OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 28 March 2017

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 28 March 2017

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HEALTH AND SPORT COMMITTEE
9th Meeting 2017, Session 5

CONVENER

*Neil Findlay (Lothian) (Lab)

DEPUTY CONVENER

*Clare Haughey (Rutherglen) (SNP)

COMMITTEE MEMBERS

*Tom Arthur (Renfrewshire South) (SNP)
*Miles Briggs (Lothian) (Con)
*Donald Cameron (Highlands and Islands) (Con)
Alex Cole-Hamilton (Edinburgh Western) (LD)
*Alison Johnstone (Lothian) (Green)
*Richard Lyle (Uddingston and Bellshill) (SNP)
*Ivan McKee (Glasgow Provan) (SNP)
*Colin Smyth (South Scotland) (Lab)
*Maree Todd (Highlands and Islands) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Aileen Campbell (Minister for Public Health and Sport)
Jillian Galloway (Perth and Kinross Health and Social Care Partnership)
Daniel Kleinberg (Scottish Government)
Beth Macmaster (Her Majesty's Inspectorate of Prisons for Scotland)
Fiona McNeill (Glasgow City Health and Social Care Partnership)
Teresa Medhurst (Scottish Prison Service)
John Porter (National Prisoner Healthcare Network)
Professor Sir Lewis Ritchie (Scottish Government)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 28 March 2017

[The Convener opened the meeting at 10:16]

Subordinate Legislation

Personal Injuries (NHS Charges) (Amounts) (Scotland) Amendment Regulations 2017 (SSI 2017/58)

National Health Service (Payments and Remission of Charges) (Miscellaneous Amendments) (Scotland) Regulations 2017 (SSI 2017/59)

The Convener (Neil Findlay): Good morning and welcome to the ninth meeting in 2017 of the Health and Sport Committee. I ask everyone to ensure that their mobile phones are set to silent; it is acceptable to use phones for social media in the room, but please do not take photographs or record the proceedings.

Agenda item 1 is consideration of two Scottish statutory instruments that are subject to negative procedure. No motion to annul either instrument has been lodged, and the Delegated Powers and Law Reform Committee has made no comments. If members, too, have no comments, does the committee agree to make no recommendations?

Members *indicated agreement.*

The Convener: Thank you. I have also been remiss in not mentioning that we have received apologies from Alex Cole-Hamilton.

Healthcare in Prisons

10:17

The Convener: Agenda item 2 is two evidence-taking sessions for our inquiry on healthcare in prisons. I welcome to the meeting Beth Macmaster, national prison monitoring co-ordinator, Her Majesty's inspectorate of prisons for Scotland; Teresa Medhurst, director of strategy and innovation, Scottish Prison Service; Fiona McNeill, head of adult services south, prison and police custody healthcare, Glasgow city health and social care partnership; Jillian Galloway, head of prison healthcare, custody and forensic healthcare and out of hours, NHS Tayside—Jillian also represents Perth and Kinross health and social care partnership; and John Porter, national nurse adviser, national prisoner healthcare network.

We will move straight to questions. Given how far we are down the line of putting healthcare in the hands of the national health service rather than the Prison Service, why does the healthcare that is provided to prisoners differ so much from that which is provided to those who are not in prison?

Fiona McNeill (Glasgow City Health and Social Care Partnership): Perhaps I can respond to that, convener. The transfer of responsibilities has been a significant challenge. The health and social care issues associated with the day-to-day provision of social care in the community are significant, and we need also to factor in the issues associated with the healthcare of the prison population. For example, no two prisons are the same. Each of the three prisons in the NHS Greater Glasgow and Clyde area has different premises and buildings, different levels of access to support and a whole range of different requirements. It is difficult to give the challenge a particular size or scale.

There are many examples of our having improved services for prisoners—indeed, lots of different areas can cite examples of improvement of many different aspects—but there is still a long way to go. Five years is a long time in some respects and a very short time in others.

The Convener: How long will it take?

Fiona McNeill: I cannot answer that question.

John Porter (National Prisoner Healthcare Network): I am not too sure that the statement behind your question is correct, convener, because, as far as I can see from research, the population in the prison environment is one that has been very much underserved by the care that it receives in the community; unfortunately, it is prison that provides the opportunity to start to

establish the health needs of what is a very challenging population.

The Convener: Are you saying, then, that the service that is provided in prison is better than the service people receive outside of prison?

John Porter: There is an opportunity to start to tackle that population when they are in the prison environment. I think that they have been underserved in the community.

The Convener: Are they better served in prison?

John Porter: Their health needs are attended to once they are in the prison system. I do not think that I can comment on whether the service is better or worse than that which is provided in the community.

Jillian Galloway (Perth and Kinross Health and Social Care Partnership): I echo Fiona McNeill's point about there having been some significant improvements in a lot of the establishments across Scotland, as demonstrated by some of the throughcare work that has been carried out to give prisoners who are being released not just equal but equitable access to services while they are in prison to meet their healthcare needs. When we go into establishments, we find, as John Porter said, that the group of prisoners and patients is quite complex and needy, and we have an opportunity to work very closely with them, alongside the Scottish Prison Service, to meet not just their healthcare needs but all their needs. There have been quite significant improvements in the past five years.

The Convener: Who in Scotland leads on prisoner healthcare?

Jillian Galloway: There is the national prisoner healthcare network advisory board, which was chaired by Andreana Adamson. It comprises NHS and SPS representatives and provides some direction, but perhaps John Porter can say some more about it.

John Porter: Accountability for delivering prisoner healthcare sits with the health boards. The network was put in place to ease the transition in 2011 and to support health boards, the Scottish Government and other agencies. Whether it leads on the issue is debatable, but it provides a valuable service with regard to practice. It has a work plan and work streams that consider areas of risk to prisoners in the context of healthcare, and it provides support and advice to a host of agencies.

The Convener: Who is leading on this at Government level?

John Porter: I would find it difficult to name a person. With the departure of the NHS director for health and justice, I would struggle to give you a single policy lead from the Scottish Government.

The Convener: Does anyone know? No. Okay, thank you.

Alison Johnstone (Lothian) (Green): One of the panellists has suggested that no two prisons are the same. I appreciate that, but is there a recognised workforce model for healthcare in prisons?

John Porter: Actually, no. In one particular group, the NHS board leads get together to look at sharing best practice and have developed a work plan, and one of the work plans that that group has in place is about looking at the workforce. There is an intention—and a new workstream—to develop a national workforce tool in liaison with Scottish Government colleagues who lead on planning workforce models.

Alison Johnstone: How, then, can budgets and services be directed to improve prison healthcare?

Jillian Galloway: In NHS Tayside, we used the workforce tools that were available, along with our professional nursing judgment. We worked closely with our nursing directorate and the head of nursing for prison healthcare in Tayside, and also involved pharmacy and general practitioners—it was a multidisciplinary approach to workforce modelling. The majority was professional judgment, because there is not a national tool, but we looked at the tools that were available for acute wards, emergency medicine and community nursing and adapted them to look at the issue and came up with a baseline establishment for Tayside.

Fiona McNeill: I echo what my colleague has outlined. When we assumed responsibility, one development was to have a professional nurse adviser in NHS Greater Glasgow and Clyde. The postholder covers police custody and prisoner healthcare, so that there is some continuity. We take the advice of that individual on what appears to be needed, day to day and on-going, and we have adapted the tools that are available for our use. Professional judgment is much more the order of the day in the absence of a validated workforce tool for prisoner healthcare.

Alison Johnstone: The committee has spoken to ex-prisoners. One of them said that when he first went into prison in 1984-85, prison was full of criminals, but that on subsequent occasions, he had felt that some prison halls looked like mental health wards. HM Inspector of Prisons for Scotland also noted the

"frustration that people with mental ill-health are ... in prison, when a hospital setting would be more appropriate, but ... not available"

due to a lack of beds. What steps are being taken to ensure that people are not imprisoned inappropriately due to a lack of services outwith?

John Porter: That is quite a question, and I am not sure that we can answer it. Therefore, this is a personal statement. There are those who deem prisons to be the safe environment, so a sentencer will place someone with a mental health condition in a prison environment because it is a place of safety. It strikes me—as a health professional—that we do not have it right in the community. I would not support those with mental health challenges in prison being in a hospital environment either. I think that we need resources in the community to support people and reach them when they are becoming unwell, before they reach prison. If the only option is to place someone in prison because it is a place of safety, that is an indictment of Scotland's approach to people with mental ill health.

Jillian Galloway: The placement of prisoners does not sit with health, but once health needs are identified, it is important that there are clear pathways in place for people to access the care that they need, whether that is provided within or outwith the establishment.

Teresa Medhurst (Scottish Prison Service): We have anecdotal information from courts to suggest that sheriffs sometimes feel it necessary to place someone in custody for their safety. That happens probably more frequently with women than with men.

Sometimes, people are put into custody for assessment purposes and are assessed within our establishments. As Jillian Galloway pointed out, when somebody comes into custody and it is clear on admission or very shortly after that they have acute mental health problems, we all work together to support their placement in a more appropriate setting and move them there as quickly as possible. The position is variable across the country.

Alison Johnstone: What would a "more appropriate setting" look like, and is that setting always available?

10:30

Teresa Medhurst: A mental health facility would be a more appropriate setting than a prison facility. Obviously, prisons are designed for locking people up rather than for treating them, and there are certain restrictions on what types of support can be offered in a custodial environment as opposed to in a psychiatric facility.

Alison Johnstone: So if you had concerns, you would take action to have the prisoner removed.

Teresa Medhurst: Yes.

Alison Johnstone: Thank you.

The Convener: Do we know what percentage of the prison population have mental health problems?

John Porter: There is various data around—

The Convener: Is any of it accurate?

John Porter: It is accurate for the time it was published. We are probably talking about 70 per cent of the prison population having a mental health challenge.

The Convener: Okay.

Miles Briggs (Lothian) (Con): Good morning, panel. What research have you seen on the relationship between mental health and reoffending within the prison population? In many cases, we see cycles of reoffending. To what extent is that being addressed?

Teresa Medhurst: I am not aware of any research that looks specifically at mental health, reoffending rates and the move from custody back into the community. In recent years, there has only been research to try to quantify the level of personality disorders in the prison population. We did work on that when I was at Cornton Vale. I am not aware of any research specifically on mental health and reoffending rates.

John Porter: One of the recommendations of the mental health workstream was that a mental health needs assessment be undertaken for the prison population. That has not been implemented yet, but there are efforts to source funding to enable that research to be done.

Miles Briggs: Another area that I want to look into is head trauma. I have been struck by the number of people we have met—professionals in the prison setting—who have said that that is a major issue that has never been addressed early on. What work is being done in the prison service to look at that and at how support can be provided?

John Porter: The Justice Committee requested an examination of brain injury in prisons, and a workstream was secured that was led by Professor Tom McMillan. The report, which has now been published, contains a host of recommendations. I hope that you will not ask me to name them, but the report is a concise, evidence-based piece of work from a very reputable chair.

Miles Briggs: My final question is on another area that I have been quite shocked about. Professionals say that online records are a major issue and that they are prevented from being able to improve treatment for the prison population by following patient records. Have you tried to improve that but had pushback? Is it a budgeting

issue? It seems that something simple could make a huge difference.

John Porter: I did not quite understand the question.

Miles Briggs: It is about the development of online patient records. Most of the professionals whom we have come into contact with have complained about the paper trail and have said that they are unable to really focus on individuals in a prison setting. It is about throughcare—especially when people leave prison and register with a GP, it is important for information to be passed on to the GP and other professionals.

Jillian Galloway: I can speak to that, and Fiona McNeill will probably want to comment as well. Clinical information technology is an issue for everybody who works in prisoner healthcare. One system—called GP Vision—covers all the establishments, but it does not allow us to access people's GP records from the community when they are admitted to prison, because community GPs use a different GP Vision system. Therefore, the transition and throughcare back into the community are a significant challenge for us. We all have to find local solutions in how we work with primary care services to ensure that, on liberation, the transition is as smooth as possible for the patient.

National work is on-going around GP reprovisioning but, unfortunately, the prison side is out of scope for the national GP reprovisioning programme. John Porter and Tom Byrne have been working hard with the Scottish Government on clinical IT systems for prisoner healthcare. It is a significant challenge, along with the fact that we cannot electronically prescribe—all of the information about prescribing and the administration of medication is on a Kardex, which is challenging given the number of patients that we medicate.

The Convener: Are you saying that if a prisoner went to prison today and had an immediate health need, you could not access their patient record?

Jillian Galloway: We can access what is called the emergency care summary, which has key information for that patient, but we cannot access the records from the patient's GP.

The Convener: So does the GP or health professional have to guess what is wrong with the person?

Jillian Galloway: Prisoners are initially seen by a nurse who goes through quite a detailed admission process with them.

The Convener: Yes, but the prisoner might have mental health problems, substance issues or a whole range of issues that mean that they are not coherent, cannot remember or whatever.

Jillian Galloway: If the professional nurse who was undertaking the admission process had acute concerns, they would seek support from a GP.

The Convener: Would the GP be able to access the records?

Jillian Galloway: They would not; we cannot access them. If there were specific questions, they would have to phone the GP practice.

The Convener: It might be closed.

Jillian Galloway: It might be, so all we would have would be the emergency care information and whatever is on the clinical portal, which holds some key information as well.

The Convener: That is a huge gap in the system.

Jillian Galloway: Yes, it is a significant challenge.

Clare Haughey (Rutherglen) (SNP): I thank the panel for coming today. I want to take a different direction. The committee received written evidence from the British Psychological Society that noted the need for

"collaboration between the different agencies operating within the prison, including the NHS, the Scottish Prison Service and the various third sector organisations providing ... health services".

That was also raised by healthcare professionals when we sat down with people who work in the prison service to talk about the different cultures of the SPS and the NHS and how they can come together. How has that progressed over the past five years, and in which areas do we still need to see improvement?

Beth Macmaster (Her Majesty's Inspectorate of Prisons for Scotland): That is something that we frequently notice in inspection and monitoring. To make the most of the opportunity to provide healthcare in prisons, it is important that all the pieces work together. We see things going well for prisoners when there is clear shared vision and joint leadership on provision.

Teresa Medhurst: Because colleagues worked jointly over the years prior to the transition, there has been a continuing positive working relationship at operational level. There are occasionally operational difficulties, either on the NHS side or the SPS side, that hamper relationships, but we are all very clear that healthcare is a significant issue. The healthcare needs of the population that is now coming into custody are more complex, not just in terms of mental health, which has been described, but in terms of addictions, the increase in social care needs, and age, as it is a much more elderly population than we had previously. All those

complexities together mean that healthcare is much more of a priority for all of us in the prisons.

We work very hard, but there are obvious differences for a prison service. We are there to manage the criminogenic as well as the healthcare needs of individuals, and our healthcare colleagues are working in a secondary setting. We work through operational challenges and difficulties together, but the point that was made earlier about relationships is critical and key, and at operational level those relationships tend to be very positive.

Clare Haughey: It is interesting that you say that, because we heard evidence that up to 50 per cent of appointments are missed due to prisoners not being taken to the healthcare facilities in the prisons. We heard evidence of prisoners not being able to access out-patient appointments, because no escort had come for them, and we heard that there is inefficient use of healthcare facilities in prisons, because of issues to do with transferring prisoners from halls to healthcare settings. You say that prisoner healthcare is a priority but, from some of the evidence that we have received, it does not sound as though the SPS is prioritising it.

Teresa Medhurst: We absolutely see healthcare as a priority. If we cannot meet the healthcare needs of individuals, they cannot be supported to work with us on the criminogenic factors that affect them—they need to be healthy and well to be able to do that. Healthcare is a clear priority for the organisation.

I was surprised to hear you say that 50 per cent of appointments are missed. I would welcome your sharing that information, because I do not have it. Where we know that there are difficulties, we work with our colleagues. For example, when the inspection report on Grampian prison was published and it identified difficulties in the prison, we set up a strategic workshop with SPS and NHS colleagues and developed an action plan to support improvements.

Prisons are complex environments, and we must meet a number of competing demands. We need to ensure that, where there are difficulties and issues, we work together to resolve them. As I said, I am not sure about your 50 per cent figure, because it is not something that I have heard.

Clare Haughey: I should clarify that. What we were told was that about 50 per cent of clinical time is not being utilised—

Teresa Medhurst: Ah, right—

Clare Haughey: It is not that 50 per cent of appointments are missed; I apologise if that is what I said. We heard that clinicians were waiting for prisoners to be brought to their appointments. That is an inefficient use of healthcare staff time, which is finite, of course.

Teresa Medhurst: Absolutely.

The Convener: I can support what Clare Haughey said; we heard that, in addition to waiting for prisoners, healthcare staff are spending a huge amount of time investigating complaints.

Teresa Medhurst: The complaints side of things is an NHS issue—

The Convener: We will come on to that.

Teresa Medhurst: We no longer deal with medical complaints.

Let me give you an extreme example of the complexity that I talked about. Edinburgh prison has six different population types: women, remand prisoners, long-term prisoners, short-term prisoners, non-offence protection prisoners and sex offenders. It is a complex establishment, which contains populations that cannot mix. That means that people have to be taken for appointments when that is safe for them. We cannot have women in the health centre at the same time as some of the other populations. We try as far as possible to reduce operational difficulties, but where such complexities exist there is unfortunately an impact on people who are accessing services and on how access is managed.

Clare Haughey: Is that something new? Has there been a change in Edinburgh prison's population?

Teresa Medhurst: Edinburgh prison has had that population mix since 2011, I think, so—

Clare Haughey: For six years, then.

Teresa Medhurst: Yes.

Clare Haughey: Why has a system not been put in place that makes more efficient use of healthcare staff's time?

Teresa Medhurst: The issue is that Edinburgh prison has to keep populations separate; that is how it operates—

Clare Haughey: That is why I am asking. If that is a given, why has a system not been put in place that uses healthcare staff's time efficiently?

Teresa Medhurst: As far as I am aware, the establishment works to do that on a day-to-day basis. The approach that has been taken should maximise the amount of available time, but there will be operational difficulties from time to time, which will mean that the position deteriorates.

Where we are aware that there are issues and difficulties, we manage the clinics and the support that we provide. The most recent population to go

into Edinburgh prison was women prisoners and, when that happened, additional operational staff were put in to support women's attendance at appointments. Where we know that there are potential difficulties, we look at the resource requirements in order to better manage the situation.

The Convener: Let us be straight here. The staff who work in your establishments tell us that there are huge problems and that they spend lots of time on non-clinical work because they are hanging around or answering complaints. The prisoners who are in, or who have come through, your establishments tell us that they need healthcare but that they ain't getting it because the staff are spending lots of time doing nothing. That is an issue for your organisation, and it has been for some time. We are not seeing a lot of evidence that that is being resolved.

10:45

Teresa Medhurst: I will make two points. I cannot comment on complaints. On the question of down time, there are times when clinicians will not have access to individuals, because of mealtimes and other types of activity that are going on in the establishment. For example, someone may have to attend a visit with their family. There are competing demands from the other things that happen in prisons, which means that, at times, there is down time for clinicians. However, those routines have existed in prisons for some time.

The solution is to make sure that all sides are working to achieve a better outcome. As I have said, when there were issues and difficulties in Grampian, we held a strategic workshop with the NHS to look at an action plan. If there are other areas in which we require to do that, we will absolutely work with NHS colleagues to make improvements.

The Convener: Jillian, are you getting back from your staff what I am saying? I am looking at the area that you represent, and it was some of your staff who raised the issue with us.

Jillian Galloway: We are doing a lot of work locally with our SPS colleagues to improve the efficiency of the health centre clinics. On the matter of down time, we are limited in when we can access the patients. We have two or three hours in the morning for direct patient contact and the same again in the afternoon.

The Convener: Why is that?

Jillian Galloway: That fits in with the SPS regime.

The Convener: Is the SPS regime wrong, then?

Jillian Galloway: At the moment, the SPS is doing work to look at how a day runs in the service, and it is engaging with colleagues on how that can improve for both the SPS and the NHS in terms of access to patients. We are limited in the time that we have to see patients, which is different from how things are in the community.

The Convener: Out of an eight-hour day that an average clinician would work, the maximum is a six-hour window, and there is potentially a four-hour window.

Jillian Galloway: That is the case for direct patient contact, but there are other clinical duties that do not need direct patient contact, such as looking at Kardex and prescribing.

Donald Cameron (Highlands and Islands) (Con): To follow on from that, it seems to me that the relationship between NHS staff and SPS staff is the crux of the issue. That relationship has to work, and it has to do so at every level. What do you do to bring those two cultures together? Is there training? Do you work together? Will you give the committee some idea of what is done on the ground?

Jillian Galloway: NHS Tayside has a clear process for engaging with the SPS. We have a higher-level meeting with both governors of the two establishments that we have in Tayside. Part of that is to look at direction and vision for where we are going. There is also an operational meeting at which the head of nursing, the head of offender outcomes and the deputy governor discuss any operational issues. There is clear escalation from that if there is anything that we need to support. Also, some of the team leaders and nurses work very closely with the first-line managers and the unit managers in each of the halls. That is quite a new process that we have put in place in Tayside, to try to improve the relationship so that there is an element of the SPS understanding what the NHS has to do and the NHS understanding the SPS and the constraints that come with it.

Donald Cameron: What if the issue is very personal, and a prisoner says to the SPS staff member whom he or she knows best, "I have a problem with my healthcare"? Are you content that a relationship exists between that staff member and their equivalent NHS nurse, or whoever might be prescribing, or at least providing, medication?

Jillian Galloway: I am certainly not aware of any issues with the relationships that people have with their personal officers or the relationships that the officers have with healthcare staff that have caused people to feel that they could not approach healthcare staff. There are also independent monitors who come in and act on behalf of the patients and liaise with healthcare, and we work

closely with them if there is anything that we need to address.

Teresa Medhurst: There are usually designated healthcare staff for particular halls, so they will build up a relationship with the hall staff over time and they will have more knowledge and understanding of the individuals in their care. The SPS has case management and risk management processes that involve input from our NHS colleagues, so they have direct input into how we case manage individuals throughout their time in custody.

You touched on training. There are a number of areas where our training is delivered to all colleagues who work in prisons, which would include NHS colleagues, but there has been some more specific training in recent years and in some establishments on mentalisation and personality disorder, which has been jointly led by the NHS and the SPS and delivered to colleagues across prisons. As far as we can, we try to integrate as much as possible and to develop that shared understanding.

Donald Cameron: That should eventually overcome the operational difficulties that you spoke about when questioned by the convener.

Teresa Medhurst: Prisons have to provide individuals with meals three times a day, we have a legislative requirement to provide an hour's exercise every day, and we have to ensure that people have clean bedding, clean laundry and enough kit and equipment, and that the prison is cleaned, so there are a number of functions that a prison has to undertake during the course of a day. The time that is allocated for things such as access to medical care is therefore constrained by the time that it takes to provide those things to quite a significant population.

John Porter: Teresa Medhurst has touched on a good point. The efficiency of officers is paramount in determining the time that clinicians get to spend with their patients. I have heard on a number of occasions from healthcare colleagues, healthcare managers and board leads that the system works well where the health centre has dedicated officers. I am not saying how the SPS should operate, but I have heard that it works better when there is a known body at the health centre. Things seem to be slicker and more efficient and less time is wasted while people are waiting about. I know that the SPS is keen to work with healthcare colleagues to deliver that degree of efficiency.

Beth Macmaster: On the point about relationships, we see some good examples of things that work really well, but what we do not see as an inspectorate is national consistency. There is a real question for us about how some of those good examples are rolled out nationally. Although we recognise that those relationships exist in some areas, we see them working less well in others.

Donald Cameron: Can you tell us why?

Beth Macmaster: That is a hard question for us to answer. It is probably more appropriate for some of my fellow witnesses to answer it. It is about communication and, as I said at the start, leadership.

Donald Cameron: I have a specific question about the healthcare assessment. I think that you said that every prisoner receives a healthcare assessment. Are you content that that is being done to a satisfactory level in every prison and with every prisoner?

Jillian Galloway: I cannot comment on every prison, but the admission screening process that prisoners go through in NHS Tayside—I am sure that Fiona McNeill can comment from a Glasgow perspective—is quite robust in helping to identify any healthcare needs, including those relating to mental health and substance misuse. It gives access to national screening. It is a robust process.

Fiona McNeill: I echo Jillian Galloway's point. I think that there has been work to define the process over time. The questions that are incorporated in that process might look slightly different now. From an NHS Greater Glasgow and Clyde perspective, we might need to do a wee bit more work on issues such as the mental health questions that we ask. We are having a look at that at the minute, but it is in the context of a robust process in which some areas need to be a bit better.

Maree Todd (Highlands and Islands) (SNP): I have a number of questions in a number of different areas, so forgive me if I dot around a wee bit.

First, I want to tease out more information about the anecdotal evidence that we have heard of people being sent to prison as a place of safety. I have heard that a number of times when I have spoken to folk who work in prisons, and I heard it again in the evidence-gathering sessions that the committee has held here. For people with very chaotic lives, and possibly with personality disorders and addiction difficulties, prison is sometimes considered to be preferable by the sentencer, because it takes those people out of the chaotic situation that they are in.

I wonder whether that thinking underestimates the harm that is caused by prison and shows a lack of understanding. It has struck me throughout this process that the treatment of addiction and personality disorders that happens on the outside

is very recovery oriented. That type of treatment is almost impossible to deliver in a prison, which is, essentially, institutional and punitive. Will you give me your thoughts on that problem, and on how we might consider tackling it?

Teresa Medhurst: I would not want to speak on behalf of sheriffs and people who are further up the criminal justice chain than those who work in prisons, but often people who are chaotic have failed to engage with the healthcare system, and I think that sheriffs sometimes get to a point at which they are quite frustrated over that lack of engagement.

Going into prison stabilises individuals, in that they get three meals a day and have their health needs identified and dealt with. Generally, those people have not engaged with healthcare in the external environment. When they do, as I have seen from an operational perspective when I was a governor, over the first two or three weeks they start to improve, in terms of their understanding of where they are and what was happening to them, as well as in terms of just looking and feeling much better. They feel better able to engage with services and to understand what needs to come next.

The question about recovery I would leave to my healthcare colleagues, although we try to work very hard in prisons with those colleagues on recovery. There are a number of good initiatives across prisons specifically on addiction, and there is developing work around personality disorders.

John Porter: Maree Todd's assessment is spot on, and I agree entirely with what she said. With regard to recovery and all the terms that have been bandied about, and to sentencers placing people in prisons, I say that damage is done—severe damage, to some individuals.

I would be careful about the idea of recovery in prison, because people are generally in prison for a short space of time. What can we do with that population to make them recover? They will very quickly go back into that chaotic lifestyle.

For me, the issue is actually way upstream. Scotland is not particularly good at challenging health inequalities—we have a dreadful record. I think that the model is wrong. In terms of what that population needs, we need to go way back to early years and good parenting.

The effort to prevent people from going to prison should be put into in their early years. We can see that it is a postcode lottery and we can identify the individuals who are likely to go into prison. I know that it may sound like a theoretical point, but Scotland needs to have some sincere thoughts about the model and the way in which we deal with that part of the population.

11:00

Beth Macmaster: I will build on what John Porter said. Prevention is very important, and we have the opportunity to engage with people in prison and get them on the right track, but it is really frustrating that when they get out they often return to exactly the same situation that they had been in, so all that work and potential can be lost. We think that that needs to be tightened up. In theory, the transfer should have us enabled us to do more to keep any good work going, but we do not always see that happening.

Jillian Galloway: The new community justice partnerships give us a really good opportunity to build on through care. Although people are working towards recovery and rehabilitation while they are in an establishment, there should be pathways for them back out in the community that can support that and try to prevent them from returning to that chaotic lifestyle. That is a good opportunity to make a difference.

Maree Todd: We had a look at the inspection of a prison and saw that there are lots of points where you highlight good practice that is worthy of sharing. How does that process happen?

Beth Macmaster: That is a good question. Highlighting good practice is something that we could build on, nationally. There are structures and routes for sharing good practice, for example the health board lead networks and the national prisoner healthcare network. However, it is safe to say that although we see positive practice and we always comment on it, we do not always see that practice being transferred to other places. We understand that that is partly due to the complexity of different prisons and populations and the different relative scope of health boards to prioritise prisoner healthcare, but there is definitely potential for a quick win there.

John Porter: The chief inspector of prisons produces an annual report. In the past five years I have produced a summary of the health component parts of that and shared it with all the prison establishments and the Scottish Prison Service. I have not done it yet this year, so thanks for that reminder.

Maree Todd: Finally, I want to ask about data sharing. We have identified that you guys are pretty much in the same boat as an accident and emergency department or a psychiatric hospital—one of which I used to work in—in that you cannot access GP records. You can access the emergency care summary, which gives you a bit of information about current medication and allergies and so on, but it is not particularly detailed—it tells you only about the drug treatment, and nothing about the diagnosis. Another issue that has been identified by many people to whom we have

spoken is the need for electronic prescribing and administration systems. The question about whether medication has been administered seems to be a source of huge conflict within prisons. I know that electronic systems are not particularly straightforward, but could that also be a quick win? Would it be high on your priority list?

Witnesses *indicated agreement.*

Fiona McNeill: As you can see, everyone agrees, and from a health perspective we are unanimous in wanting to make more progress on that than we have been able to do to date. It is one of the things that have the potential to bring big gains to the delivery of healthcare, both in terms of effectiveness and safety issues and in terms of taking a holistic approach by having as much information as possible on which to base decisions. It would also help to reduce some of the areas where there is undoubtedly conflict.

The Convener: I am looking at the submissions and some of the issues that the national prisoner healthcare network has raised about IT. It has been five years; I presume that everyone has been moaning about IT for five years, yet nothing seems to change. Why does nothing change in something as fundamental and basic as getting a bloody IT system that works?

John Porter: I assure you that everyone around the table and our colleagues in the gallery are really frustrated too.

The Convener: So who is responsible for fixing it? If it is not you, who is it?

John Porter: We need a strong Scottish Government policy lead in order to take many of those clinical IT issues forward. It needs those e-health and other advisers in the Scottish Government to lend support. Unfortunately, the problem has taken a long time to reach the eyes and the ears of people who will enable those IT systems to be put in place. That may sound like an excuse, but it has been a frustration for all of us round the table for many a year—including prior to the transition.

The Convener: Is it the same situation with a number of the other workstreams that the national prisoner healthcare network has been working on but that do not appear to have been implemented? Is it the case that those pieces of work are done and fed up the line, but nowt happens?

John Porter: To a degree, yes—particularly those that require finance.

The Convener: Is that the experience of others?

Jillian Galloway: I think—

The Convener: Sorry—Teresa Medhurst is nodding. Is that a yes?

Teresa Medhurst: The board does not have any direct authority to implement the recommendations, and it has to go—

The Convener: So who does?

Teresa Medhurst: It has to go to the health boards and it is for the health boards to then prioritise things within their funding.

The Convener: Jillian—have you had the same experience?

Jillian Galloway: We have a clear prioritisation process to go through and, in our experience, we get support from NHS Tayside and the integration joint board to support anything that we need to do.

The Convener: But you do not have an IT system.

Jillian Galloway: We do not, but IT is a national issue.

Fiona McNeill: That would be my point—the IT issue is a national issue.

The Convener: But there are other national issues that you are frustrated with, where somebody is not making a decision to fix them. Yes? No?

Fiona McNeill: From time to time.

Maree Todd: For clarity's sake, will you tell us whether there is an off-the-shelf system out there that would give you electronic prescribing and administration or whether, as is the case for many hospitals in Scotland, such a system does not actually exist? It is not simply a financial issue, is it? There is not actually a tailor-made package there. Is that correct? Does anywhere use an electronic prescribing and administration system that you guys would like to use?

Jillian Galloway: In terms of general systems, there is GP Vision, which obviously—

Maree Todd: But that is not an administration system—that is the problem.

Jillian Galloway: Yes.

Maree Todd: So you do not have an off-the-shelf package that is ready to use?

Jillian Galloway: Not that we are aware of, no.

Maree Todd: So it is not a financial issue. Something needs to be developed.

Colin Smyth (South Scotland) (Lab): I will move on to an issue that Teresa Medhurst touched on, which is caring for older prisoners. A number of the submissions that we received highlighted that a key challenge over the next 15 years is that we will be dealing with a lot more older prisoners with more complex health and care needs. The Care Inspectorate, the British Medical

Association, the Royal College of Nursing and the Royal Pharmaceutical Society all made that point in their submissions.

What key pressures will the service face as a result of an ageing prison population? Do you consider that those challenges are being adequately met and will be met in the future?

Teresa Medhurst: We recognise that an older person in custody is someone who is over 50, which is 10 years younger than an older person in the community is—they are generally over 60. That difference is due to the health issues that are presented by people in prison. The statistics show that we are receiving more prisoners who are over 50 and that number is likely to increase due to the historical sexual abuse inquiries.

We have been working with health colleagues and with local authorities on individuals with more complex cases when they come into custody. We have also recently undertaken an assessment, which is not yet ready for publishing, to help to inform our strategy over the next three to five years so that we are clear about what actions we should be prioritising.

Currently, we have particular difficulty in accessing social care for individuals. We also sometimes have difficulty in accessing equipment. We have had to spend a considerable amount of money to ensure that individuals have appropriate care from social care providers while in prison. Unfortunately, on occasion, even though it is not part of their remit, our NHS colleagues have had to step in and assist us with particularly acute cases where we cannot access social care within the community. There is a lack of clarity about who is responsible for social care in prisons, and we were not included in the legislative changes. In one or two individual cases, we have had to accelerate decisions up to chief officer level to get agreement on who is responsible for social care support for individuals while they are in custody.

We think that that will be an ever-increasing problem in the future. The evidence that we have so far shows that there is a proportion of the population under 50 with social care needs as well—such needs exist across the range of ages. We would welcome clarity, which there is in other jurisdictions, about who should be responsible for the increasingly complex needs for which individuals require support once they come into custody. It is clear from our memorandum of understanding, which was signed in 2011, that it is not an NHS issue.

Colin Smyth: Whose issue is it? When you talk about legislative changes, are you referring to the integration of health and social care?

Teresa Medhurst: Social care in prisons was not referred to in the legislation that set up the IJBs. Therefore, it is not clear whose responsibility it is. At the moment, when we require it, we pay for agency support to ensure that individuals get the most appropriate care while they are in custody. However, there is a lack even of agency support in Scotland, so we have to try to work with our colleagues in the NHS. In some quite challenging cases, they have stepped in to provide us with the appropriate levels of care.

John Porter: Macmillan Cancer Support liaises closely with the SPS. NHS Forth Valley is working closely with the SPS, particularly in relation to the elderly population in Glenochil prison. They have adopted or adapted standards to support that prison environment and I believe that a professional lead was appointed in January to assist in driving some of those standards forward from, I hope, a national perspective, rather than just containing the work in Forth Valley and Glenochil. Good work is in progress.

Ivan McKee (Glasgow Provan) (SNP): I will touch on a couple of issues that have been covered already to some extent. I want to understand throughcare in a wee bit more detail. I ask the witnesses to describe the process for ensuring that, at the point of release, an ex-offender is registered with a GP, that they have access to other medical services that they may need and that information is passed on. I know that this is not in the scope of our discussion but I also ask them to comment on wider issues that have an impact on health, such as housing. What does that process look like and who provides it?

Jillian Galloway: On healthcare and GP registration, I will mention a couple of groups of patients. The first group is planned liberations, and we work closely with the community healthcare teams to ensure not only that throughcare is available so that the individuals can access, and have continuity of care from, mental health and substance misuse services, but that they have a GP to go back to. However, if they do not have a permanent address to go back to, that makes GP registration difficult. In Tayside, we are working closely with our primary care services on how we can support that work further. I cannot comment on the work that the throughcare officers do but, where we can, we work closely with them to ensure that there is support for throughcare for all the healthcare needs of the individuals.

The second group, and where we encounter challenges, is people who are liberated directly from court but we do not know that they are being liberated. That makes throughcare very difficult for us.

11:15

Ivan McKee: Does that happen if someone has been on remand, for example, and is released after going to court?

Jillian Galloway: Yes.

Ivan McKee: How long, typically, will you be engaged with an ex-offender after their release?

Jillian Galloway: We would not be involved post-release, but if there are complex health needs, we sometimes liaise with key individuals in the community, to ensure that key information is passed on because we do not have the clinical IT to support that throughcare.

Ivan McKee: I assume that the effectiveness of that process could have a big impact on reoffending rates, which we touched on earlier. Could improvements be made in that regard that could have an impact? I think that you said that there is no data on reoffending that we can use to guide our approach.

Teresa Medhurst: In 2015, we introduced throughcare support officers across establishments in Scotland. They focus mainly on our short-term population—so not the statutory cases—and support individuals who agree to work with them to prepare for release.

As Jillian Galloway said, one of the biggest barriers can be access to housing. We work with housing providers throughout Scotland to support individuals who leave custody, but if someone does not have an address—if they are of no fixed abode—and no housing provision has been made for them, it can be difficult for them to find accommodation on release. Indeed, very often it is a question that arises on the day of release. The throughcare support officer goes along with the person to all their appointments—with housing, with the benefits office and with the GP—to ensure that they are supported to get the best possible outcomes.

The throughcare support officer continues to work with the person for up to three months after release, to ensure that they are in a stable environment. We are talking about individuals who can be very challenging. On occasions, an individual falls out with someone at an appointment and becomes aggressive, so throughcare support officers continue to work with people to overcome as many of those difficulties as possible.

Ivan McKee: Is that support having an impact on reoffending rates?

Teresa Medhurst: The system was introduced throughout Scotland only in 2015, so it is too early for us to be able to say.

Ivan McKee: I will have a go at asking about IT, given that everyone else has done that. I want to be clear about this. GPs have a system that they use to access medical records. Can they access other GPs' medical records, or can they access only their own data set?

Jillian Galloway: The GP Vision system, which is used in prison healthcare, covers all establishments. When patients are transferred between establishments, the patient journey is reflected on Vision; it is when they go back into the community that that stops.

Ivan McKee: You cannot access GPs' records and GPs cannot access your records. Is that a technical issue or a procedural issue?

Jillian Galloway: It is a systems issue. There are two different Vision versions. John Porter might say more about that.

John Porter: It is a bit of both. Technically, such access cannot happen, and therein lies the problem with engagement. The system is not fit for purpose.

Ivan McKee: Okay. Thanks.

The Convener: We can put a man on the moon, Ivan, but we cannot do this, apparently.

Ivan McKee: Tell me about it.

The Convener: Let me make a couple of final points. First, on budgets, the table in the analysis of the committee's prison healthcare survey says that, at Shotts prison, £2,455 is spent per prisoner, whereas at HMP Grampian the figure is £6,000. Does the panel have any idea why there is such a disparity? If you had a health problem, would you rather be in Grampian than in Shotts?

Jillian Galloway: I suppose that it depends. The number of prisoners and the size of the establishment will be different.

The Convener: There is a wide variation, from £2,500 right up to £6,000, and everything in between.

Fiona McNeill: When we were pulling that information together from the perspective of NHS Greater Glasgow and Clyde, we really struggled with the question, because the way in which we had to answer it gave a false picture. Dividing the budget by the number of prisoners takes no account of prisoners who have extremely complex needs and who require lots of healthcare input. If we were able to quantify that and give much more detailed information, we would see quite a disparity in the cost, depending on the prisoners we have to deal with and the needs that they present with.

In some respects, the figure is historical. It is associated with what was available at the point of

transfer, with uplifts over each of the five years since then. However, in other respects, it is not a true reflection—it is simply a mathematical exercise—and the actual picture for a prisoner or patient might look quite different, depending on the needs that they present with.

The Convener: If only we had an IT system that could quantify those costs.

The final issue relates to healthcare complaints. If we look at the table that has been provided, we see that complaints seem to have increased dramatically over the five-year period. Why would that be?

Beth Macmaster: I can say a little bit from the perspective of the independent prison monitors, who deal with a large proportion of complaints in relation to healthcare. When monitors look into these matters, they often find that nothing has gone wrong with regard to clinical decisions or policy not being followed. What is wrong is the extent to which people feel involved in or informed about decisions on or plans for their care, because communication has been lacking.

The Convener: That is not what is in our briefing from the Scottish Parliament information centre, which says:

"The most common reasons for complaints tended to be around the treatment received, waiting times, staff conduct and medication."

Beth Macmaster: Absolutely. For instance, on medication or waiting times, the issue is often partly to do with people feeling that they do not have clear information about how long they will have to wait for an appointment. It is not necessarily that the waiting time is longer than we would see in the community; the problem is that people do not know how long they will have to wait. Similarly, with medication—

The Convener: Are they not told?

Beth Macmaster: Often they are not—they do not receive that information.

Fiona McNeill: I echo Beth Macmaster's comments. We recognise that communication is an issue. It is about people's expectations. Across the prisoner healthcare sector, we are trying very hard to be much clearer about what patients can expect from healthcare provision. We provide literature and face-to-face information, and communicate in lots of different ways about, for example, dental care and the likely waiting time for an appointment for a routine dental inquiry, or what patients can expect and what we ask of them with regard to medication. We recognise that the more information that we provide up front, the easier it is for patients to understand what to expect from us. The hope is that that approach will promote a dialogue, rather than people complaining if something does not go the way that they expect.

The Convener: If the waiting time is two weeks and a complaint comes in from a patient saying, "I have waited two days and I have not been seen", that is not a real complaint.

Fiona McNeill: There has been a fair bit of debate and communication between us and the ombudsman about how we handle those issues. There is an aspiration that, with its greater emphasis on resolving issues informally and a longer period of time in which to do that, the new complaints procedure that is being introduced from 1 April will have an impact on the number of complaints, and on communication and expectation more generally.

The Convener: I am afraid that time has beaten us, but there I have one final question for John Porter. Can you help the committee by providing some additional information about work that your organisation has done, and any recommendations that have been made and whether or not they have been implemented? It would be good to hear about both the work that has been done and has been followed through, as well as the work that has not been followed through. We will finish the inquiry very soon—at the end of next week—so you would need to send us that information as soon as possible.

John Porter: By the end of next week?

The Convener: Yes, if you can. I am sorry about that.

John Porter: That is okay.

The Convener: I thank the panel for attending this morning. I suspend the meeting briefly.

11:24

Meeting suspended.

11:29

On resuming—

The Convener: We will continue our work on healthcare in prisons. I welcome to the committee Aileen Campbell, Minister for Public Health and Sport and, from the Scottish Government, Daniel Kleinberg, head of health improvement, and Professor Sir Lewis Ritchie, adviser on public health.

Minister, would you like to make a brief opening statement?

The Minister for Public Health and Sport (Aileen Campbell): Thank you, convener and members of the committee. I will offer some brief introductory remarks.

The aspiration for parity and consistency of care, both in prison and in the community, unites everyone concerned with prisoner healthcare. However, it is important not to lose sight of the fact that the prison population is already very different from the general population, precisely because prisoners come from some of the most vulnerable parts of our communities. That means that many of the people who are most at risk of offending and being deprived of their liberty already come from places in our society where ill-health rates are unfortunately very high and where the impacts of poverty, addiction and mental and physical disease are much greater than average. As HM inspector of prisons, David Strang, points out in his submission to the inquiry:

"Many have poor health before they are sentenced to a term of imprisonment; this can be exacerbated by a period of incarceration."

That is not to suggest that we can be complacent. I am simply reflecting the fact that, as in the general population, some of the poor health that prisoners have is produced over lifetimes by the environments from which they have come. However good our healthcare is, whether in the community or in prison, those inequalities need to be addressed beyond treatment in isolation. In the general population and in the prison population, the effects of those inequalities are long lasting and complex. That is why since April 2013 we have invested £296 million in mitigating the harmful effects of welfare reforms, and it is also why public health measures that are focused on the most deprived communities—for example, smoking cessation and minimum unit pricing—will be disproportionately important.

Turning to the provision of healthcare in prisons, I want to thank the staff from the NHS, partners and the SPS who, day in and day out, work hard to support prisoners and their families. There is a frustration that, since the transfer of responsibilities to the NHS, progress has felt slow, but almost all involved recognise that progress has been made in parts, and an aspiration for more consistency in provision is a common theme among those who work in what is a hugely challenging environment.

Macmillan Cancer Support's partnership working with the SPS, the NHS and local authorities to support prisoners' palliative care needs is a good example of what is possible, as is the work on dementia that Alzheimer Scotland has done at Shotts. There is always more to do, but the extension of waiting time standards to drug or alcohol treatments in prison settings has been a real positive and is an example of seeking to make an offer that meets the standards outside the prison walls. In prisons, 1,136 people started their first drug or alcohol treatment between October and December 2016, with 96.8 per cent waiting three weeks or less. That sits alongside the hugely beneficial local work on recovery that is taking place in individual prisons.

It is also important to keep sight of the structures that are there, even if we need to increase traction. Prison healthcare is the responsibility of integration joint boards and health boards, and Healthcare Improvement Scotland provides the health input to the inspections of prisons that are carried out by HM inspectorate of prisons for Scotland. Where recommendations are made in those inspections, local boards will work with the prison authorities to meet the required standards and levels of care.

I share the analysis of some of the challenges that we and partners face going forward. Having better data collection and a move towards a consistency of care are things that we all want and which we will seek to deliver against a challenging backdrop and inherited legacy systems. Given that ensuring the safety of prisoners and staff is a critical part of prison care, issues with general things such as transport and specific things such as needle exchange cannot be overcome easily. I believe that the collection of data and partnership working on access to services need to be front and centre of the forthcoming work programme for local partners and the national prisoner healthcare network.

NHS standards for provision of primary care apply to the provision of care within the prison setting 24 hours a day. Sir Lewis Ritchie's report "Pulling together: transforming urgent care for the people of Scotland", which was published in November 2015, acknowledges that more work needs to be done to improve the resilience of out-of-hours services for prisoners, particularly with regard to electronic national record linkage and quality assurance of the services that are delivered across Scottish prisons. Work is already under way to ensure that the clinicians who work in prisons will have access to the information in the healthcare IT system for people who are in police custody. Up to now, that has been a gap in data access, and that work will be built on with the further exploration of access to data and data linkages as part of the report's implementation.

We also know that many people have poor mental health before they are sentenced to a term of imprisonment, and we know that, if we can get things right—or at least better—for those with mental health issues who come into contact with the justice system, the benefits will be felt across communities in terms of longer and healthier lives, reduced reoffending and reduced victimisation. We expect the next mental health strategy, which is due to be published imminently, to give renewed impetus to collaborative working on prisoner mental health. In order to strengthen the drive for

change, we are making the improvement of our response to mental health in justice settings a key priority in the justice strategy for Scotland, which is presently being refreshed.

We are glad that the SPS is taking on the commitment to make prisons smoke-free in the next five years, for the sake of prisoners and staff. For my part, that means an on-going focus of cessation resources in areas and communities of greatest need and deprivation.

I conclude by going back to my opening comments about the environment and the wider context from which prisoners come. Prisoners often have young families, and—in addition to treatment within prison walls—our support for the expansion of prison visitor centres to support families is hugely important.

We have worked to move away from short sentences and the unnecessary use of remand because the deprivation of liberty is, rightly, a last resort. It is encouraging that Scotland's average daily prison population is at its lowest level for a decade. All the moves that I have set out are important in adjusting the use of prison so that it supports rehabilitation as much as possible.

I thank the committee for its interest, and I am happy to answer any questions.

The Convener: Thank you, minister. We are very tight for time, so short questions and answers would be appreciated.

Donald Cameron: I thank the panel for coming along today. In the evidence session that we have just held, Teresa Medhurst, who is the director of strategy and innovation at the Scottish Prison Service, made a startling admission about who is responsible for social care in prisons. She said that the SPS was not included in the legislation for integration; that the NHS was categorically not responsible; and that she was unclear as to where responsibility lay.

Given that we have an ageing population in our prisons, and in the context of integrated health and social care, do you recognise that there is a gap there? If so, what is the Government doing to identify who is responsible?

Aileen Campbell: On a range of issues that the committee has been looking at, it is fair to say that—as we have heard from the witnesses earlier today and from witnesses at previous meetings—despite the improvements that have been made, there is still room for further and greater improvement and for the pace to pick up.

The SPS is responsible for social care, and we would expect it to take the lead on that. That work will be enhanced by the integrated joint boards as part of the structures that support social care provision across the country. I understand that the SPS has recently completed a review of social care provision across the prison estate. There are national care standards to which the SPS must adhere, and HMIPS, assisted by the Care Inspectorate, is responsible for inspections in that regard. A regime and a structure are in place.

On the point about whether there are improvements to be made, I imagine that that is the case in all areas of healthcare and social care across the prison estate. The SPS is responsible for leadership on social care.

Donald Cameron: The organisation Families Outside said in its submission that, although the new national standards to which you referred

"make a welcome recognition of the ... issue of"

social care for prisoners,

"many of the Standards fail to apply to the care of people in prison."

What steps are being taken to ensure that the standards apply? It is obviously important that they apply.

Aileen Campbell: Absolutely—and we will continue to work with partners across the piece to make the necessary improvements in light of the comments that the committee has received. Again, there must be collaborative partnership working among the health and social care partnerships. There is advice from the Care Inspectorate that goes to HMIPS, which will add to the process of regulation and scrutiny. We have in place the structures and a regulatory and inspection regime. Together, those things will help us to motor forward in making improvements in social care.

The Convener: I want to pick up on something. You said that it is the SPS that is responsible for social care. Would it surprise you to know that the director of strategy and innovation for the SPS told us in the earlier session that she is unaware of—or it is not clear to her—who is responsible for social care?

Aileen Campbell: The SPS currently pays for social care services for prisoners who require care—

The Convener: So there is absolute clarity that it is the SPS that is responsible for social care.

Aileen Campbell: If there is a feeling that there is not that clarity, we will continue to work on that, but the SPS currently pays for social care services.

The Convener: The SPS is either responsible or not. Is there any dubiety about whether it is responsible?

Aileen Campbell: No—there is no dubiety.

The Convener: That is fine.

Colin Smyth: To follow up on that point, the memorandum of understanding is currently between the Scottish Prison Service and the health boards, and it does not seem to include integration joint boards. Why are health boards responsible for healthcare in prisons, but integration joint boards are not responsible for social care in prisons? Why is there a difference between the approach to social care and to healthcare?

Aileen Campbell: You are right that the landscape is changing. The biggest fundamental shift since the inception of the NHS involves how health services are delivered, with the integration of health and social care. Prisons are not part of that legislative change and have some distinct needs that I think are rightly addressed by prisons themselves, given the complexity of the need and of the challenges that exist within the prison estate. Therefore, there are good reasons for them not necessarily to sit within the legislation. However, partners are expected to work together collaboratively to ensure that prisons get the services that they are entitled to, and those include healthcare and social care.

Daniel Kleinberg (Scottish Government): That is right. Prisons were not left out of the Public Bodies (Joint Working) (Scotland) Act 2014; the legislation focuses on delivery of the service. Health services are provided to prisoners on the same legal basis as they are provided to the rest of the population. Health boards work very closely to make services available to persons who are physically present in a health board area. However, because of the special circumstances of prisons, there is a different type of negotiation. In practice, that means buying the service in, and the SPS does that through third-party providers, typically.

Colin Smyth: I am not clear why health boards are responsible for healthcare in prisons but the Scottish Prison Service is still responsible for social care. Why did we not change that when integration came in?

Daniel Kleinberg: As the minister said, change has come along since integrated authorities came into play. There is perhaps a case for considering how things are operating in practice in local areas.

Aileen Campbell: The inspection regime and how things are monitored will drive forward improvements, and that will illustrate where further work possibly needs to be done. If that is considered to be a gap, we can reconsider the position and refresh. At the moment, however, the memorandum of understanding between the NHS and the SPS illustrates the different responsibilities of the two, with social care resting with the SPS, inspected by HM inspectorate of prisons for Scotland and supported by the Care Inspectorate.

Daniel Kleinberg: As far as I can see, the population is already accommodated, fed and cared for within a prison environment, nearly uniquely, so quite a lot of the things that would be attended to under care standards in the general population are already a feature of what is required in a prison setting. There are also security requirements over and above that, and there are specific considerations, with services being brought into the generality and on-going negotiation required.

Colin Smyth: For instance, the Government has a commitment to ensure that everyone who requires it has palliative care by 2021. Are you saying that the Scottish Prison Service will be responsible for delivering that and ensuring that palliative care is available to everyone in the prison service? There will be growing demand. Are you happy that the SPS is in a position to ensure that that type of commitment is delivered?

Aileen Campbell: There is already good practice around palliative care, with the partnership between the SPS and Macmillan. Other partners are brought in on palliative care standards, too—whether that is the local authority or the NHS more generally. That illustrates precisely where good collaboration exists across a number of disciplines, professions and boundaries to drive forward standards of care for that ageing demographic and for those prisoners in the prison estate who have conditions that require such support.

Maree Todd: I want to ask about IT. The issue came up pretty much across the board—with everyone we spoke to. The Vision system that is used in prisons is unique and does not connect with the Vision system that is used by GPs. The GP Vision system is being rescoped at the moment, and the prison system is outside of that. I can understand that in a way. However, clearly, the prison system needs electronic prescribing and administration. I just want to check that that will be getting looked at somewhere.

11:45

Aileen Campbell: Absolutely. That has been a clear theme throughout your deliberations and in the evidence from the people on your panels today and previously. No doubt the issue has also been raised with you in your engagement with the various stakeholders who are involved in this work.

There is a clear issue that we need to address, and that is why the Government's e-health division has commissioned further analysis with regard to establishing more functionality in the system as

well as the technical requirements for the prison Vision system. The on-going work and the recommendations to follow from that will also include e-prescribing.

The issue that has been identified is causing a challenge, but I think that the work that we are doing to address it will allow us to make significant improvements. With a number of the issues that have cropped up, the collection of data and the inability to do things in a timely and efficient way have been clear components. The work will unpick and unlock a lot of the challenges that exist.

I do not know whether Lewis Ritchie would like to add to that.

Professor Sir Lewis Ritchie (Scottish Government): Clearly, IT development is something that is compelling not only in the prison sector but in all healthcare settings in Scotland. I conducted my review of out-of-hours services 18 months ago and the report was published 16 months ago. One of our recommendations was that we should try to unleash the considerable potential of electronic records, which we have yet to do. In order to move this on, one of the things that I am currently doing with colleagues is looking at how my report is being progressed in reality. There were 21 recommendations, and we are currently looking at progress.

The Convener: How many of the recommendations have been implemented?

Sir Lewis Ritchie: I cannot tell you that yet, sir, but the progress report is likely to be available within the month. I am encouraged that there is some progress, but there is still a lot to be done. When I produced my recommendations, I said that some things would come quickly and some would take much longer, particularly those in relation to workforce issues—11 of the 28 recommendations were on workforce development.

One of the principles that we identified was that any development of services should be intelligence led. That takes us back to the point about the importance of data collection, electronic systems that can communicate more effectively and the capacity to shape services with up-to-date information and diligence.

The Convener: The impression that we got from the previous panel was that everybody has known for five years that IT is a problem but not a lot has happened. That appears to be due to a lack of implementation and of leadership from above. Why have we not seen any movement on such a fundamental thing as the ability to access patients' full records when they come into the service? That is just a basic, fundamental thing. When can we expect to have a functioning IT system that talks to the GP system?

Aileen Campbell: The way that you articulate the issue maybe belies the complexity of some of this, and the sensitivities. We have identified that this is an issue, and that is why the Government has commissioned the analysis and research to look into the system and see what improvements we can make around functionality, including electronic prescribing and a host of other things. That involves making the systems talk together more effectively to ensure that data collection and sharing can be done in a much more adequate way. The first bit of work is expected to be with us in May, and thereafter we can keep the committee informed about what practical improvements we can make going forward.

The work has been commissioned to identify the gaps and improvements to increase and enhance functionality and to identify where we can collect the data that is so important to move forward the health of the prisoner population. That information will be with us in May; we will keep you informed as the practical improvements can be rolled out.

The Convener: Have you any predictions of a date when we might have a system?

Aileen Campbell: I have given you the date when we will get the analysis of where the gaps are. What we need to do—

The Convener: The analysis has been there for five years. People know—it has been raised by the network and others—

Aileen Campbell: The work is about the specificity and functionality. It is a complicated issue, but no one is under any illusion—the system is not ideal. If the people who work with it feel that it is clunky, does not deliver what they want and causes issues, that is something that we want to sort. That is why the Government has commissioned work to identify what practical improvements we can make to enhance the system. The analysis will be with us in May, and we can then work out how we will roll out practical improvements. I offer to keep the committee informed as that work progresses.

Are there any further issues?

Sir Lewis Ritchie: Optimal use of current systems is important for urgent care services across the country. Consistent data sharing will be key, so this is not just about new systems, but about how best systems are used.

Alison Johnstone: The Royal College of Nursing comments:

"Not unlike other services within Scotland's NHS, budget and workforce were seen as the main pressure points in terms of delivering healthcare in prisons. The demand for services in prison outstrips the resources available to fund and deliver care."

Furthermore, the British Dental Association notes that

"waiting lists have increased and the general oral health of the prison population ... is not improving."

We heard from the earlier panel that there is not a recognised workforce model for healthcare in prisons. Do we need to address that? How can budgets and services be better directed to improve the health of the prison population?

Aileen Campbell: On your last point, in my opening remarks, I talked about how the health inequalities that we experience in society are further magnified within the prison setting. There is a need to tackle some of those ingrained and deep-seated health inequalities in the prison population, which make healthcare complex, challenging and tricky. The shift towards ensuring that we treat prisoners within the health setting, as opposed to where it was done before, is the right move, because prisoners should be entitled to—and rightly expect—the access to healthcare that they deserve and need, in the same way as if they were not in a prison setting.

For that reason, we expect NHS boards to marshall resources in an appropriate way to cope with the health issues that are experienced in a prison setting. As a Government, we have invested in our NHS—there is record investment in the NHS and greater numbers of people working there. That does not take away from the fact that this is a challenging set of circumstances with a challenging fiscal backdrop to making progress, working with the resources that we have to make the improvements that we and prisoners expect.

On the issue of one model or template, it is important to recognise that every prison is different, so perhaps the expected outcomes of improvement might not be delivered if we were to have a one-size-fits-all approach for prisons. We cannot compare HMP Cornton Vale with HMP Peterhead, which might make it more difficult to have a single model for how to configure the workforce. For those reasons, I do not think that that would be the best way forward. Nevertheless, the RCN is right to point out where improvements need to be made, and our chief nursing officer, with her colleagues, is working through the RCN report recommendations to make further improvements and to take forward some of the actions in the report.

Daniel Kleinberg: I am in the health improvement division, which works on public health, so my most immediate contacts are around tobacco, alcohol and substance misuse as well as wider health inequalities. On the point about a single workforce template, we have done an awful lot of work with the prison service, the NHS and local health and social care partnerships on drug and alcohol waiting times and treatment in prison, which is a very challenging environment. The thing that I take away from that is just how difficult it would be to apply a national workforce standard in different areas.

The submissions to the committee from individual health and social care partnerships show that it is hugely important that each partnership works through the needs of its prison population. We need to make a very different offering in Polmont than we do in Perth. The nature of the men is different, the treatment required is different and what recovery might look like can be very different. Therefore, I am not sure that I could ever generate one workforce template for drug and alcohol treatment. What is required is to input clinical and professional judgment into understanding local populations.

Aileen Campbell: I think that Alison Johnstone also mentioned dentists. Work will be done this year to survey improvement in oral health since the NHS took over responsibility for healthcare in prisons. That will give us more data and an understanding of where further improvement is needed.

Sir Lewis Ritchie: Needs assessment is why you cannot have one size fitting all. What we have discovered in relation to urgent care in the round—clearly, it also applies to the prison service—is that, basically, we need to scale up our workforce according to the needs of the population, which are changing. As we have heard, the prison population is ageing and new needs are appearing, such as a need for palliative care—and good work is being done on that, sponsored and supported by Macmillan Cancer Support. Interagency collaboration of a very high order will be required. The prison setting is a good example of where that should happen, and where it is happening.

Alison Johnstone: I am aware that we are tight for time, convener, so, if I may, I will ask my two final questions together.

Our papers show that there are clear differences in the budget spent on healthcare per prisoner and that prisoner healthcare complaints rose markedly between 2012 and 2016. In 2012, there were 37 complaints from HMP Edinburgh, but the figure rose to 513 in 2016. Has any work been done on the correlation between the spend per prisoner and those complaints?

My final question relates to the comment by John Porter, on the earlier panel, that with regard to health inequalities, we still do not have the appropriate model. Obviously, we would like more emphasis on prevention, which would help to reduce the number of people who find themselves in prison. When people are in prison, there is an

opportunity to tackle health inequalities. However, we have heard from ex-prisoners about a lack of throughcare when they leave prison. One prisoner told us that, after managing to be clean for eight months in prison, he came out and found himself with a needle in his arm within 48 hours. That lack of throughcare and services when people leave is a universal experience.

Will you address those issues about complaints and the need for better throughcare?

Aileen Campbell: On complaints, prisoners have the right to ensure that their voices are heard and that their concerns are known. Obviously, we also have the inspection regime in place. We have taken action to ensure that prisoners have equitable access to the NHS complaints procedures following the NHS assuming responsibility for healthcare in prisons.

We probably all appreciate that more needs to be done on throughcare. We also need to ensure that our public services understand the vulnerabilities of the population at the point of liberation, what support people need and how they can get it. We need to ensure that the good work that is often done in prison is not undone because of a lack of support once people are back in their community. It is a frustration that is probably felt in the prison service generally that all that good work has been for naught if a person spirals back into their old habits.

We want to ensure that the right support is there. That is why the Cabinet Secretary for Justice is leading work on reoffending by chairing a group of ministers with a host of responsibilities, including Kevin Stewart, with responsibility for housing, Jamie Hepburn, with responsibility for employability, and others with responsibility for social security. We need to get the holistic picture right and to make improvements to throughcare to ensure that vulnerable individuals are given the support that they require.

There is a statutory obligation to provide throughcare support to individuals who come out of prison after four years. A range of people, organisations and groups are there to support prisoners. Some of the learning from your earlier session is that perhaps people feel that there is not such consistency, so we need to make sure that that is done better.

12:00

Clare Haughey: I want to ask about mental health in prisons, and I refer members to my entry in the register of members' interests, which shows that I am a mental health nurse. We know that prisoners tend to have proportionally more mental health difficulties than the general population. We heard in the previous evidence session that up to 70 per cent of prisoners have a mental health difficulty. What planning is in place to ensure that prisoners have timely access to mental health services?

Aileen Campbell: That is the subject of considerable effort, which will be further enhanced by my colleague Maureen Watt's refreshed mental health strategy and the work that justice colleagues are doing to refresh the justice strategy. The strategies will provide a sharper focus and allow for greater collaboration on the improvements that need to be made in relation to mental health in the prisoner population. In common with people outside prison, those in the prisoner population have the right to expect adequate and timely input from the right mental health practitioners. The mental health strategy and the collaborative work by justice colleagues will create an impetus and drive further improvements on that.

Miles Briggs: I want to touch on issues around liberation. When we meet professionals and prisoners to talk about reoffending, it is interesting to hear how important liberation and breaking the cycle of offending are. What health expectations should someone leaving prison have?

Aileen Campbell: I think that you are asking about what responsibilities health boards have. To pick up on some of the themes that we have been discussing, there should be adequate transition for mental health support, if that is required, and continuation of work on smoking cessation or drug dependency. That will transfer to the individual's GP through their records. Although we acknowledge that there are improvements to be made around data sharing, some of that work is transferred to their GP in the community setting. Those individuals should expect the same help as anyone else. There should be adherence to the same targets and guidelines, regardless of whether an individual has had a period in prison.

Daniel Kleinberg: I want to add something on the substance misuse work, given the terrible story that we heard earlier. Quite often prison is a setting where we can stabilise somebody, but however good the throughcare outputs are—they are variable—when the person is out of prison they still have to want to attend their local group and they still need to be able to get to it or to access whatever harm reduction or recovery approach they want to take. That is challenging, because quite often we are dealing with people who have chaotic lifestyles and who, having just been released, do not necessarily want to engage with the authorities. That is partly why we have supported the provision of Naloxone kits within prison, because liberation is a risky time for individuals who already have a high-risk lifestyle.

Miles Briggs: We have heard evidence that the opportunities are not really being realised in that regard. Someone might not be registered with a GP before they leave or they might not have their housing organised before they walk out. Giving someone £70 to go and sort their life out is not really going to resolve anything.

More important, according to the people I spoke to, was the option to have a placement or accommodation away from their home community, because they knew themselves that they would be returning to a peer group where reoffending would take place within hours, as Alison Johnstone mentioned, which would just put them back. That is an area where we need to see improvements made. People wanted to be helped, but that help was not available.

Sir Lewis Ritchie: I regard it as a form of anticipatory care planning. In order to transform health services, there needs to be a significant endeavour to pre-empt things and to plan ahead, rather than just waiting for the crisis to happen because an opportunity has been missed. That is important in relation to the prison population, but it is also true of other vulnerable members of society, who should get the best service according to their need.

Aileen Campbell: The prison services liaise to bring together the support that is required for social care in the prison setting and we would expect the same holistic approach to be taken when somebody leaves the prison setting. That is why the Cabinet Secretary for Justice, Michael Matheson, has convened the ministerial group on offender reintegration, because we have all got a stake in reintegration. That includes housing, employability and the mental health support that people require, so it is broader than just health. It is a bigger task that requires many different players, disciplines and departments to come together and to work on anticipating the vulnerability of somebody who is leaving the prison setting. Also, while the prisoner is still in the prison setting and the prison service is responding to their social care needs, they are taking the lead on bringing together a whole host of disciplines to ensure that that prisoner gets the holistic support that they require.

The Convener: The previous panel was at a loss to tell us who leads on that work. Can you tell us who the lead civil servant and the lead minister are?

Aileen Campbell: I have just described how there are a number of different ministers with a stake in reintegration; unfortunately, life does not fit neatly into one ministerial portfolio. There is blurriness around the lines, because my colleague Maureen Watt has responsibility for mental health and I have responsibility for public health, so a range of ministers have a cross-portfolio interest. Healthcare in the prison setting sits with the health department. I have outlined a number of ways in which—

The Convener: Who are the two leads on prison healthcare?

Aileen Campbell: It sits within the health team.

The Convener: Is it yourself?

Aileen Campbell: It is myself, and Maureen Watt will take an interest around mental health, which is a huge part of the whole picture. It is more than just one minister. It is a department and it is cross cutting many other areas in terms of throughcare.

The Convener: Is it the same for the civil service side?

Aileen Campbell: Yes, I would expect that to be the case.

The Convener: You see, minister, I think that that is a problem, because people do not know who they should feed the information to. It seems to be very much across the piece. The witnesses on the previous panel did not know who they were reporting to or who they were getting information from.

Aileen Campbell: Leadership is also required at local level. Rightly, we need to drive forward improvements in a national sense, and that is why we have commissioned work to analyse the greater functionality that we require around our IT systems and what more we need to do around throughcare. The chief nursing officer is working with her colleagues and through the national prisoner healthcare network to determine what improvements are needed in light of last year's RCN report. There are also the integration joint boards and the health departments, so a collaborative approach is required, and there is a requirement for national leadership to drive forward improvements in a prison sitting.

Healthcare sits with me, with the cabinet secretary and with Maureen Watt across the piece, because of the complexity and need of the prison population. That means that the civil service has to work across portfolio, but that is better than having prison healthcare sitting in one, strictly defined place, without that collaborative work across government. We recognise the requirement to drive improvement and that is why we work across portfolios and different departments, to ensure that we do that holistically, as well as in the throughcare of prisoners once they have been liberated.

The Convener: Finally, it may have been a slip of the tongue, but you mentioned Peterhead prison, which closed in 2013.

Aileen Campbell: I apologise for that.

The Convener: I thank the panel for attending the committee this morning.

12:10

Meeting suspended.

12:11

On resuming—

NHS Governance

The Convener: The third item on our agenda is NHS governance. We had an informal evidence session with NHS staff this morning. I put on record my thanks to the staff for coming in and speaking to us candidly. Does anyone want to reflect on what we heard this morning?

Clare Haughey: I found it a really interesting session and I would like to thank the staff who gave their time to come along and talk to us. One of the things that I picked up was that staff are keen on having an NHS Scotland-wide governance strategy or guidance. Although each health board has its own governance, the staff felt that, given that we are a small nation, it should be an easy win to have a national framework.

The Convener: Are there any other issues that members want to put on record?

Miles Briggs: Everyone that I spoke to this morning kept coming back to the word "communication". They were quite clear that communication in our health service has taken many steps backwards—that is from whistleblowing right through to people wanting to feed their concerns to management but not feeling confident to do so or that those concerns would be acted on. Some of the specific points were about the increasing levels of long-term sickness and management not ever linking in with staff. A key issue was that it is not only that people who have problems do not even know who the management are and so do not know to whom to take those problems, but also that there is a need for senior management to shadow staff and see what they are dealing with, so that they are not just looking after the beans but understand what people are facing on the front line. It was disappointing to learn that that problem is widespread across the health service.

Alison Johnstone: I got an impression of an organisation under a great deal of stress. I learned that they were working at 100 per cent capacity all the time with probably around 85 per cent of the staff that they need and that that lack of communication often came from a lack of time—managers simply do not have time to manage properly and develop their own skills and expertise in management.

I also heard about a culture of under-reporting incidents because of fear of the potential implications. I was also told about a lack of consultation, even about something as simple as decisions on uniforms: a move to a one-uniform-fits-all policy had led some to feel faceless, as if

they were numbers, not people. I also picked up that people felt that they thought that they had entered a profession, but that it had been turned into an incredibly hard job.

12:15

Donald Cameron: I echo what Alison Johnstone has said. I sensed a lot of strain and stress in what people were saying. I was also struck by the use of the phrase "defensive culture" with regard to the NHS, and the sense that everyone felt very defensive about what they were doing. That is something that we need to address.

The Convener: I picked up a number of things, but one thing that I noted was that, at the end of the discussion, everyone asked us to ensure that our work makes some kind of difference. The majority of people said that the pressure that they were under was unlike any pressure that they had felt before in their career in the NHS. All of them were able to highlight the camaraderie and the solidarity that they have with each other in providing healthcare; however, they said that although they got great support from their colleagues and that they often received letters, cards or whatever from patients who had been provided with very good care, they were rarely told "Thank you" with any sincerity by people up the tree in the management system. That was a general theme that emerged from quite a few people.

In fact, a number of people told us that they did not know the senior managers in the system—they did not even know the name of the site director of a particular hospital. I find that quite remarkable. I am not talking about one or two people who might have had a grievance or problem; it seemed to be a general theme.

I wrote down a number of concerns or issues, but I really want to highlight the issue of long hours, on the basis of its being in the media both yesterday and today. A junior doctor told me that she had just come off five shifts of seven days on, two days off, working for 11 hours each day. To me, that does not sound healthy either for her patients or for her. She also mentioned that a number of her junior doctor colleagues had already left either the country or the profession, because of the pressure that they were under. I found that quite concerning, given what is in the media.

A whole range of other issues, including staff appraisals, sickness absence and continuing professional development were also raised, and we will ensure that those and everyone else's points are captured in our report. To that end, I ask that people forward such issues as soon as possible.

Maree Todd: The stress associated with having to work at 100 per cent all the time was undoubtedly raised with us, and it was certainly made clear that there was a culture of working overtime and that many of the staff found that difficult. However, I want to highlight some of the positives that were highlighted; indeed, one of the people in our group commented once or twice that we seemed to be talking entirely about the negatives without mentioning the positives.

One of the positives that was mentioned and which we should get on record was the fact that there is now much better multidisciplinary team working than there has been in the past, and that is considered to be a real strength in terms of governance. Moreover, despite the risk of CPD time being lost and the fact that it is the first thing to go if the system is under pressure, there was a perception that the situation was slightly better than it had been a couple of years ago. People felt that there might have been a slight improvement, with CPD being given a higher profile than it had a couple of years ago.

The Convener: A couple of people said that if sickness absence went up, it ate into the CPD budget. I could not quite understand the link between those two things—we can look into it—but according to those people, if sickness absence goes up and up, the CPD budget goes down and down. That seems like quite a strange way to operate. Did you hear that, too, Miles?

Miles Briggs: Yes, and I have to say that I was not sure how that was budgeted for.

I also want to mention targets. Obviously work is going on in that respect, but some of the people to whom I spoke said openly that targets were constantly being fiddled. A lot of that was about being asked to say that you had met targets that, in many cases, people thought were completely unachievable. I was concerned by what seemed to be a culture of fiddling to chase a target instead of looking at the patient experience. Moreover, I got the sense that we had this incredible resource of people who had worked in the health service for, in some cases, 30 years but who felt that they were not being listened to at all.

Ivan McKee: On your point about management, convener, when I asked the folk who worked in acute hospitals what the management structure above them looked like, they sort of laughed at me. They could not begin to describe, say, how many levels there were, who was responsible for what or who was in charge. I therefore echo your point that there seems to be a lack of clarity and transparency around who is responsible and who is managing things.

The Convener: To be fair—and many of the people to whom we spoke this morning were fair—

I should say that those who made that point did not particularly blame the people at management level, because they know that they are under immense pressure to deliver whatever they have been told to deliver. The whole issue is the tension between the pressures that are on the system and the fact that things are being driven from the top without consultation with the people at the bottom about how they should be implemented. The people we spoke to said that they had many ideas about how to implement change but they just did not know how a change that came from the top down rather than the bottom up could ever be implemented. They said that they were able to implement some change in their ward or section, but when they saw the bigger changes that needed to happen, they found it very difficult to influence what was happening at the top. That is what I picked up from the discussion.

Maree Todd: Our group raised the issue of the system not having enough room at the moment to test change. Clinicians are naturally very cautious about changing procedures, because they do not want to move from what they know is an effective system to something that is new and which might be less effective. There was therefore a concern about it not being possible to test change because the system is running at such capacity.

The issue of targets also came up in our group, but no one mentioned anything about fiddling. Instead, we heard that targets were being adhered to almost without any possibility for clinical judgment to be made. With a target that might have been plucked out of the air—say, 12 weeks for a certain operation, or something like that—there was no room for a clinician treating a patient to make a clinical judgment as to whether the patient could wait longer or whether they needed the treatment sooner. The target was driving when care was to be delivered, instead of the matter being left to individual clinical judgment.

Alison Johnstone: One point that was made quite strongly by a couple of people was the reliance on or promotion of fixed-term contracts and the offering of part-time posts to new graduates. If those people came in for a few hours and were then asked to stay on for the rest of the day, they would be paid just time, not overtime, and it was felt that the use of fixed-term contracts and part-time posts was all about avoiding having to offer permanent contracts with more expensive terms and conditions. The committee was also asked to look at and further investigate the number of locum consultants who would not accept permanent posts but, instead, worked in a way that was incredibly expensive.

The Convener: If there are any other issues that members picked up on, they should feed them back to the committee clerks, and we will try to cover them all.

As agreed at a previous meeting, we will now go into private session.

12:24

Meeting continued in private until 13:00.

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