern in terms of equalities is that across the test sites there have been a number of instances where the impact of autism, learning disability or dementia has meant that people have not been able to progress through their sentence. Their disability has meant that they have not been able to successfully complete programmes or maintain a move to more open accommodation. One site specifically mentioned that people with autism (which may or may not be diagnosed) and who may react to the expectations of the prison regime, were more likely to be the subjects of the Governor’s report or management meetings. At least two tests sites came across people whose ability to progress through their sentences was hampered by the lack of social support in prisons. One specifically referred to people with autism, head injury or learning disability being unable to complete the necessary tasks required for parole application.

One prison site recommends that people should have access to practise and learn daily living skills throughout their prison stay, not just as preparation for liberation. There was also an observation that whilst a lot of information is given to people on their induction to prison, this is often not retained or is not relevant at the time and that thought should be given to reminding people over time.

In the community, integrated services enable people to improve their independence and to be supported to engage in work, education and leisure activities where they need more direct support. Here, the Third Sector provides support that people can drop into, self-refer or have a more formal entry route that is not available in the prison setting.

The SPS is fully aware of the range of physical issues the environment presents and is working with Scottish Government on the estate strategy. Local strategic needs assessments and resource reviews at each prison site would offer more clarity about both the individual support required and the more universal support services that might help engagement.

## 5.13 Throughcare and Transitions

In 2019-20 nearly 11,500 people left prison. Of people who were released in 2016-17, 41% were reconvicted within 12 months[[28]](#footnote-29). The imprisoned population of Scotland comes disproportionately from the most deprived communities in Scotland and the probability of imprisonment increases with increasing deprivation (Houchin, et al 2005[[29]](#footnote-30)). The domains of deprivation include economic factors, as well as health, education and access to services. This indicates a significant level of support need for people in or leaving the prison system if they are to move on, lead stable and fulfilling lives, seek employment, support their families and contribute positively to their communities.

People in prison serving sentences longer than four years are subject to Statutory Throughcare, overseen by SPS, Justice Social Work and others. This focuses predominantly on the risk of reoffending and harm but, where people have health and social care needs, arrangements are made between the prison based social worker and the adult social services in conjunction with community-based justice social workers in the receiving local authority.

Those who serve sentences of less than four years and are not subject to statutory supervision on Licence on release from prison can request Voluntary Throughcare up to 12 months after they are liberated. This offers support to help people achieve housing, apply for benefits and is an opportunity to help people plan positively for their liberation by identifying supports they might need. The language in the Social Work (Scotland) Act 1968 s27 1(a) does not offer an expectation of the level or type of service but leaves it to the local authority to decide the level of provision. This does not support a consistency of approach across the 15 prison sites and the 31 HSCP areas.

The tests of change were asked to consider how a fully integrated adults’ service could improve Voluntary Throughcare by ensuring that assessments of need and care could be transferred on release. The generally low level of uptake of any sort of Voluntary Throughcare can be viewed as a missed opportunity to engage with and support people who have multiple needs (as per the Hard Edges Report) who make up the majority of people who return to prison following a crisis after release. Social work staff spent 25 of the 42.4 weekly support hours during the tests of change at HMPs Perth and Castle Huntly supporting people preparing to leave the prison. At HMP Shotts, two people needed Occupational Therapy assessment for future housing needs. Whilst these are low levels of intervention in the larger scale of numbers of people leaving prison, it shows there is a role for integrated support services for improving outcomes following liberation.

Many organisations involved in Justice recognise that given the profile of people who return to prison (with substance use, homelessness and mental health needs), a more direct and formal assessment of needs and system of support should be delivered as part of Throughcare if these returns are to be reduced. In the HMPs Perth and Castle Huntly test site, of the 192 people screened or assessed, 38 were liberated before the assessment was complete. At HMP Grampian, two people out of the 19 referrals were liberated before their needs could be assessed. This may simply have been due to a short window of time before release when the assessment processes became available but perhaps also indicates the challenges around quickly developing shared priorities across organisations.

All the sites reported difficulties in connecting with the home HSCPs in preparing for or at the time of liberation.

One example included the test site recommending to a home HSCP that a person needed 24-hour support.  This was rejected on the grounds that the person had previously not needed this level of support.  The person subsequently went into a homeless unit, that placement quickly failed and they needed to move into a care home.

In every Scottish prison, there are or can be people serving sentences who are from every local authority area.  To be effective in helping smooth transition, each prison site would need to maintain a relationship with all HSCPs.  They would need to be able to navigate to the correct team which could be a team in adults services or the justice social work team.  To do this they might need to understand whether Justice Services are part of the HSCP or are delivered directly by the local authority, often as part of Education and children's Services.

Currently PBSWs do not have the capacity to maintain and navigate relationships with all 31 HSCPs. The operational activities and roles across PBSW, CBCJSW and Adult social services and the financial arrangements to support them currently do not take this complex work into account through the Memorandum of Understanding and Statement of Assurance between Local Authorities and Scottish Prison Service.  In addition, there are tensions over sharing information not only across community and prison services but between health and social services. Sometimes prison workers find they have to persuade the "home" or "receiving" HSCP workers to share information to deliver and plan support for the person in prison. Assessments completed by the prison HSCP  are not always accepted by the home HSCP when the person is liberated.  Assessments may, therefore, be done twice which is inefficient and can lead to disputes. All HSCPs must be encouraged and enabled to take up their responsibilities for their citizens coming home from prison so that the transition from prison to community is smooth and that risks to the person and, in some cases, the public are properly managed in a coherent way.

Two national approaches to Voluntary Throughcare from “New Routes” and “Shine” offer mentoring and support for people leaving prison to enable access to services. Other Third Sector organisations are commissioned locally. Most requests for help under Voluntary Throughcare are related to social support needs: housing, benefits, employment, help to keep appointments, family issues and so on. Scotland’s future approach to Throughcare should assume a need to connect with mainstream local health and social care services.

People often move around the prison estate across Scotland for a variety of reasons including sentence progression, access to programmes and best use of the estate. Nine people transferred across the estate either to or from HMPs Perth and Castle Huntly during the test of change. None had plans in place to continue care and support at the receiving prison. HMP Shotts, being a long term prison, did not have the opportunity to test out transferring care plans and information across the estate. With further time and improved information sharing about liberations and transfers (where these can be anticipated), care and support could be more effective.

People remanded in prison may face additional problems in accessing health and social care as they may not be in prison long enough to benefit from any additional supports. Consequently, they may then find themselves back in the community potentially in a more vulnerable situation than they were before they went in, particularly in terms of housing and benefits where arrears may have built up and benefits stopped. The SPS has engaged with housing stakeholders to agree the SHORE standards of best practice for identifying and supporting the housing needs of prisoners, including multi-agency work on arrival in prison, during a sentence, and to plan for release. Prisoners will have their housing situation assessed as part of induction, and local services are advised (in case action can be taken). Prisoners living alone can continue to claim housing benefit for 52 weeks whilst on remand, or 13 weeks when sentenced. Case management and pre-release planning for sentenced prisoners can be developed for longer periods spent in prison, and with the co-operation of the prisoner – but the short timescale of many remands leave little scope for detailed planning. This and the experience of organisations supporting the early release of people in prison in relation to the pandemic in May 2020 supports the suggestion that everyone entering prison would benefit from having a release plan covering housing, finance, primary health care and pharmacy arrangements as a minimum.

HSCPs already have a hospital discharge model that begins to plan for discharge almost as soon as someone arrives in hospital. The use of this model with responsibilities shared between SPS and the HSCPs would be worth exploring further.

Drawing together observations and thinking from the test sites and from conversations with a wide range of stakeholders, a future whole system approach to Voluntary Throughcare could encompass:

* Screening at the point of admission
* Information on health and social care needs that impact on the person’s ability to access purposeful activity being available at admission and being transferred seamlessly on release
* A release plan being an central part of the prison journey for everyone with an identified lead professional taking responsibility for this
* Focus on the retention and development of daily living skills whilst in prison, supporting people to manage their citizen rights and responsibilities
* Recognition of the challenges for people of engaging with statutory services, the need to build trust and stick with people
* Development of Third Sector support within and outwith the prison based on strategic needs assessments and plans.

**Recommendation 7**: Existing Throughcare and release planning should be enhanced to include a greater focus on health and social care needs at transition alongside the existing considerations around housing, benefits etc. This might help to reduce the number of people who return to prison, particularly those serving shorter sentences. Planning for release for those not subject to statutory Throughcare needs a multi-agency approach that continues to integrate with SPS case management processes and connects more robustly with local care and support systems. A review of the resource requirement for support systems within prisons and Throughcare could, in the future, reduce the impact of crisis in people’s lives and make better use of public funds.

## 5.14 Local governance and infrastructure to support multi-disciplinary working

The importance of working closely across organisation boundaries in order to deliver health and social care in prisons is apparent throughout the evaluation reports. Decisions were more easily made when the SPS was part of local operational health, social work and social care meetings and where social work staff were incorporated into regular meeting structures for both health and custodial related matters.

All sites had two clear routes of decision-making: a Steering or Strategic Oversight Group and an Operational Group comprising of members from the HSCP and SPS (in HMP Grampian, Aberdeen City HSCP was also included to reflect the large proportion of people from Aberdeen city in HMP Grampian). Operational groups drawn from the disciplines in each test of change managed day to day issues including ensuring the most appropriate professional led each case.

## 5.15 The multi-disciplinary team

All sites used a multi-disciplinary approach and found that this mirrored the way that teams in the community work. Appendix 4 illustrates the professional roles each test used. The contribution to the work from both SPS Headquarters and the Governors of each prison establishment hosting a test of changes was viewed by the test teams as supportive and enabling. Together, the MDTs and senior leadership in each area enabled each test site to succeed in creating a referral and assessment process which ensured that people with physical needs could access a range of professional support and personal care where needed. Most teams acknowledged that they were only beginning to identify where future services, including early intervention and prevention, might need to focus.

Communication across professions worked best when there were regular management or case focussed meetings that the adults’ service staff could join in. Team space presented a problem for several sites, both in terms of the needs of the team and in finding interview space to meeting with people who were referred. This became more challenging after COVID-19 and issues such as physical distancing measures increased time from referral to first meeting. As each prison site presents a different environment, there has been some variance across the estate as to the capacity for interview space. All sites found that in the future they would want to have more joint training across all members of the multi-disciplinary team and opportunities to shadow others both within and outwith the prison setting. Several test sites found that whilst needs for and service delivery around personal care was well understood, there was limited understanding of the wider functions of social work and social care support for disabilities that are not physical.

## 5.16 Social work roles

Throughout the project, the issue of the role of community and prison based social workers generated discussion about how best to make use of the social work resource. During the tests, stakeholders were frequently confused about which bodies or roles should undertake which functions. Should prison based social workers (PBSW) undertake a wider role and encompass the social support element of assessment and care planning or should community based social workers in adults’ services (CBSW) learn how to work in the prison setting? Most social workers are generically qualified and, with the right access to appropriate training, supervision, resource and professional referral pathways, can quickly adapt to different functions. This role needs to be firmly embedded in integrated health and social care which may be challenging given that not all Justice Social Work services are delegated to the IAs. To deliver through PBSW might therefore be more complex in some areas and might risk further differentiation of people in prison from the population in the community in terms of access to equity of health and social care outcomes. The other complexity about PBSW is that it is effectively procured by the SPS through a Memorandum of Understanding from the local authorities (LAs) for particular tasks. The findings from this Workstream present an opportunity to review the current Memorandum of Understanding between PBSW and the SPS as well as undertake a review of the role of social work within prisons. As part of this, consideration could be given to bringing adults’ social work services into the prisons. Currently, adding to the suite of PBSW tasks would require separate funding and considerable resource considerations. Going forward, the responsibility would fall to local authorities and Integration Authorities.

**Recommendation 8**: The Memorandum of Understanding between SPS and the LAs on PBSW and the connections with the IA, as well as the role of social work within prisons more widely, should be reviewed to establish and promote a more cohesive approach to social work in prisons in the future.

One test of change based its workers with PBSW but on reflection reported that better working relationships would have resulted had they sited themselves with their health colleagues. All sites agreed that co-location and frequent multi-disciplinary meetings are essential for better team work. Another test recommended that a role of prison social worker be explored which would be a generic role that could work across the range of teams usual in social work: mental health, learning disability, substance use, physical disability and sensory impairment. They felt that such a role could be linked in to local community teams when more specialist advice might be required. And that this would promote the sharing of knowledge and development of appropriate services across social work specialisms especially for the many people who have multiple areas of support need.

The HMPs Perth and Castle Huntly test not only aimed to train team members in safety and management of keys in prison but also began to join up the management of risk and need by training its adults’ services social workers in the formal risk assessment tool for people in the justice system (LS/CMI[[30]](#footnote-31)). This helped to develop appropriate and informed care management plans alongside carers and care providers. This team was also able to be involved in a small number of pre-sentencing reports which helped to prepare prison colleagues for the possible arrival of someone with additional care and support needs. The team felt this worked well and afforded the Sheriff a full understanding of the supports someone would need if sentenced to custody and the options for community based sentences for someone with very little freedom of mobility. Some people who were progressing to the open prison at HMP Castle Huntly were assessed by the team before their arrival which again helped local colleagues to prepare. This test illustrated some of the options for bringing tasks usually associated with either justice or adults’ services social work together.

## 5.17 Recruitment

Nearly all the tests of change experienced some difficulty in recruiting the necessary additional expertise (occupational therapy, social work etc.) and project support into the prison setting. There were a variety of reasons including the short timescale for the posts, but also:

* Working in prison was not seen as an attractive opportunity. This has previously been an issue for NHS prison based recruitment.
* The test of change recruitment timetable was not compatible with local authority procedures which could take several months before a post could be advertised even when external funding for the post was available.

## 5.18 Support for the multi-disciplinary team

In order to enable workers previously based in the community to work safely and confidently within the prison setting, they all undertook some basic prison orientation, personal protection and SPS suicide prevention training. Those who were to spend a significant amount of time based in the prison did their personal protection and key training which enabled them to move around the prison without an escort. Members of the multi-disciplinary teams found that they needed access to a range of IT systems to find and create records. The issues around IT access are dealt with elsewhere in this report.

The prison is a specific setting not experienced by most people in the course of their daily or work lives. It has routines and structures that people need to learn about in order to work effectively. Community social work staff had to learn about types of sentence, prison reception processes and Throughcare routes. SPS staff reported that they would have liked more information about what the tests entailed and the context of adults’ services social work and social care. Each test of change worked with the SPS managers to ensure that written information about the tests was available and there were opportunities to talk to prison officers about the work but the questionnaire responses indicate this was not sufficient. This may also relate to general perceptions of social work and social care being about statutory Throughcare or personal care rather than a holistic service. During the project, contact was made with the SPS College to consider what should be included on health, social work and social care both in the six week prison officers’ induction course and in their ongoing professional development.

Implementation science[[31]](#footnote-32) shows there are some key elements that must be taken into account when rolling out a new way of doing work. It advocates that support for staff teams in the future must consider the way workers are selected, how they are inducted and trained and include coaching as a key element in delivering and sustaining change.

## 5.19 IT systems in prisons

SPS have their own records system, PR2, and also use SharePoint for multi-disciplinary work in the prisons. Other organisations are enabled to access these as necessary. Prison health centre workers have Vision, a GP system which is under review separately, and Docman for document storage. PBSW can access their LA system through a limited number of computers in each prison.

As the tests of change started, the Scottish Government commissioned a short piece of work from NHS National Services Scotland (NSS) to make recommendations about how tests of change workers might access the systems they needed. This piece of work was affected by COVID-19 and the cessation of the tests of change in March 2020. This work should be reviewed and revisited before implementation as the current position presents very significant barriers for LA teams who need to access their records and email systems.

**Recommendation 9**: To enable workers in prison to gain access to LA IT systems, the Scottish Government should review current progress and direction of travel on commissioned work to date. This review should focus on access to systems in prisons, ensuring that this is aligned to SPS digital strategies and the refresh of Scotland’s Digital Health and Care Strategy.

One local solution was to use SPS SharePoint for storage of case notes and related documents. Drawbacks here include that key information about people in prison using services is not captured on the core LA systems which include case tracking and key data input. This risks omitting people in prison from a range of HSCP reporting activity and information sharing across key partners. Another site managed to use the LA remote access portal from a health centre terminal which would seem to be an ideal solution and the NSS work was to investigate the possibility of using this solution nationally. However, bringing additional staff into the prison exposed the low number and, in some cases, the slow and old nature of terminals.

The Perth tests evaluation mentioned the impact of not being able to flag cases on the SPS system. They found it contributed to delayed and disjointed communication which demoralised the adults’ services team and did not allow for good outcomes to be evidenced and followed through. The Glasgow test instigated a protocol whereby the LA assessment document was copied into the NHS Docman site and a case note made on NHS Vision indicating a person was referred or assessed. This is clearly cumbersome and relies on individual memory. A similar flag was not able to be placed as yet on the PR2 system to alert SPS staff that a person was being assessed or had a care plan as it has not yet been agreed where to place this flag.

As part of their digital strategy, SPS has completed the delivery of mobile telephony to the population and provided facilities for virtual visits cross the estate. Work is now underway on a multi-year replacement programme for PR2 and on the expansion of the PPN network in prisons to support the delivery of wireless solutions to the population. This will offer opportunities for additional services to be provided in support of the tests of change. The intended replacement for PR2 will include open data sources to allow other approved agencies to retrieve appropriate information as required.

During the pandemic, great strides have been made in pushing video conferencing forward especially the Near Me programme for health services. Unfortunately, most of the tests of change withdrew from prisons before the end of March so were not able to explore this technology. The Glasgow site that restarted in July found that whilst the technology is going to be a key element in assessing and supporting people in prison whilst there are infection risks, it requires significant staff resource which may not always be available to enable it to be used. Options for people in prison to access a wider range of hospital and community based services, such as physiotherapy, are likely to be considered in the future.

## 5.20 Information Sharing

There were two sets of data sharing protocols to consider during the tests of change:

1. Data sharing agreements (DSAs) between LAs, HBs and the SPS to deliver the service to people in prison.
2. Appropriate information governance arrangements to enable the test teams to share data with the Scottish Government and Social Work Scotland (SWS) to inform the national evaluations and recommendations for the future.

In the first case, where test partners were part of a HSCP operating under existing agreements in delivering integrated health and social care, this streamlined any additions thought necessary to cover the delivery of service during the tests; Aberdeenshire felt their existing arrangements between LA/NHS/SPS covered the work. Perth and Kinross decided to draw up a specific DSA.

Discussions on the necessary governance around sharing data from the tests of change with the Scottish Government and SWS to inform the national evaluations and recommendations were far more complex. At the time of writing, these discussions were still ongoing. This has impacted on the volume of data from the tests in both this report and available to the social care needs modelling project.

Teams at each test site reported no barriers within the prison setting to sharing information. However, gaining information as people arrived at the prison and being confident to share if people transferred within the estate or were liberated was not as easy. Each prison site has to be able to communicate effectively with every HSCP in Scotland and sometimes beyond. A leaflet was created to help test sites explain to other HSCPs the purpose of the tests and the reasons they would be looking to connect with them. This remains a challenge for any service that operates across local authority boundaries.

# 6 Resource

## 6.1 Tests of change resource

The budgets for the tests of change is at Appendix 4. The evaluations from each test indicate that the resource they used delivered the referral and assessment service as planned. Some reflected they might benefit from different ratios of input from the various disciplines (OT, physio etc.) in the future. One noted an increase in urgent referrals to OT from 31% in 2017 to 65% in 2019 reflecting the aging population in prisons, noting their one day per week of OT time might not be enough in the future. All felt they had achieved a referral and assessment service but that care and support delivery using the Third Sector would require further development.

The tests of change did not assess everyone in their prison although they linked in with the health screening that each person arriving at prison receives. Some responded only to referrals, some sought out referrals more actively through records, such as the prison evacuation lists which name people who need help in case of fire. The Perth and Kinross HSCP team also managed to extend their referrals to screen nearly everybody over the age of 50.

As mentioned throughout this report, the tests did not at this point effectively address invisible and hidden needs, particularly those around trauma, mental health and substance use. In the community these needs may often be met in ways that are not possible in prison through family, friends and the wider community, including using the internet. Delivering support for these needs in prison will be a challenge for future delivery in terms of working with the SPS policy developments on the environment and the regime to make prison a place which fulfils social expectations of punishment without creating further inequality and future harm.

Whilst the tests of change all had access to a small budget to enable them to have some agility to buy in additional care and support, the SPS retained the financial responsibility for personal care. Very little additional personal care to that already identified by the SPS was identified by the tests, so the amount for 2019-20 at £960k remains a realistic snapshot resource requirement although the trend over the last few years is at the moment clearly increasing rapidly.

Prison officers are a key resource in the identification of need and in enabling health and social work staff access to people in prison. When the SPS workforce is reduced (usually due to ill health, or during the pandemic, shielding) there is a direct impact on the ability of the other professions to get to see people and so to see changes in peoples’ wellbeing and to assess and deliver care and support. As the nature of the needs of people in prison changes, so the supports the workforce needs will change. Over time, it will be important to dovetail organisational strategies and practices related to recruitment, training and support to clarify responsibilities and promote even better multi-disciplinary working. This is a responsibility for all parties in health and social care in prisons.

## 6.2 The Third Sector

Voluntary organisations have delivered a wide range of services into prisons over the years. A survey of eight prisons in Scotland in 2019 found over 120 examples of services delivering a wide range of supports (Appendix 8). This represents potentially a significant resource and an opportunity to work with the sector to align these services with local need. This will require a strategic planning and commissioning approach which will need to respond to demand for different services in different localities. There are opportunities to develop focussed prevention and early intervention support to reduce the likelihood of crisis and people needing statutory services. The HMPs Perth and Castle Huntly tests found a small number of people using one or more Third Sector service; the most popular being advocacy and the men’s club. Here, the advocacy staff member undertook key training so they could move about the prison without the need of an escort which resulted in a large increase in the number of referrals for this service.

## 6.3 Availability and suitability of providers in the market

Whilst the SPS is generally able to procure personal care, there have been some instances where this has historically proved difficult either due to the lack of services in the local area or because care is required in an emergency and the systems are not there to enable this to happen.

In the last couple of years there have been several occasions when a person has arrived from court to a prison with significant personal care needs and the prison has had no notice and is not able to access the support. The Scottish Government undertook a short piece of work in 2019 -20 to bring together SPS and prison health staff with community adult services managers in the locality to agree interim support measures until such time as the LA/IA become formally responsible for social care in prisons.

East Ayrshire tests of change, which have not completed yet, undertook to trial some potential solutions to these issues:

* To invest in training for either their in-house care at home team or a local partner provider to test out the impact of having a small team trained and ready to deliver care at a moment’s notice in the prison.
* To make the health and social care element of criminal justice social work reports more overt and explicit and ensure this was passed to the receiving prison in good time.

Whilst these two small tests are yet to report, it is clear that these elements need to be part of a whole systems approach (WSA) to personal care and social support following individuals from the community, into prison and back out again.

# 7 Implementation

The tests of change were devised in order to explore the potential of and the barriers to the wider roll out of integrated health and social care across all prisons in Scotland. The learning from the test sites has been helpful in illustrating some of the challenges that all prisons and HSCPs will experience should the decision be taken to mainstream. This report shows the complexity of the governance arrangements around assessments and service delivery as well as the complexity of the needs of people who arrive and leave the prison estate. The tests of change demonstrate some of the opportunities for people in prison that integrated health and social care might provide, particularly when provided alongside the SPS case management and Throughcare processes. Moving forward it will be vital to ensure that there are supporting structures to share the learning from the tests, promote consistency and continually improve quality.

## 7.1 Implementation planning

The Active Implementation Resource Network recommends a detailed and thorough implementation process that takes into account the drivers in the diagram below



Figure : Implementation drivers

This approach is compatible with best practice in programme management techniques for roll out and mainstreaming but focusses on the role of coaching to enable successful implementation. The means by which the knowledge and skills gained through the tests of change can be used to bring other areas to the same level of practice should be fully considered and thought given to the resource that may be needed. Appendix 10 includes some recommendations for implementation arising from this report and offers a short guide on the essential elements that SPS and the local HSCP will need to address in setting up an integrated health and social care service for the prison in their area. Appendix 11 recommends some tools and structures to support a multi-agency approach to active implementation.

**Recommendation 10:** Given the range of potential governance and management structures a national implementation support structure is recommended which would:

* + Communicate consistently about the change in responsibility and coach local stakeholder groups in taking up this new role.
	+ Support consistent data collection to inform future decisions.
	+ Disseminate learning from the tests of change and early implementers to support quicker and more robust implementation.
	+ Escalate issues requiring national resolution.

## 7.2 Improvement and scrutiny bodies

There has been contact with the key improvement and scrutiny bodies throughout this project including: Her Majesty’s Inspectorate of Prisons (Scotland), The Care Inspectorate, and the Scottish Social Services Council. This is another element that will need to be further considered and clarity about inspection programmes and the application of standards to support implementation and improve quality over time.

**Recommendation 11:** Scrutiny and Improvement bodies should work together to ascertain roles and clarify inspection regimes of integrated health and social care in prisons.

## 7.3 Scottish Health in Custody Network: Prison Care

In June 2019 the Network transferred from Healthcare Improvement Scotland (HIS) to National Service Scotland (NSS) to support a ‘Once for Scotland’ approach to the planning, design and delivery of an integrated, holistic, person-centred care pathway across the health and social care system for people in custody. The Network provides national strategic leadership and advice to NHS Boards, Integration Joint Boards (IJBs) and other partners in relation to the delivery of services, using the most up to date evidence base and in line with strategic local, regional and national NHS and IJB priorities. One of the elements of implementation planning will be to consider how to bring a social work and social care in prisons focus formally into the Network.

**Recommendation 12:** Scottish Government should link with the Scottish Health in Custody Network to clarify the Network's role in supporting the implementation of integrated health and social care prisons.

# 8 Conclusion

Whilst the tests of change did not complete as anticipated due to the pandemic, the key stakeholders in this project achieved some fundamental agreement about the future direction of health and social care in prisons. The intention is to not only ensure that people in prison access their human rights to care and support in Scottish prisons but also to achieve a justice system more able to rehabilitate and support people to lead healthy and engaged lives on release.

The recommendations in this report were revised in July 2021 to reflect the Scottish Government’s commitment to a National Care Service and the position of prisons as a setting (alongside, home, hospitals and care homes) in which integrated health, care and support should be delivered as seamlessly as possible. All stakeholders recognised the impact of transitions in and out of prison, the difficulties of delivering care in the prison environment and the potential of a holistic approach to influence positive outcomes for people in the prison system and beyond.

Whilst the vision appears straightforward, our existing systems are complex, particularly where there has been no formal recognition of some of the responsibilities around social care for people in prison. Implementation of these recommendations will need to work across the key stakeholders to bring a robust operational framework offering individualised healthcare and support services with national oversight for consistency that can address the often deep-seated health, personal and social problems that impede movement away from criminal activity, that will reduce the number of future victims and deliver a stronger human rights approach in Scotland.

1. Scottish Government: <https://www.gov.scot/publications/guide-social-care-self-directed-support-scotland-act-2013/> [↑](#footnote-ref-2)
2. [Independent Review of Adult Social Care - gov.scot (www.gov.scot)](https://www.gov.scot/groups/independent-review-of-adult-social-care/) [↑](#footnote-ref-3)
3. <https://nationalperformance.gov.scot/national-outcomes> [↑](#footnote-ref-4)
4. <https://www.gov.scot/publications/scottish-prison-population-statistics-2019-20/> [↑](#footnote-ref-5)
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7. <https://www.mwcscot.org.uk/sites/default/files/2019-06/Mental%20health%20of%20Prisoners%202011.pdf> [↑](#footnote-ref-8)
8. <http://scotlandinstitute.com/wp-content/uploads/2015/07/Mental-health-and-Scotlands-prison-population.pdf> [↑](#footnote-ref-9)
9. <http://www.knowledge.scot.nhs.uk/media/11318713/20160226%20nphn%20substance%20misuse%20report%20final%20v1.0.pdf> [↑](#footnote-ref-10)
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12. <https://lankellychase.org.uk/resources/publications/hard-edges-scotland/> [↑](#footnote-ref-13)
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14. <https://www.sps.gov.uk/Corporate/Information/SPSPopulation.aspx> [↑](#footnote-ref-15)
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18. <https://www.gov.scot/groups/homelessness-and-rough-sleeping-action-group/> [↑](#footnote-ref-19)
19. <https://www.gov.scot/groups/social-renewal-advisory-board/> [↑](#footnote-ref-20)
20. [↑](#footnote-ref-21)
21. <https://hscscotland.scot/integration/> [↑](#footnote-ref-22)
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