



PRISON HEALTHCARE ADVISORY BOARD

Potential Transfer of Enhanced Primary Healthcare Services to the NHS

**REPORT TO CABINET SECRETARIES
For Health and Wellbeing, and Justice**

14 December 2007

Volume 1 of 2

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1. EXECUTIVE SUMMARY

1.1 Since the mid-nineteenth century, primary healthcare services in Scottish prisons have been provided directly by the Scottish Prison Service (SPS), outwith the National Health Service (NHS). Ministers had considered transferring responsibility for all prison healthcare to the NHS and formed the Prison Healthcare Advisory Board to investigate the legislative, operational and financial issues and **to report to Cabinet Secretaries on the feasibility of transfer.**

1.2 There are a number of drivers for change that have informed Ministers' considerations. Prisoners have **extremely poor health and poor prospects for good health.** There is a need to tackle **health inequalities**, to meet **accepted international standards**, and to develop and improve **continuity of care** to minimise the potential for re-offending. These need access to the **wider clinical expertise of the NHS.** Additionally, present arrangements within the SPS for primary healthcare are **not sustainable** for the foreseeable future.

1.3 The Board has come to the view that **transfer of responsibility for primary healthcare services to NHS Boards is feasible.** There are risks associated with any transfer of responsibility. These risks are manageable with careful preparatory work, good planning and the right project management arrangements. Effective working relationships with national and local partnerships between SPS and the NHS will be essential.

1.4 There are financial consequences of transfer to NHS Boards because the current arrangements are not providing treatment to NHS standards, and there will be an immediate cost to NHS Boards of meeting its regulatory and legal obligations. If transfer is to proceed, the Board recommends that the appropriate additional finance should be made available to NHS Boards to meet these commitments.

1.5 Legislative change will be needed in the form of repeal of section 3A of the Prisons Scotland Act 1989 which puts a specific duty on Ministers to provide medical services to Scottish Prisons. Once repealed, NHS Boards would become responsible under their duty to provide medical services for their resident population. There are opportunities in 2008 for the changes in legislation to be promoted.

1.6 There are practical operational issues that will need to be addressed if transfer were to proceed. A National Partnership Board should be formed to oversee preparations and operational transfer in partnership between the SPS and NHS Boards, supported by a new legal duty to co-operate. The TUPE regulations will be applied to the resultant transfer in employment which will follow the transfer of service to the appropriate NHS Board. Regional managed clinical networks are likely to be developed to promote prison healthcare and offender health as a specialised sector of care. NHS Quality Improvement Scotland would review healthcare delivery in prisons as they do for other NHS care.

1.7 This report asks Cabinet Secretaries to note that :

1. transfer of responsibility for primary healthcare from the SPS to NHS Boards is feasible, and
2. If Cabinet Secretaries decide that they wish to proceed with transfer,
 - preparatory work on the necessary legislative change should be authorised
 - a National Partnership Board should be formed to oversee the preparatory work for transfer, and
 - NHS Boards should be funded to meet the additional costs of meeting their regulatory and legal obligations.

2. INTRODUCTION AND BACKGROUND

2.1 Primary healthcare services and some specialist forensic psychiatry services in Scottish prisons have been provided outwith the NHS by the Scottish Prison Service since the mid nineteenth century. Specialist and hospital services to prisoners are provided by the NHS. In autumn 2005, Ministers expressed an interest in transferring responsibility for all healthcare in Scottish Prisons to the NHS. In early 2007, Ministers set up the Prison Healthcare Advisory Board to look at the feasibility of transfer and to report back to Ministers by the end of 2007.

2.2 The Prison Healthcare Advisory Board comprises senior NHS and SPS staff, NHS and SPS staff organisations, and Scottish Government advisors. A Chair with both NHS and SPS non-executive responsibilities was appointed by Ministers. The Board was given a remit by Ministers **to advise them on the legislative, operational and financial feasibility of transfer**, if the NHS took on responsibility for health service delivery. The detailed remit and membership of the Board is in Volume 2, Section 4.

2.3 This report from the Prison Healthcare Advisory Board, submitted on 14 December 2007, comprises two volumes. Volume 1 provides Ministers with a report on the key issues regarding feasibility of transfer; Volume 2 contains joint contributions on the key issues from members of the Board. It provides supporting reference material and will be of value for future planning purposes, should transfer of responsibility proceed.

3. CURRENT PRISON HEALTHCARE

Prisoners and their health

3.1 Prisoners represent a section of the poorest parts of Scottish society. They have a very poor health profile in terms of life circumstances, lifestyles, risk factors and disease as Table 1 demonstrates:

	Prevalence on admission to Prison	Prevalence in the Community
Alcohol problems	41% male/36% female	13% male/7% female
Illegal Drug Use	67%	8%
Smoking Rates	78% male	26% all
Hepatitis C	20%	1%
Asthma	12%	5.4%
Epilepsy	2.1%	0.7%
Chlamydia	12%	0.8%
Severe dental decay	29% male/42% female	10% male/3% female
Schizophrenia	9% male/36% female	0.5%
Depression	25%	5% approx
Personality disorders	66% approx	5% approx

Table 1: from Health Care Needs Assessment, Dr Lesley Graham, SPS 2007

3.2 The prison population has a high turnover. Two thirds are serving short sentences; one third of the daily prison population (2,700) is serving long-term sentences at any one time. The majority are short-term and unconvicted prisoners (4,500 on any one day; 20,000 individuals over a year) who show signs of greater personal chaos, instability and consequently, more acute health needs than the general and more stable population. Their daily population is rising (it rose by 5% overall in the past year). Increasing numbers of offenders that come through the prison gate mean rising work levels and increased resource in admitting and assessing them, and ensuring their care. By far the vast majority

of people leaving prison are liberated from local prisons. Many are returning to prison and their needs are usually greater than when they left on the last occasion.

The Prison Healthcare Service

3.3 The current model of healthcare to prisoners is that of an enhanced primary care service, with the enhanced care delivered in addictions, mental health and blood borne viruses. It is a nurse-led service, with nursing and administrative support staff employed directly by the SPS. The service is supplemented by contracted staff of general practitioners, pharmacists, specialist addiction staff and agency nurses. Nursing cover is available for the extended working day in most establishments and doctors are on-call at all times.

3.4 Out-patient and secondary care is provided by local NHS Boards, including in-reach provision. Local arrangements are in place for provision of certain healthcare services such as specialist forensic psychiatric services, dentistry and Allied Health Professionals (AHP) input on an establishment by establishment basis.

3.5 The Scottish Prison Service has made considerable investment during recent years in healthcare and there is evidence that some improvement to prisoners' health takes place during the time that they are in prison. Access to healthcare is sometimes better than that in the community in terms of waiting times for primary care and substance misuse services. Initial research on self reported *comparative* health and wellbeing *between arriving and leaving* the prison is generally positive, both for physical and mental wellbeing. However, in spite of this their health remains poor as shown in Table 1.

4. DRIVERS FOR CHANGE

Tackling Health Inequalities

4.1 The Government's strategic objective for the health of the people of Scotland is: "To help people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care"

4.2 Reducing health inequalities has been a Government priority for improving the health of the people of Scotland and preventing disease since the late 1990s. This was first set out in ***Towards a Healthier Scotland*** and has been reinforced and developed in successive Government policy statements since then. Most recently, the Government has reinforced this in their consultation document ***Better Health, Better Care***, and also with the establishment of a **Ministerial Task Force on Health Inequalities**.

4.3 In general terms, inequalities in health between groups in the population mean that some people are more likely to be ill or have low levels of wellbeing and to die younger than others. As seen in the table in Section 4.1 prisoners have significantly higher rates of some serious conditions, have poorer mental health and also have generally unhealthier lifestyles. While significant developments have taken place in the enhanced primary healthcare service in the SPS in recent years, tackling inequalities and poor health will take considerable further development, and access to specialist resources that have not yet been involved in the treatment of this group of people.

Sustainability

4.4 The SPS has invested considerably in healthcare over the last 10 years or so and has made significant improvement. However the investment needed to bring the service fully up to accepted national standards requires access to a wider range of healthcare expertise and professionals than is feasible at the moment. As a relatively small organisation, the ability of the SPS is limited in attracting the wide range of expertise needed to keep pace with the developments in the wider NHS. Already the SPS is having difficulty attracting medical staff of sufficient skill and expertise, and the service is fragile. The medical service is not sustainable in its present format due to better career opportunities being available for general practitioners in recent years. There is a need for access to wider clinical expertise and for integration with wider community based services. The only way for the service to achieve longer term sustainability is for it to be part of a larger service and to have the support of a wider cohort of clinical expertise and community based services to meet the changing needs of the prison population.

Meeting Accepted International Standards

4.5 Scotland is out of step with two international standards. These are:

- The United Nations Basic Principles for the Treatment of Prisoners. Article 9, provides that “Prisoners shall have access to the Health Services available in the country without discrimination on the grounds of their legal situation”.
- The World Health Organisation in 2003 issued the Moscow Declaration in which it stated that penitentiary health must be an integral part of the public health system of any country.

4.6 This is not the situation in Scotland where prisoners do not have access to the same health services available in the country as far as primary care services are concerned. Given that NHS national protocols and guidelines do not apply to all SPS healthcare and the SPS does not have access to the wider range of clinical expertise that the NHS has, this is a significant risk for the future.

Independent Regulators’ Views

4.7 Her Majesty’s Chief Inspector of Prisons in Scotland, on the advice of NHS Quality Improvement Scotland who raised significant concerns with him about quality of healthcare provision, recommended in his Annual Report for 2005/2006 that healthcare should be provided by the NHS. Although improvements had been made in recent years he recognised the “desperate state” most prisoners are in on admission and that the healthcare staff in prisons do not have anything like the resources of the NHS at their disposal.

Accountability for Continuity of Care

4.8 At present, the Scottish Prison Service has responsibility for primary care inside prisons and NHS Boards for care before and after people leave prison, so responsibility for continuity of care is split between SPS and NHS Boards. It is vitally important that care started in prison is carried on and properly planned and co-coordinated when people leave prison. This is when individuals are at their most vulnerable with increased risk of suicide and re-offending through inadequate continuity of care and support. Given the high incidence of mental health, drug and alcohol issues, NHS Boards having responsibility for continuity of care would be of real benefit. This would ensure that vulnerable and at risk people have properly planned after care.

5. IMPLICATIONS OF TRANSFER

Legislative

5.1. Section 3A (2) of the Prisons (Scotland) Act 1989 puts a duty on Scottish Ministers to provide medical services to prisoners in Scottish prisons. Ministers are able to contract with others to provide these services for them, but the legal accountability rests with Scottish Ministers. The NHS, in the form of Health Boards as the public bodies concerned, is not empowered to provide services in Scottish Prisons because of the provisions of the Prisons (Scotland) Act. While Ministers may contract with others to provide these services, the contracting would be subject to EU competition regulations and would need to be tendered competitively throughout the EU.

5.2. To enable the NHS to become responsible for all Prison Healthcare, primary legislative change will be required. The legislative measure would be to repeal Section 3A (2) of the Prisons (Scotland) Act 1989. This would then enable the NHS to provide services through the duty on Health Boards under the 1978 National Health Service (Scotland) Act to provide medical services for the population resident in their area, which would include those resident in prisons in their area.

5.3. Some other legislative changes will be required to facilitate an appropriate pattern of NHS care for dentistry, optometry and pharmaceutical care where prisoners have been an excluded category in regulation because of the historical provision by the SPS.

Operational

5.4 Operational implications would need to be carefully managed. Healthcare is an important component of prison life and the Scottish Prison Service will want to be reassured that transfer to NHS Boards will not impede the smooth running of the prison. Work will need to be done to articulate clearly the responsibilities of the SPS and NHS Boards. The role of the SPS will be to facilitate the provision of healthcare services, ensuring that premises are available and up to standard, that prisoners needing healthcare can have access to healthcare staff and facilities. The role of NHS Boards will be to provide healthcare services as required, as well as providing anticipatory healthcare, health improvement and health protection services. The role will also ensure that appropriate medication is provided through an agreed formulary.

5.5 Concerns have also arisen in the course of discussions that NHS Boards may decide to reduce the budget for prison healthcare, or redeploy staff to meet other priorities and that this could have an effect on the good order and wider social environment in prisons. Equally NHS staff have raised concerns that the SPS may alter routines or deplete resources, for example, reducing investment in infrastructure and prisoner escorting that may impact on their ability to deliver care.

5.6 It is important that the partnership between SPS and NHS managers operates successfully, and that there are safeguards in place to ensure that no unilateral decisions are made by either side of the partnership. Good working relationships and mutual respect between SPS and NHS staff will ensure that potential problems are minimised, underpinned by co-ordinated working practices and appropriate communications. To reinforce the need to work in partnership, a new legal duty should be introduced to require the SPS and NHS Boards to co-operate and work in partnership through a National Framework to secure appropriate healthcare services in Scottish Prisons. The SPS and the NHS would also require to jointly sign-off a formal partnership agreement with local service and investment plans for healthcare in prisons.

5.7 There are other operational implications in migrating from the current SPS contracts for healthcare supplies and services to NHS arrangements. These may require a regional or Scotland-wide approach and further legal advice will be required.

Clinical

5.8 Nationally agreed standards and guidelines, and local protocols on the treatment of illnesses such as mental health including dementia, diabetes, epilepsy and cardiovascular disease would be provided. NHS addiction services, forensic and sexual abuse services would be introduced. Other services such as speech and language therapy, physiotherapy and occupational therapy would support the work of the prisons healthcare teams with in-reach, as would dietetic and podiatry services. Integrated care pathways would be introduced for all specialties and discharge planning by NHS staff would be developed enabling better continuity of care. Further detailed work would be undertaken to develop new and appropriate models of clinical service delivery. Clinical staff would be involved in shaping this.

5.9 The existing arrangements for doctors, dentists and others would migrate to NHS standards. Clinical staff could benefit from practice development opportunities and there would be better opportunities for introducing different skill mixes from a much wider and varied cohort of professional expertise. Clinical expertise could be developed further with regionally managed clinical networks for healthcare staff, providing opportunities to enhance the specialty of prison health and healthcare with nurse specialists, GPs with special interests, nurse consultants and addictions specialists. There could also be development opportunities for existing prison healthcare staff to use their expertise in wider areas such as offender health and health inequalities.

5.10 NHS Boards would be responsible for 24 hour clinical cover for prisons as they are for the rest of their population. The most likely approach would be to follow similar arrangements as those currently in place for nursing homes. Agreement would need to be reached with NHS Boards on the best method of integrating with their out of hours arrangements. A number of options are available and some of these are explored in more detail in Volume 2, Section 12.

Workforce Planning Implications

5.11 The healthcare service within prisons is led, clinically provided and supported by a range of directly employed staff and contractors, mostly highly skilled and qualified.

- SPS employed staff based in the Health and Care Directorate at SPS HQ.
- SPS employed healthcare staff – clinical and support staff – based in the public prisons (approx 240 wte staff)
- Healthcare staff – clinical and support staff employed by the private prison in Kilmarnock. The construction of a second private prison in Addiewell is currently underway and the resultant healthcare staff would also be included. (approx 30 wte staff)
- SPS contracted services, including doctors, enhanced addictions casework, dentistry, psychiatry, agency nursing, ophthalmic, physiotherapy, chiropody, and others such as counselling, well woman and infectious diseases.

5.12 The SPS and NHS Boards are different employers with their own terms and conditions and employment, management, governance, safety and security arrangements. However in terms of healthcare provision significant common ground exists which would be the foundation for strong partnership working. This will ease the transition between employers, as both organisations and their respective staff are striving to provide the best possible quality healthcare to their client groups to the highest possible standards. The qualified nursing staff are the largest group within the healthcare workforce and are all registered nurses. All have worked within the NHS during their training, and many post qualification. They are therefore very familiar with the culture and ways of working within the NHS.

5.13 TUPE (Transfer of Undertaking (Protection of Employment) Regulations 2006) would apply to the directly employed healthcare staff, which is the largest group affected by the change. This is the case where the staff are wholly or mainly assigned to the SPS healthcare undertaking. With regard to the contracted individuals, preliminary legal advice is that TUPE may apply but detailed legal advice is awaited.

5.14 Staff value the training and development opportunities currently made available by the SPS and are keen to maintain this level of access and opportunity following any transfer. However, there will be real benefits for staff in transferring into the employment of a bigger healthcare organisation with the resultant opportunities that would be available. The NHS would provide access to a wider range of clinical training, career movement and development opportunities, in an environment with increasing emphasis on offender health as part of the wider health inequalities agenda.

5.15 Effective workforce planning will help ensure that the right staff with the right skills are in place to deliver future services. Any review of services to reflect changing needs would be done in partnership between the NHS, the SPS and the staff concerned. Both the SPS and the NHS have considerable experience of managing organisational change, TUPE transfers and the complexities of employing staff on different terms and conditions.

Financial Implications

5.16 **Additional investment will be required** in prison healthcare to meet NHS legal obligations and good practice standards against which NHS Quality Improvement Scotland assesses healthcare delivery.

5.17 Prison health is a complex undertaking and it is not straightforward to state, for a given added level of investment, what might improve and how. A health needs assessment of the prisoner population was carried out by an Associate Specialist, Public Health to help inform the work of the Advisory Board. The information on which the assessment is based is the best available and incorporates comparisons with the general population and studies of other prison systems. This work underpinned the financial implications of transfer on the basis of unmet need.

5.18 The experience in England has also been taken into account. The Board recognised that the pre-transfer healthcare service provided by HMPS (England) was significantly different and that comparisons would not be constructive. However, the lessons learnt from England and their experience of the transfer process have been very useful and have informed the Board's approach on the development of local partnerships and the change process.

5.19 Current investment in prison healthcare is approximately £16m. The gap between current services and levels required to comply with legal, basic policy and regulatory requirements is principally in dental care, vaccination programmes and IT systems to support care. Addictions management, pharmacy and professional staff training are already substantially invested. The value of likely additional investment is estimated at £0.6m in the first year, of which £0.4m is recurring.

5.20 The 'equivalence gap' is the gap between current services and community services. This is principally with mental health care in addition to structured multi-disciplinary care for long-term conditions and better continuity of care, with a marginal further increase in dental care investment. The value is estimated at £1.3m, rising to £1.5m, predominantly recurring and £1m greater than compliance levels.

5.21 The 'inequalities gap', service developments to achieve better health for prisoners within the current service model, places further resource into mental health care and continuity of care. The value is estimated conservatively at £2.55m, and is a further £1m more than 'equivalence' levels of additional resource.

5.22 As a comparison, an assessment of services needed for a new 700 place prison in Glasgow was used to extrapolate the potential cost of current NHS standards being implemented across Scotland. This suggests that there is a requirement for additional investment of up to £8 million per annum recurring to ensure provision of adequate health services.

5.23 In summary, the current cost of providing care by the SPS amounts to around £16 million per annum. To meet NHS equivalence, would require around £1.5 million additional investment per annum. To close the inherent health inequalities unmet need gap beyond that would involve, conservatively, £2.5 million as a minimum, per annum with £1M invested on top of £1.5 million. To provide the same level of service as estimated for the new Glasgow prison the additional investment could be as much as £8M per annum.

5.24 Despite the lack of certainty at this stage of the review process around required investment, however, the financial implications of potential transfer of primary healthcare

responsibility from the SPS to NHS Boards of between £4M and £8M should not be seen as a major stumbling block. The cost of providing such services is relatively small in the context of the overall health budget. If transfer is agreed, however, it is important for individual NHS Boards which could be impacted upon disproportionately, that:

- existing financial responsibilities are confirmed as accurately as possible
- as much clarity as can be achieved within reason on the status of unmet need and a NHS Board by Board assessment of the financial impact including capital and revenue streams with the latter split between recurring and non-recurring in nature
- a pragmatic method for allocating funds to individual NHS Boards is developed and implemented.

6 ALLOCATION OF FUNDS

6.1 If transfer is to proceed, funding would need to be transferred from the SPS to individual NHS Boards and therefore a mechanism is required to allocate funds to each Board.

6.2 In summary, to recognise that prisoner populations may vary significantly as the SPS develops its estate, splitting the allocations to NHS Boards for prison health into a fixed and variable element would ensure that even the smallest prisons receive sufficient funding to cover core administrative, management and equipment costs that vary little as populations rise and fall. The bulk of the funds would be allocated, however, on a weighted population basis, recognising that variable costs are affected significantly by the size and profile of the prison population. The balance between fixed and variable elements would be worked out as part of any implementation phase.

7 HEALTHCARE GOVERNANCE

7.1 At present a healthcare governance framework is under development in the SPS but still needs to develop a full range of checks to monitor standards and to implement essential computerised information systems. With potential transfer to NHS Boards, there is an emerging expectation that a move would mean better continuity of care, integrated care pathways and greater patient involvement, as well as the capacity to meet the needs of a population in generally poor health.

7.2 NHS clinical governance arrangements would be introduced to ensure that quality of care is optimal and links to corporate governance. The Community Health Index (CHI) number for patients would be used to support better continuity of care. Medical staff and other healthcare professionals would be properly registered with continuous professional development plans and practice development opportunities. Prisons would have access to a wider cohort of infection control and health protection expertise.

7.3 NHS QIS would review the care in place against national NHS standards and assessments would be public documents. The standard NHS risk management framework would be introduced to assess and manage clinical risk. NHS Board Clinical Governance Committees would oversee the governance arrangements and would ensure systems were in place to deliver to national standards.

8 RISKS AND RISK MANAGEMENT

8.1 There are a number of risks in transferring services to NHS Boards. In the process of transfer itself, the main operational risks are keeping the services functioning to their current standards in a period of change. There are risks that, while NHS Boards get to grips with the new service, the specific timetable to which each Prison adheres is adversely affected and that the relationship between healthcare staff and other prison staff may alter. There are clinical risks that practice will change to NHS standards in advance of well co-ordinated clinical team protocols being developed and understood by all. There are staffing risks that in the process of change staff anxiety leads to increased turnover with resultant retention and recruitment difficulties. There are financial risks that the need for different treatments and more comprehensive care may be discovered after transfer that have unplanned financial consequences for NHS Boards.

8.2 None of these is an unmanageable risk, and if transfer were to go ahead, there would need to be close joint planning of transfer at local level, joint risk management and close joint monitoring of the transfer process. Close co-operation must continue between the clinical teams, the Prison Governors and the appropriate Community Health Partnerships/NHS Boards.

8.3 Maintaining the status quo has risks because Scotland is already out of step with other UK countries and will be increasingly out of step with most of Europe and the international community over the universal right of citizens to have their healthcare delivered by the national health system. The current medical services are fragile and cannot be sustained in their present format, and the investment and expertise required to keep pace with the wider healthcare agenda will be difficult for an organisation the size of the SPS. These risks are not manageable in the medium or long term.

9 NEXT STEPS

9.1 If responsibility were to transfer to NHS Scotland, a Scottish Prison Healthcare Partnership Board should be set up to oversee a complex programme of strategic change nationally and in nine NHS Board areas.

9.2 The responsibilities of the Partnership Board would include the development of a National Framework. This would describe the strategic aims and objectives of the programme as well as guidelines and principles to help inform NHS Boards and prisons in the development of their local service delivery plans.

9.3 At the end of the transfer process, it is envisaged that there would be a National Partnership Agreement, a formal agreement between the SPS and NHS Boards including roles and responsibilities, a performance framework and local service delivery plans.

10 CONCLUSIONS AND RECOMMENDATIONS

10.1 This is a group of people with poor health, high incidence of illness, high addiction problems and poorer prospects for good health. There are a number of drivers for change:-

- **Accepted international standards** – Scotland has taken a leading role in the international community in developing minimum standards for the treatment of people in prison, but has not yet implemented those standards here.

- **health inequalities** – prisoners suffer profound health inequalities, have higher levels of physical and mental ill health, poorer prospects and shorter lives, and the resource and expertise of the NHS should be brought to bear to improve this.
- **better continuity of care** and the ability to ensure follow through in people's treatment will provide better opportunities to help resolve lifestyle and addictions issues that affect offending behaviour. Treatment would be provided to national standards with independent review and access to a wider range of healthcare expertise.
- **sustainability** - the current medical services and current clinical governance arrangements are fragile and cannot be sustained in their current format.

11.2 In addition, transfer offers opportunities to develop healthcare in a way that would be more difficult for the SPS to provide on its own. It offers opportunities to tackle health inequalities, improve anticipatory care and the treatment of long term conditions, and provide a single focus for improved continuity of care. There will be better career development opportunities for staff and independent assessment of healthcare services through NHS QIS. Transfer also meets international standards for the treatment of healthcare for prisoners.

11.3 There are risks associated with transfer, but they are manageable and outweigh the disadvantages of maintaining the status quo. Maintaining the status quo has risks because Scotland is already out of step with other UK countries and will be increasingly out of step with most of Europe and the international community over the universal right of citizens to have their healthcare delivered by the national health system. The current medical services are fragile and cannot be sustained in their present format. These risks are not manageable in the medium or long term.

11.4 On balance, the risks of maintaining the status quo outweigh the risks of transfer. Transfer has benefits for prisoners, for staff and for the wider community and are consistent with the Government's strategic aims. Accordingly, we advise Cabinet Secretaries that the transfer of responsibility for providing healthcare to people in prisons to NHS Boards is feasible.

Accordingly, it is recommended that Cabinet Secretaries note that:

- 1) transfer of responsibility for primary healthcare from the SPS to NHS Boards is feasible, and
- 2) if Cabinet Secretaries decide that they wish to proceed with transfer,
 - preparatory work on the necessary legislative change should be authorised
 - a National Partnership Board should be formed to oversee the preparatory work for transfer, and
 - NHS Boards should be funded to meet the additional costs of meeting their regulatory and legal obligations.