Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Local Review of the Quality Governance Arrangements in place within Swansea Bay University Health Board, for the delivery of Healthcare Services to Her Majesty's Prison Swansea

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales.

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people.

Our goal is:

To be a trusted voice which influences and drives improvement in healthcare.

Our values

We place people at the heart of what we do. We are:

- **Independent** – we are impartial, deciding what work we do and where we do it
- **Objective** – we are reasoned, fair and evidence driven
- **Decisive** – we make clear judgements and take action to improvepoor standards and highlight the good practice we find
- **Inclusive** – we value and encourage equality and diversity through our work
- **Proportionate** – we are agile and we carry out our work where it matters most.

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Introduction

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales. We are responsible for inspecting and reviewing National Health Service (NHS) services and independent healthcare services throughout Wales against a range of standards, policies, guidance, and regulations to highlight areas requiring improvement. In our role, it is important that we maintain an overview of each of the NHS Health Boards and Trusts in Wales.

As part of the HIW annual reviews programme for 2021-22, we have undertaken a local review to establish whether the quality governance arrangements in place at the Swansea Bay University Health Board (SBUHB), to support the delivery of good quality, safe and effective healthcare services to the population of Her Majesty's Prison Swansea[1] (HMP Swansea).

The review set out to consider the governance processes in place within the health board for the oversight of healthcare services to HMP Swansea, to ensure that the prison population can access and receive timely, safe, and effective care.

This report details our findings and 29 recommendations for improvement. The health board and the Prison Partnership Board must consider all our recommendations highlighted throughout the report, and it is our expectation that these are taken forward in the context of broader improvement work.

Our review took place during a challenging period of the pandemic. Consequently, we express our thanks to all the staff working within the health board and prison who helped inform our review by participating in interviews and for completing our survey and sharing their experiences with us. We also convey our gratitude to the men held within the prison who also helped inform our review by completing our survey for the prison population and sharing their experiences with us.

In addition, we thank the Community Health Councils[2] (CHC) in Wales, in particular Swansea Bay CHC, and Her Majesty's Inspectorate of Prisons[3] (HMIP), who provided us with their advice and support when we were developing our questionnaire, on how to obtain views from the prison population, and again to HMIP for their support and advice when planning our review.

[1] Swansea Prison - GOV.UK (www.gov.uk)

[2] Community Health Councils (CHCs) are independent bodies who listen to what individuals and the community have to say about the health services regarding quality, quantity, access to and appropriateness of the services provided for them. They then act as the public voice in letting managers of health services know what people want and how things can be improved.

[3] Her Majesty's Inspectorate of Prisons

Summary

Our review has found that the quality governance arrangements in place at Swansea Bay University Health Board (the 'health board') do not adequately support the delivery of good quality, safe and effective healthcare services to the population of HMP Swansea. We have identified a need to strengthen these arrangements and raise the profile of prison healthcare within the health board to ensure that the quality of prison healthcare is designed, delivered, and monitored effectively.

We are not assured that effective oversight is in place to ensure that prison residents receive a safe and equitable healthcare service, consistent to that provided to people within the community. This is because we could not identify strong processes to oversee quality standards. This included weaknesses in addressing issues identified by external reports and reviews, a lack of strong evidence of learning from recommendations, and a lack of evidence of routine data being captured on patient experience to inform service improvement. Whilst the health board's quality and safety framework[4] outlines the reporting lines for quality and safety of services, our review highlights that in practice these arrangements do not provide an adequate level of scrutiny and Board oversight for the delivery of healthcare services at HMP Swansea.

In relation to strategic oversight and operational delivery and management of prison healthcare, we have identified a need to ensure that relevant partnership agreements between the health board and prison are reviewed and updated. This is to ensure that service design and delivery are reflective of the present and future intention. The absence of up-to-date delivery plans and partnership agreements could compromise effective commissioning, accountability, and overall delivery of healthcare services within the prison. Stronger partnership working is needed between the health board and the prison.

As outlined, the health board needs to strengthen its arrangements and processes for the monitoring, and scrutiny of external reports and recommendations. Whilst we identified that some work was ongoing in relation to actions following external reviews, some were incomplete with a lack of clarity around their status. Action must be taken by the health board to address this and ensure that any learning from recommendations is captured and acted upon, to ensure patient safety is maintained and improved.

[4] https://sbuhb.nhs.wales/about-us/key-documents-folder/quality-and-safety-committee-papers/quality-and-safety-committee-december-2019/5-2-q-amp-s-framework-pdf/

The health board also needs to ensure that the information it receives through its governance framework is accurate and timely, with particular attention needed in relation to the escalation of concerns and collecting and learning from patient experience. We could not be assured that there was a systematic approach to recording concerns relating to prison healthcare, at either a local or corporate level. There was also weak evidence for the triangulation of information relating to patient experience or concerns raised by prisoners through the governance framework. As a result, this may impact on the health board's ability to effectively improve services and the delivery of safe healthcare at the prison.

Specific attention is required from the health board regarding risk management. Our review has identified weaknesses in how risks relating to prison healthcare are recorded, escalated, managed, or mitigated, and there was insufficient oversight from the health board. Action is required to ensure there are clear and comprehensive risk management arrangements in place to support the safe delivery of healthcare services within HMP Swansea.

It was positive to find that the health board has reviewed some aspects of the delivery of healthcare services to the prison, with the recent introduction of a new model of care for the provision of General Practitioner (GP) services. In addition, a new Pharmacy model was supported by the introduction of a new electronic pharmacy system. The local delivery of mental health services to the prison residents has also been reviewed and is now supported by a Mental Health Crisis Team and Substance Misuse service.

The results from our patient survey however, highlighted concerns by prison residents regarding long delays in receiving certain healthcare services. For example, the health board was not providing optometry services to the prison residents for a period of almost two years, which was impacting on their health and wellbeing. Whilst this time period coincided with the pandemic, this issue was the result of the end of the existing contract in place, and a new contract (with any provider), had not been implemented. This demonstrates a need for the health board to strengthen its oversight of healthcare provision in partnership with the prison, to ensure that excessive waiting times or gaps in provision are minimised wherever possible.

Whilst we acknowledge that the pandemic had an impact on elements of oversight of prison healthcare services, our review has identified that there is now a need to ensure the relevant prison partnership arrangements are reinstated in full. This is to ensure that they are robust, and function as intended and address the improvements identified by our review.

Overall, we have identified a need to improve oversight and raise the profile of prison healthcare within the health board's quality governance arrangements. Many of the issues that have been identified by our review are likely to be a result of the low-profile prison healthcare has had within the health board historically. Prison healthcare, including the quality of the service, needs to feature more prominently on the health board's quality agenda, so that safe, effective care can be provided to the prison residents, equitable to that received by the broader population it serves.

Context

In its Operational Plan 2021-22, HIW committed to a programme of local reviews, which included the intention to review the governance arrangements in place within Swansea Bay University Health Board (SBUHB) for the provision of healthcare services to HMP Swansea. The decision to undertake this review was based on our concerns relating the health board's response to implementing improvements following HMIP inspections.

HMP Swansea is a Category B[5] prison situated in the city of Swansea, providing prison services to a male population and has a baseline normal certified capacity of 255 prisoners. However, at the time of the review there were 360 men held within the prison. The population of the prison is made up of those on remand[6], others awaiting sentencing, and those who have been given a determinate prison sentence[7].

The Ministry of Justice[8] has overall responsibility for HMP Swansea. However, overall responsibility for prison health and social care in public sector prisons in Wales sits with Welsh Government. Accountability for planning and delivery of healthcare services within the prison sits with NHS Wales, in partnership with Her Majesty's Prison and Probation Service.

Accountability for the governance of prison health and social care within Wales, lies with Prison Partnership Boards (PPBs). These are jointly chaired by a delegated representative from the relevant health board and the relevant prison governor.

Since April 2016, the health board has the responsibility and accountability for the delivery of healthcare services at HMP Swansea, following the Transfer of Undertakings (Protection of Employment) (TUPE)[9] of healthcare staff from the prison service to the health board. The healthcare team in HMP Swansea sits within the Primary, Community Care and Therapies Services Group (PCT) of the health board, except for the Mental Health In-Reach team, which sits under the health board's Mental Health Services.

[5] A category B prison is a male only local prison holding sentenced and remanded adults and young persons.
[6] On remand indicates the individual is in custody awaiting trial.
[7] A determinate prison sentence is where the court sets a fixed length for the prison sentence.
[8] Ministry of Justice
[9] TUPE transfer happens when an organisation, or part of it, is transferred from one employer to another, or when a service is transferred to a new provider, for example when another company takes over the contract for providing the same service.

HMP Swansea is a Victorian prison and its primary healthcare services are delivered from existing room space. Like other prison healthcare wings/centres in England and Wales, it is not considered to be a hospital setting, being specifically excluded from being such, by the National Health Service Act 1977[10].

Healthcare Services at HMP Swansea

According to Public Health Wales, those in prison often have much higher levels of morbidity and suffer greater health inequalities than the general population. Public Health Wales works to protect the health of those within the criminal justice system, and in doing so protect the health of the wider community, contributing to reducing inequalities and reducing reoffending[11].

The healthcare services available to the prison and which are delivered by health board include:

- Primary Care
- GP services
- Pharmacy
- Mental Health Crisis Team
- Mental Health In-Reach Team (MHIRT)
- Substance Misuse service.

There are also outsourced services provided for dental and optometry services, which include:

- Dentistry services provided by Time for Teeth[12]
- Optometry services provided by The Prison Optician Trust[13].

All relevant NHS standards in Wales apply to healthcare services for prisoners, with exceptions only where the constraints of the custodial environment are over-riding.

The NHS Wales complaints and concerns process *Putting Things Right*[14], must be followed by the public sector prisons, and patient safety incidents in all prisons should be reported through the NHS Wales reporting mechanism. Health boards and Trusts across Wales use an online system called Datix[15] to report and record complaints and incidents.

[10] National Health Service Act 1977.
[11] https://phw.nhs.wales/topics/prison-health-in-wales/
[12] Time for Teeth Prison & Secure Environment Dentistry
[13] The Prison Opticians Trust
[14] Putting Things Right
[15] Datix is a risk management database used to report and manage incidents and concerns.

HIW's role in prison healthcare

We have the legal power to inspect prison healthcare services provided by NHS Wales. We have a remit to enter and inspect any premises where care is provided by Welsh NHS bodies, under the Health and Social Care (Community Health and Standards) Act 2003[16].

We discharge our role in respect of prison healthcare by:

- Contributing to Death in Custody (DIC) investigations
  The Prison and Probation Ombudsman (PPO) is required to undertake an investigation of every death that occurs in a prison setting. HIW contributes to these investigations by commissioning an independent clinical review of any death within a Welsh prison or approved premises. This arrangement is defined within a Memorandum of Understanding between the PPO and HIW.
  The DIC investigations critically examine the systems, processes and quality of healthcare services provided to prisoners during their time spent within a prison or approved premises. The DIC report may present a series of recommendations that identify areas for improvement following a DIC, for both the prison service and the organisation delivering healthcare services.
- **Contributing to inspections of prisons conducted by HMIP**
  HMIP has a statutory duty to inspect prison environments and their healthcare and substance misuse services within all custodial settings in England and Wales. It is therefore responsible for, and leads inspections of, prisons in Wales. It aims to inspect each prison in Wales at least once every five years. HIW has a Memorandum of Understanding with HMIP, and wherever possible, will accompany its inspection teams on their routine inspections of prisons in Wales. We also share intelligence with HMIP regarding any concerns we receive about Welsh prisons, or healthcare services provided to a prison population in Wales.

HIW action following HMIP inspection of HMP Swansea

In August 2017, we assisted HMIP during its inspection of HMP Swansea. Significant concerns were identified during this inspection, which were outlined in the published inspection report[17]. These were largely in relation to clinical practices and the health board's overall governance arrangements for the provision and management of healthcare services at the prison.

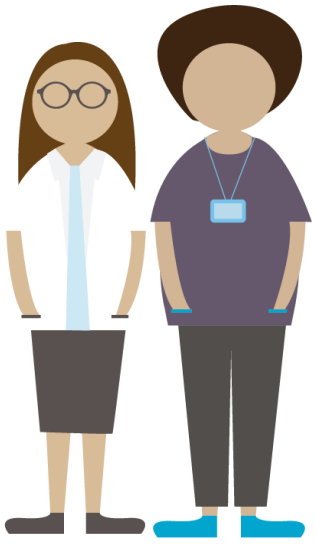
[16] Health and Social Care (Community Health and Standards) Act 2003

[17] See: https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/01/Swansea-Web-2017.pdf

In August and September 2020, we accompanied HMIP on a further inspection of HMP Swansea, and the findings are again outlined in a published inspection report[18]. It was disappointing to note that several concerns were again identified, with some reflective of those previously found in August 2017. Both inspection reports highlighted concerns around the effectiveness of the health board's quality governance arrangements in relation to the provision of healthcare services at the prison.

As a result of these concerns, we formally met with senior health board members in December 2020. The purpose was to seek assurances over actions taken in response to the issues found during the HMIP inspections. In response, the health board developed its own improvement plan to address the concerns, and this was shared with us.

These matters informed a decision to undertake a review of the effectiveness of the health board's quality governance arrangements for the provision of healthcare services at the prison. The purpose of the review was to assess the actions taken by the health board to address the issues highlighted by previous HMIP inspections. In addition, to consider the governance processes in place for the provision of healthcare services to HMP Swansea, to ensure that the prison population can access and receive timely, safe and effective care.



[18] See: https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/10/Swansea-SV-web-2020.pdf

What We Did

Focus of Review

The focus of our review was to explore whether the quality governance arrangements in place at the health board support the delivery of good quality, safe and effective healthcare services to the residents of HMP Swansea.

The review sought to address the following overall question:

Do the quality governance arrangements in place at the health board support the delivery of good quality, safe and effective healthcare services to the population of HMP Swansea?

Throughout the review we explored:

- **Quality governance arrangements**
  To understand the processes in place at the health board, for monitoring and evaluating the provision of healthcare being provided at the prison

- **Organisational structures**
  To establish whether the quality and safety of prison healthcare services are understood at an operational level, and whether concerns and issues arising are adequately acted upon by the health board

- **Patient experience**
  To understand the overall experience of the prison population who have healthcare needs and require healthcare services

- **Board oversight**
  To consider whether the quality and safety of prison healthcare services are understood at Board level within the health board, and whether any concerns and issues arising are adequately acted upon in line with corporate procedure.

We considered the following key questions:

- What are the current quality governance measures in place at the health board, to monitor and evaluate the provision of care being provided at the prison?

- Is the quality and safety of prison healthcare services understood at an operational level, and are any concerns and issues arising adequately acted upon by the health board?
- Is the quality and safety of prison healthcare services understood at Board level within the health board, and are any concerns and issues arising adequately acted upon in line with corporate procedure?

Scope and methodology

We focused on the health board's quality governance arrangements and considered both the health board processes and the healthcare services it provides to the residents of HMP Swansea.

To review the areas detailed above, we:

- Requested relevant documentation from the health board prior to and during our fieldwork in relation to healthcare services at the prison
- Held interviews with a range of health board and prison staff
- Conducted an online survey for both health board and prison staff
- Conducted a paper survey to the residents at the prison.

As a result of widespread restrictions in place in response to the COVID-19 pandemic, our fieldwork was completed remotely. We therefore did not undertake work onsite within the health board or at HMP Swansea.

Staff survey
We developed and undertook a staff survey, to obtain the views of health board and prison staff on governance, employee support, and the standard of care provided at HMP Swansea. The survey was shared with health board staff and healthcare professionals who provide services to the prison, and to prison employees. This was to help us understand the staff experiences, and to help identify any areas for improvement.

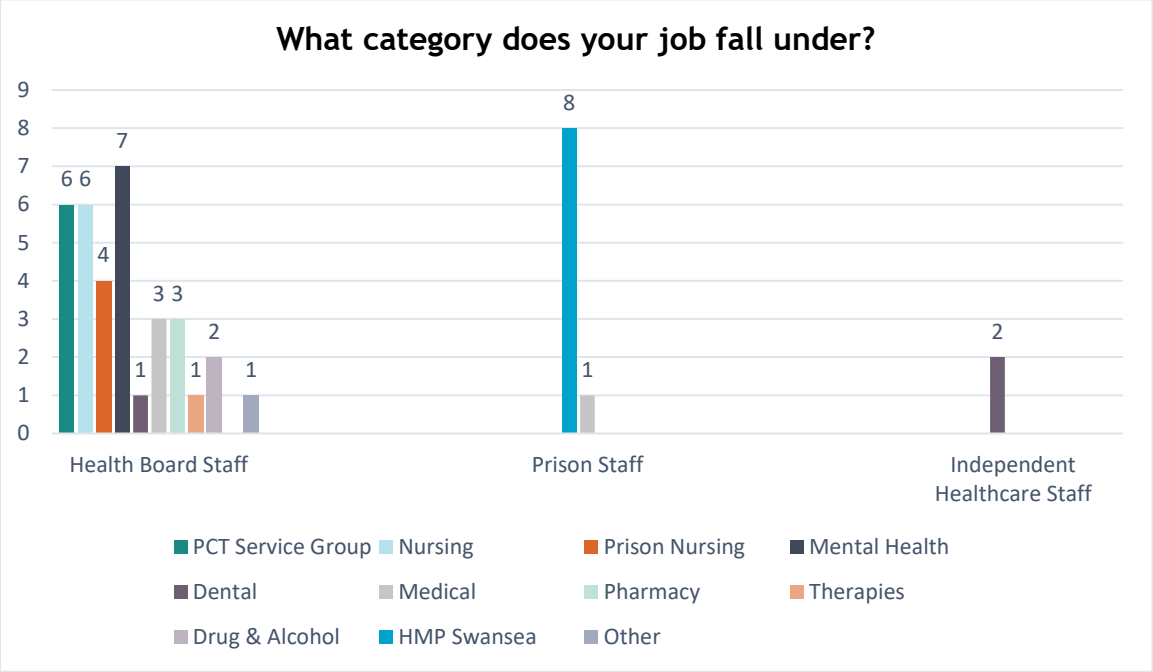
We asked the health board and prison governor to distribute our online smart survey details to relevant staff, and we also promoted the survey through our social media channels.

We received a total of 35 responses which included:

- 24 Health Board Staff
- 2 Independent Healthcare Staff
- 9 Prison Staff

Breakdown of staff responses

The responses came from a range of staff groups, which are highlighted in the chart below:



Our staff survey findings will be highlighted throughout the report.

Patient survey

In addition to a staff survey, we also conducted a survey to capture the views of the prison population who had requested or used healthcare services within HMP Swansea. This was to gain an understanding of their experiences of the healthcare services available and provided at the prison.

The survey was developed in paper format and was sent to the prison in November 2021. It was distributed to prison residents by prison staff. Once completed (anonymously) the surveys were collated, sealed and returned to us by post.

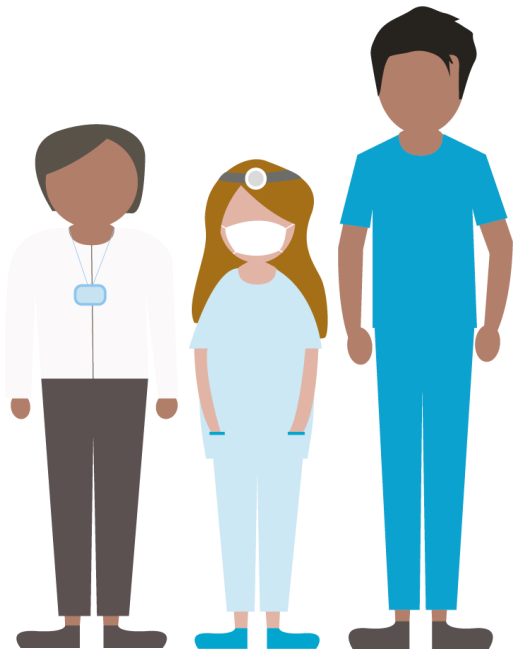
We received a total of 121 responses. Of those that responded, 96% had arrived at the prison in the last year, and 70% of those said they had a physical or mental health condition that is expected to last for 12 months or more. This number highlights the need for access to and provision of good healthcare services.

Our patient survey findings will be highlighted throughout the report.

Staff Interviews
We held multiple interviews with staff from within the health board, including clinical staff, managers and directors employed within the PCT service group, members of the executive team and independent board members.

We also interviewed staff employed by HMP Swansea, including the Prison Governor and members of the prison team.

We completed a total of 28 staff interviews, and our findings will be highlighted throughout the report.



What We Found

What are the current quality governance measures in place at the health board, to monitor and evaluate the provision of care being provided at the prison?

This section of the report incorporates the findings that help to answer the question above and understand current arrangements in place at health board level to monitor quality governance.

Partnership Agreement for Prison Health in Wales (2019)

The way in which healthcare services are managed and provided at HMP Swansea are determined by the Prison Partnership Board, in line with the *Partnership Agreement for Prison Health in Wales* (2019)[19], a *Prison Health Delivery Plan*, and the *Prison Partnership Agreement*.

The *Partnership Agreement for Prison Health in Wales*, outlines the agreed priorities between Her Majesty's Prison and Probation Service in Wales, Welsh Government, health boards and Public Health Wales[20], to drive improvements in the health and wellbeing of people held in Welsh prisons. The agreement recognises the unique statutory obligations of each partner organisation and builds on the shared objective of ensuring those in prison can live in environments that promote health and well-being, and that health services can be accessed to an equivalent standard of those within the community. This supports the overarching aim that prison should be a place where an individual can reform their lives.

All parties should work toward the three objectives of the Welsh Government *Prosperity for All: The National Strategy*[21], to ensure that prisons and health services in prisons:

- Deliver quality health and care services fit for the future
- Promote good health and well-being for everyone
- Build healthier communities and better environments.

The *Partnership Agreement for Prison Health in Wales*, introduced by Welsh Government, highlights an intention to establish a *Prison Health Oversight Group* across Wales to ensure prisons are a health promoting environment, delivering quality person-centred services.

[19] https://gov.wales/partnership-agreement-prison-health-wales
[20] Public Health Wales NHS Trust
[21] Prosperity for All: The National Strategy

Strategic Planning

A *Prison Health Oversight Group* for Wales was established by Welsh Government in summer 2020. The intention of the oversight group is to ensure prisons are a health promoting environment, delivering quality person-centred services. However, through our interviews with health board staff we were informed that they were unaware this group had met and suggested the health board had not been invited to attend.

Further to the above, the Senedd's Health, Social Care and Sport Committee published a report in March 2021, entitled *Health and Social Care Provision in the Adult Prison Estate in Wales*[22]. This report identified a greater focus is needed in planning future healthcare services to meet the needs of the prison population in Wales and is relevant to those health boards who provide healthcare services to Welsh prisons.

During our review, we discussed this report in our conversations with health board service group directors and independent board members and found many were unaware of it. In addition, we did not find evidence that the health board has considered the report's recommendations, which indicates a need to strengthen awareness of national issues that may drive and influence improvement of prison healthcare provision.

Recommendation 1

The health board and prison partnership board must consider how they gain assurance, that any reports or recommendations relating to prison healthcare published by both Welsh Government and Senedd committees, are identified, received and disseminated to the appropriate individuals throughout the health board and prison. In addition, that action is taken to ensure appropriate membership and attendance of the Prison Health Oversight Group.

Recommendation 2

The health board and prison partnership board must ensure that recommendations made in the report Health and Social Care provision in the Adult Prison Estate in Wales, are reviewed and considered, and take action where necessary.

[22] See: Health and social care provision in the adult prison estate in Wales (senedd.wales)

Prison Partnership Board (PPB) for HMP Swansea

For the effective delivery of healthcare, and to maintain the wellbeing of prison residents at HMP Swansea, a multi-agency PPB is in place between the health board and HMP Swansea. The partnership board holds the responsibility for the provision of healthcare services within the prison.

The PPB is jointly chaired by the Prison Governor and the health board's Head of Nursing for the PCT service group. The terms of reference indicates that the board should meet quarterly to jointly review and manage the healthcare needs and wellbeing for the prison residents of HMP Swansea. However, these meetings did not take place for 20 months during the COVID-19 pandemic, and only resumed in August 2021. The terms of reference also highlight that a regular prison health needs assessment should be undertaken. This is to determine the health needs of the prison population, and to assess the extent to which current need and demand for health and social care in the prison establishment are being met.

Health needs assessment for the prison population

During the pandemic, the PPB commissioned the *Tamlyn Cairns Partnership*[23] to undertake a health needs assessment at the prison. We reviewed the report completed and dated January 2021, which highlights what is required to meet the health and social care needs of the men at HMP Swansea. The report made several recommendations for the health board and PPB to ensure that the physical and mental health needs of the prison population are being met appropriately.

As part of our review, we considered the health board's action plan in response to the health needs assessment. We saw evidence that action had been taken against the recommendations, with some actions complete, and further plans in place relating to other recommendations. However, some actions remained outstanding with no evidence of any action taken. These included recommendations for the Mental Health In-Reach team to ringfence services, to ensure demands within HMP Parc do not result in a reduced service in HMP Swansea. This is discussed later in the report. In addition, recommendations for the Head of Nursing, PPB and Local Authority, to ensure a strengthened focus on wellbeing and social care for the prison population at HMP Swansea, were not complete.

We also did not find evidence to demonstrate effective prioritisation of the outstanding actions, or that the issues identified had been appropriately considered and monitored through the health board's governance framework.

[23] See: Tamlyn Cairns Partnership

This therefore demonstrates a need for the health board and PPB to ensure adequate oversight of ongoing or outstanding actions, to ensure improvements are implemented as appropriate, within the prison healthcare services.

Prison Partnership Board oversight and escalation

In terms of how the PPB has been functioning, our review highlighted weaknesses in providing oversight regarding the governance of healthcare services provided at the prison. We did not find evidence of appropriate formal engagement, communication or any PPB meetings taking place between December 2019 and August 2021. Whilst we understand this period coincided with the COVID-19 pandemic, it was at a time when the delivery of health and social care services to the prison population, a vulnerable group with distinct healthcare needs, was vital. It is clear that the prolonged absence of these meetings, reduced the health board's ability to assure itself that safe and effective arrangements were in place for delivering healthcare services to the prison. We would question therefore whether there was opportunity for the PPB to have re-engaged at an earlier juncture, given the vital role it fulfils regarding the delivery of prison healthcare.

We identified an absence of clear lines of reporting and the process for escalation from the PPB, through the health board's governance framework. This lack of escalation raises concerns over the health board's ability to gain oversight and respond to healthcare issues or concerns within the prison. In addition, the prolonged period without formal engagement between the key partners, raises concern over the health board's oversight and assurance for the provision of healthcare to the prison.

Recommendation 3

The health board and PPB must ensure there are clear lines of reporting and escalation into the PPB terms of reference, to ensure robust governance arrangements are in place for the management of healthcare services at the prison.

Recommendation 4

The health board and PPB must promptly address the outstanding recommendations made in the Tamlyn Cairns Partnership health needs assessment report and implement any actions and monitor as appropriate.

Prison Health Delivery Plan, and the local Prison Partnership Agreement for HMP Swansea

The health board's Prison Health Delivery Plan (PHDP) is a document setting out the vision for the commissioning and delivery of healthcare services, and the improvement of prisoners' health within HMP Swansea for the period 2013-2016. However, we were unable to find evidence that the PHDP had been reviewed or updated since 2013. The version of the document we were presented with referenced the authors as healthcare staff, who were previously managed by the prison (prior to the TUPE of staff in 2016). This requires prompt attention by the health board to ensure that an up-to-date delivery plan is in place, and which is reflective of current and required arrangements for the delivery of healthcare services at HMP Swansea. Similarly, whilst a local Prison Partnership Agreement is in place between the health board and the prison service, setting out the arrangements for the commissioning and accountability for the delivery of all healthcare and health promotion services to the prisoner population, it too had not been reviewed since March 2017.

Both the outdated PHDP and Partnership Agreement highlighted above, demonstrate weakness in the health board's governance arrangements, suggesting poor oversight from the health board of healthcare services at the prison. Action is required by the health board to ensure that both the delivery plan and partnership agreement are reviewed and updated promptly, to ensure the delivery of healthcare services to the prison population is in line with current or anticipated demand.

Recommendation 5
The health board must ensure that it has a clear strategy and plan for the commissioning and delivery of healthcare services, and for the wellbeing and improvement of prisoner health.

Recommendation 6
The Prison Partnership Agreement must be reviewed and updated promptly by the health board and HM Prison Service. This must reflect current arrangements for commissioning and accountability for the delivery of healthcare services at HMP Swansea.

Quality Governance Groups and Committees

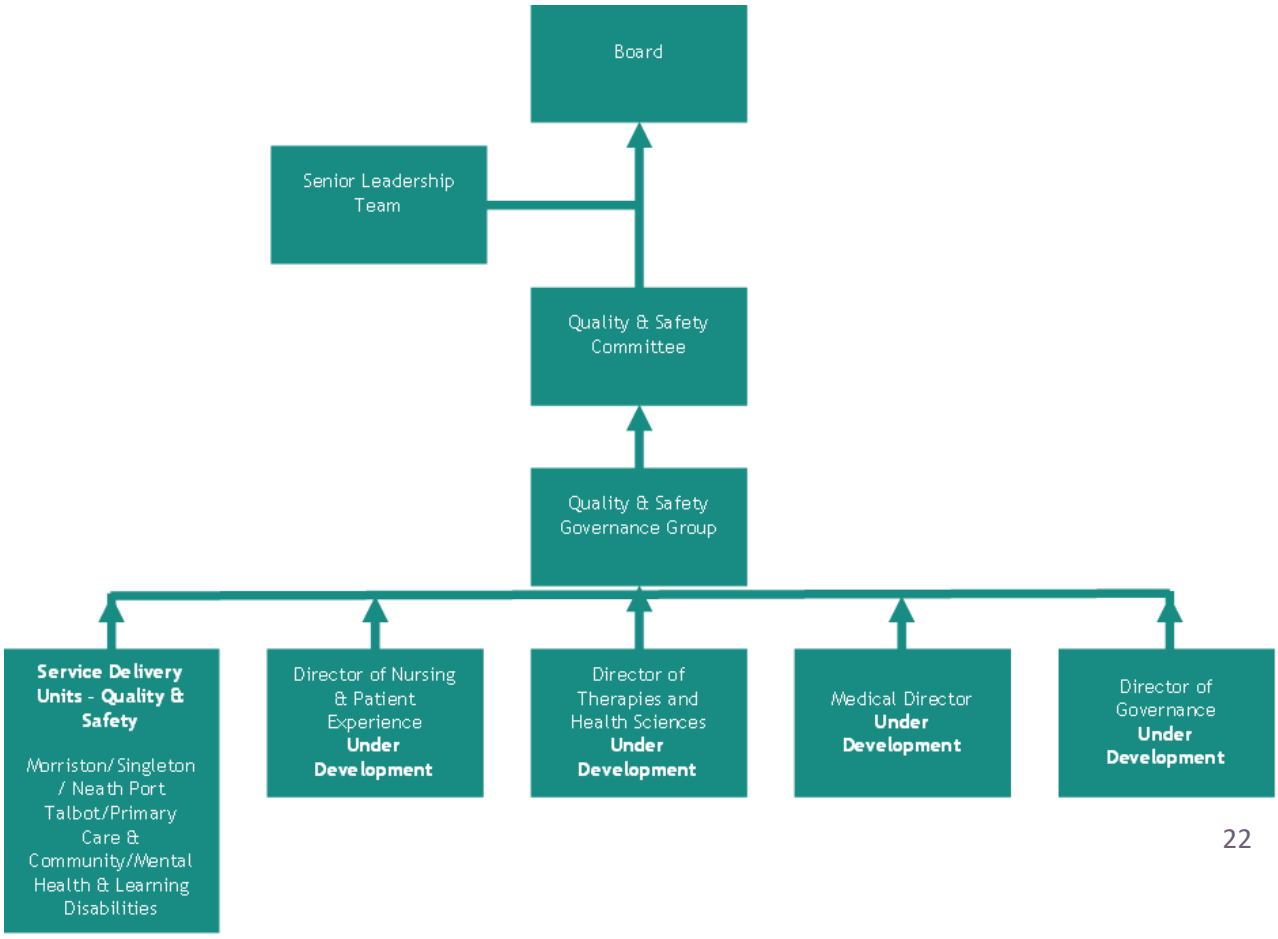
We explored further how the health board manages quality governance arrangements in relation to prison healthcare services, in addition to the PPB and partnership agreement.

Whilst the PPB is responsible for the local governance arrangements within HMP Swansea, the health board has several broader governance groups and committees in place to monitor the overall quality, safety, and improvement of healthcare services. We considered how these groups and committees function, with a particular focus on how matters relating to prison healthcare are reported throughout governance streams, and whether any actions required are monitored for progress.

We reviewed the terms of reference of quality and safety groups including:

- Quality and Safety Committee (QSC), which is a subcommittee of the Board
- Quality and Safety Governance Group (QSGG)
- Primary Care and Therapies Service Quality and Safety and Patient Experience Group (PCTQSPE)
- Nursing and Community Services Quality and Safety Group (QSN).

Flow chart highlighting the flow up to the board for the health board's quality and safety groups:



The chart above was provided to us as the most recent version in place at the health board, which outlines the health board's governance structure in line with its Quality and Safety Framework. It highlights the lines of reporting between quality and safety groups upwards to the Board. However, the framework does not indicate how the QSN group, responsible for reporting the delivery of healthcare at the prison, feeds into the health board's governance structure. In addition, the services that sit below the QSGG, are referred to as being under development. If the processes in place remain 'under development', it may not be clear to staff working across the health board, what the appropriate reporting and escalation arrangements are. This may lead to key information not being communicated effectively through the quality framework.

In order to understand the process of reporting and the escalation of issues relating to the prison healthcare, we reviewed each group's meeting minutes and other supporting documentation from 2020 and 2021. We identified regular reporting from the prison Lead Nurse to the QSN group, and the meeting minutes highlighted monitoring of ongoing operational activity relating to prison healthcare. Within the meeting minutes, we also found escalation of some prison healthcare issues to the PCTQSPE group, and also evidence that the PCT service group had submitted update reports to QSC in December 2021. These updates related to the status of actions taken against recommendations from external inspection reports and DIC reports. However, in general there were limited details within meeting minutes of the PCTQSPE, QSGG and QSC, relating to monitoring and oversight for the delivery of healthcare services at the prison.

Oversight of external report recommendations

We considered the governance arrangements in place for the oversight and scrutiny of internal and external review reports, any recommendations made within these, and the health board's subsequent action.

We reviewed the terms of reference for the QSGG and noted that the group has responsibility for monitoring progress against internal and external assurance reports and action plans. The QSGG should provide scrutiny and oversight of the responses to any action plans and is expected to advise and inform the health board's QSC of any significant risks and governance issues. In addition, it should report on actions to be taken to ensure improvement is made and implemented.

We reviewed the QSGG meeting minutes for a six-month period during 2021, and identified the agenda was extensive. We noted several papers had been submitted by the PCT service group to the QSGG, which referenced some issues relating to HMP Swansea. These referenced DIC report action plans, serious incidents, and issues around the Controlled Drugs (CD) license in the prison. In this instance, it emerged that the health board did not hold the necessary Home Office CD license to possess and dispense CDs within HMP Swansea.

This was reported to QSGG and a need to apply for a licence was actioned, with the licence being granted in May 2022. Further information around the Home Office CD licence can be found later in the report.

During January 2022, we attended the QSGG meeting, and noted there was limited discussion around external inspection improvement plans relating to prison healthcare, and no evidence of the scrutiny of any outstanding actions. However, we also observed that a significant sized agenda, coupled with a large volume of meeting papers, limited the group's ability to adequately discuss, monitor and scrutinise any outstanding inspection or review recommendation actions in any detail.

HMIP recommendations

As highlighted earlier, the health board had devised an improvement plan to address recommendations made in HMIP reports published following scrutiny visits during 2017 and 2020. The plan demonstrated that some actions had been completed, and with some in progress. We found that good progress had been made against some of the HMIP recommendations. In addition, actions and updates were being reported appropriately through the governance framework.

In support of the action taken against HMIP recommendations, the health board provided us with standard operating procedures relating to medicines management and confirmed it had changed operational practice in line with the recommendations made by HMIP regarding this area. The action plan indicated progress had been made to address medication security issues, and senior management checks were on-going to ensure compliance with the amended operational practice.

Additional actions developed in response to the HMIP recommendations, also highlighted progress on improvements for the provision of mental health crisis services. Action had also been taken to address a series of issues raised in relation to infection prevention and control, however, some actions were still in progress.

Oversight of Death in Custody recommendations

Following a DIC review, the report is shared with the relevant Prison Service in Wales, and recommendations are made to the health board regarding healthcare services and the associated governance arrangements.

Following our review of three death in custody reports associated with HMP Swansea, for the periods January, September and November 2020, we considered the health board's oversight of each report's recommendations, and action plans. We found some evidence in QSN meeting minutes which indicated progress had been made on actions.

In addition, we found the recommendations and associated action lists had been escalated and reported through the appropriate governance framework. However, there were several recommendations where no action had been recorded by the health board to address the issues raised. In addition, there was no evidence of robust monitoring or scrutiny of outstanding recommendations through its governance framework.

Within one DIC report, we found an example of poor learning as a result of the review. When considering the recommendations to strengthen the process for initial health screening when new prisoners attend reception, it appears that minimal action had been taken to address the recommendation. We are therefore not assured that learning following this death has been considered appropriately, or that appropriate action has been taken by the health board to strengthen this process to help prevent future deaths.

The health board must strengthen its governance arrangements to address recommendations made within DIC reports, and to maintain oversight of progress. The health board should also promptly review the DIC reports, to assure itself that all recommendations have been actioned and where appropriate, changes implemented.

Community Health Council review recommendations

We also considered the health board's response to the Swansea Bay CHC recommendations, from its report *Healthcare Services in Swansea: A Prisoner's view*[24]. We considered the action taken and identified a lack of a timely response to these, with a small number of actions remaining outstanding. We also noted that whilst the review was reported through the governance structure, there was little evidence to support the scrutiny, monitoring of progress or critical challenge made against this action plan within meeting minutes of the QSGG.

In a similar vein, whilst the health needs assessment highlighted earlier in the report had been discussed at QSN, we were unable to find evidence to confirm that the report's findings had been reported to the PCTQSPE or QSGG. Since HMP Swansea forms part of the PCT service group, the PCTQSPE group should have oversight of the issues, actions, and required improvements, as part of its governance for managing primary care services which includes prison healthcare.

In light of our findings relating to recommendations from external reports, we are not assured that prison healthcare quality and safety matters are being regularly reported and effectively scrutinised or monitored, through the health board's governance framework.

[24] See: https://swanseabaychc.nhs.wales/what-we-have-to-say/report-library/sb-chc-thematic-reports-2020/healthcare-services-at-hmp-swansea-report-february-2020-pdf/

This undermines the ability of the health board to assure itself about the quality and safety of healthcare services and prisoner wellbeing within HMP Swansea.

Since completing our fieldwork, the health board has informed us that it is in the process of reviewing its governance structures. In April 2022, a report was produced for the health board to consider proposed arrangements for a revised QSGG. Recommendations were made to rename the group to the Quality and Safety Patient Services Group (QSPSG), along with a new reporting structure, revised terms of reference and a new sub-group structure. It is the health board's intention to commence meetings in June 2022 and allow members to comment on the terms of reference. It is therefore too soon for us to make a judgement on the impact of these changes, and whether it strengthens oversight of prison healthcare.

Senior health board staff visibility at HMP Swansea

In addition to the formal oversight arrangements of healthcare services at HMP Swansea, we considered the visibility of senior healthcare staff within the prison healthcare services and its teams.

To help us gain an understanding for the oversight of frontline prison healthcare from the health board, we interviewed members of senior management and executive teams, service group directors and independent board members during the review.

We established that the head of nursing and lead nurse have a close relationship with the prison staff and have line management responsibilities for healthcare staff within HMP Swansea. Whilst we were told that they maintain visibility with the teams within the prison and overall prison healthcare services, a number of other senior managers and independent members said they had never visited the prison. Whilst we acknowledge the challenging logistics around visiting a secure custodial environment, lack of presence and visibility of service leaders may be contributing to the low profile and priority given to prison healthcare services, in comparison to other services within the health board. These visits provide an opportunity for senior managers and independent members to triangulate information received through the governance framework, against observations at ground level.

Recommendation 7

The health board must ensure quality and safety matters arising from HMP Swansea are defined, reported, and escalated appropriately through the governance framework. In doing so, it must:

a. Ensure that the appropriate groups within the quality and safety governance framework scrutinise and monitor actions taken to address recommendations made in all external inspection reports.

b. Ensure that all outstanding recommendations made within the HMIP Scrutiny Visit reports, CHC report, and DIC report recommendations, are considered robustly, and any actions taken should have regular review to ensure appropriate and timely actions are implemented.

Risk and Audit

Risk management arrangements for prison healthcare services

In line with the terms of reference for the PPB, a joint risk register is required for healthcare services within HMP Swansea, to record and review the risks and the required actions and mitigations. This is to help minimise the risk of harm to the prison population and healthcare staff working within or for the prison healthcare service.

We considered the governance arrangements in place for the management of risks relating to prison healthcare, and explored the processes in place for assessing, identifying, recording and managing risks. We also assessed how accessible the register is for the healthcare staff responsible for prison healthcare, both clinical and management.

We were not presented with any evidence to indicate that a prison healthcare risk register was in place. It was not clear to us how staff could raise concerns around risk, or how these would be captured to inform any health board risk register. This means that we cannot be assured that risks relating to prison healthcare are being effectively escalated, recorded, managed, or mitigated, and that there is sufficient oversight of risk from the health board.

Recommendation 8

The health board must ensure adequate arrangements to identify, escalate, record, manage, and mitigate risks in relation to healthcare services at HMP Swansea.

Prison healthcare audits

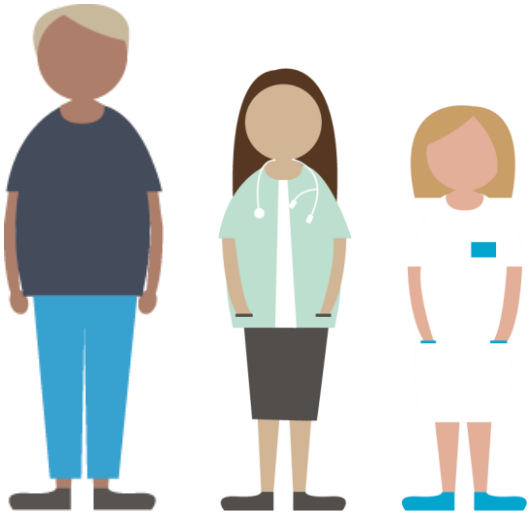
We explored the processes in place to audit prison healthcare services. Our interviews with staff highlighted that the prison healthcare team perform a series of audits within the prison healthcare environment. However, the results of these audits are not currently reviewed or scrutinised by more senior staff or reported into governance groups in the health board.

Our review also highlighted that the prison healthcare environment does not provide access to the health board's live nursing dashboard[25]. This dashboard is used across the wider health board to record audit data and measures for key quality performance indicators, nursing outcomes and other quality measures.

Whilst we acknowledge that not all data captured within the nursing dashboard is applicable to the prison environment, the health board should consider how some outcomes can be recorded and reviewed by senior teams, in relation to prison healthcare services. This is to ensure appropriate oversight and scrutiny of results, and to take action for improvement when required.

Recommendation 9

The health board must improve visibility and oversight of clinical audit, and ensure this activity is reported to relevant governance groups for monitoring and scrutiny for prison healthcare services.



[25] A digital service provided by the health board to collect and measure nursing outcomes and quality measures.

Is the quality and safety of prison healthcare services understood at an operational level, and are any concerns and issues arising adequately acted upon by the health board?

In considering this question, we wanted to understand how healthcare services functioned operationally within HMP Swansea, whether there were quality issues in relation to these services, and if so, how these had been escalated. This section has been divided into sections covering:

- Healthcare services provided at HMP Swansea
- Workforce and culture
- Patient Experience

This element of the report will also contain comments provided to us through our staff and prison surveys where relevant and consider the patient experience of the prison residents.

Healthcare services provided at HMP Swansea

COVID-19 arrangements

In relation to COVID-19, it was positive to find that the health board had implemented the appropriate and up to date COVID-19 arrangements for the safe delivery of healthcare services at the prison.

Our staff interviews indicated that appropriate COVID-19 testing was taking place in the prison, with all new prisoners receiving a test upon arrival at the prison, followed by an additional test on day five. However, in contrast to this, only 70% of those who responded to our patient survey for the prison residents, who had arrived at the prison in the 12 months following November 2020, said they had received a COVID-19 test on arrival. During our review, we did not validate this information against the tests being undertaken, however, it is important the health board undertakes regular audits to ensure such testing is taking place for the virus, or for any other screening where appropriate.

We also noted that the prison healthcare team was operating a successful COVID-19 vaccination programme and for influenza vaccines. In addition, arrangements were also in place to segregate prisoners to a wing for those displaying symptoms of COVID-19, and those positive to the virus.

It was positive to find that the responses to our patient survey within the prison, indicated the majority felt COVID-19 infection control measures were being followed, and the healthcare environment was clean and tidy. The survey also indicated that social distancing was being maintained, hand sanitisers were provided, and staff were wearing appropriate PPE.

We did, however, receive some comments where prison residents felt services could be improved in relation to Covid-19, which included:

"Our IP meds in cell should be on a repeat, so we don't have to line up with COVID19"

"When on covid wing G, [I] asked for paracetamol and did not get any until following morning at least 16 hours later, so I suffered with headache all night. [I] was not happy".

The prison healthcare environment

As highlighted earlier, whilst we did not undertake any onsite fieldwork, our previous work at the prison has given us an understanding of how healthcare services are provided within the prison environments.

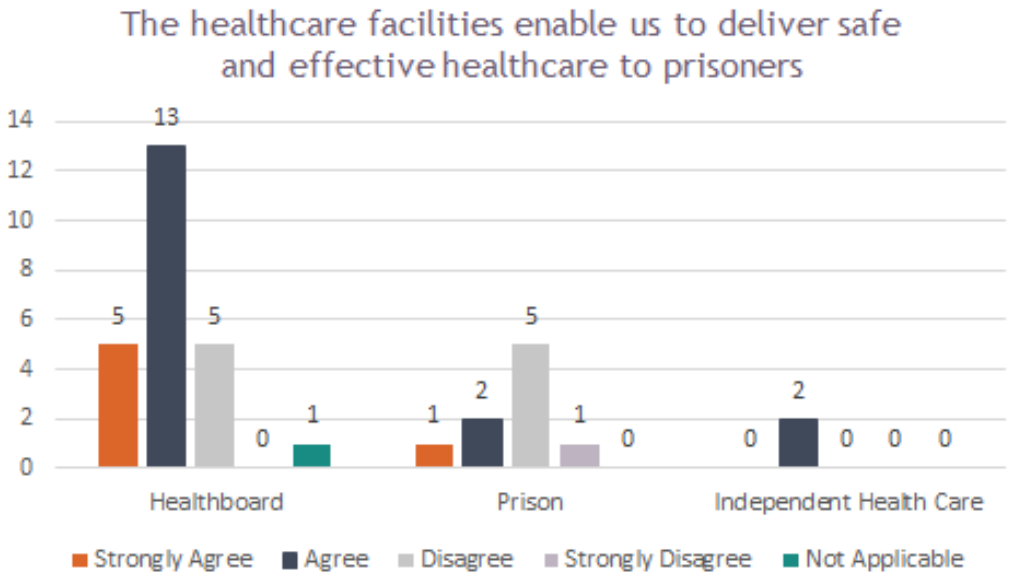
During our interviews with healthcare staff, some told us that they felt the space within the prison environment to provide healthcare to the men is limited, and the building was not designed to facilitate healthcare services. In addition, we were informed that infrastructure was very old and there were Wi-Fi connection issues affecting the communication between prison healthcare staff and the PCT service group.

Healthcare facilities within the prison comprised of:

- Pharmacy
- Four clinical rooms
- One dentistry room
- Room for Crisis Care in the Prison's Safer Custody Unit, and a room in the Prison's Wellbeing Unit
- Clinical rooms on A, D and G wings
- A medical room in Reception.

When exploring prison healthcare facilities further with staff in our questionnaire, we asked whether the healthcare facilities enabled staff to deliver safe and effective healthcare to prisoners.

The table below highlights the staff responses:



It is positive to find that most healthcare staff highlighted that the facilities enabled them to deliver safe and effective care, however, only a third of the prison staff felt the same.

In response to our survey, one member of prison healthcare staff told us:

'The clinic rooms are not ideal as the panic alarms are situated in the wrong part of the room and would not be able to use them in an emergency'.

This comment raises an issue around maintaining staff security and safety. In addition, with the absence of a risk register as noted earlier in this report, this has not been formally captured as a risk and therefore, it is unclear how this risk is being managed and addressed.

We were informed that a memorandum of understanding exists between the health board and HMP Swansea, which outlines the responsibilities for the maintenance and repair of premises and healthcare equipment. However, we were told this had not been reviewed or updated for four years, since 2017, and therefore requires a review in light of the concern about the panic alarm location. The health board must consider the issues highlighted in relation to panic alarms, and address the issue with the prison, accordingly.

Recommendation 10

The health board and prison must consider how it can address the issue identified around staff safety, and the availability of 'panic alarms' within the healthcare environments at the prison.

Recommendation 11

The health board and prison must review and update the memorandum of understanding to ensure that there is clarity around responsibility and accountability for repair of premises and healthcare equipment.

Clinical pathways

We explored whether clinical pathways were in place specifically for the prison, to manage the healthcare needs of those living within a secure environment. In addition, whether the prison healthcare services rely on the use of pathways for those who live within the surrounding communities of the health board.

We identified that healthcare staff follow community healthcare pathways to manage patient care, which are not tailored for the secure prison environment. However, when we explored this at a more senior level, it was acknowledged that these pathways are sometimes not always appropriate for the delivery of healthcare services for residents of the prison.

We were not assured that pathways are in place that are appropriate for those with mental health and substance misuse needs, which are prevalent within the prison, and for managing patients with diabetic needs. We therefore conclude that a timely review of the pathways in place (or those absent), should be considered, to ensure they are appropriate for the prison environment and prison population, and relate to the variety of patient needs.

Recommendation 12

The health board should review the clinical pathways used to deliver care to the prison population to ensure they are appropriate to the secure environment. Consideration should be given to the variety of patient needs, and to ensure appropriate and up to date guidance is available to both substantive and temporary healthcare staff.

Recommendation 13

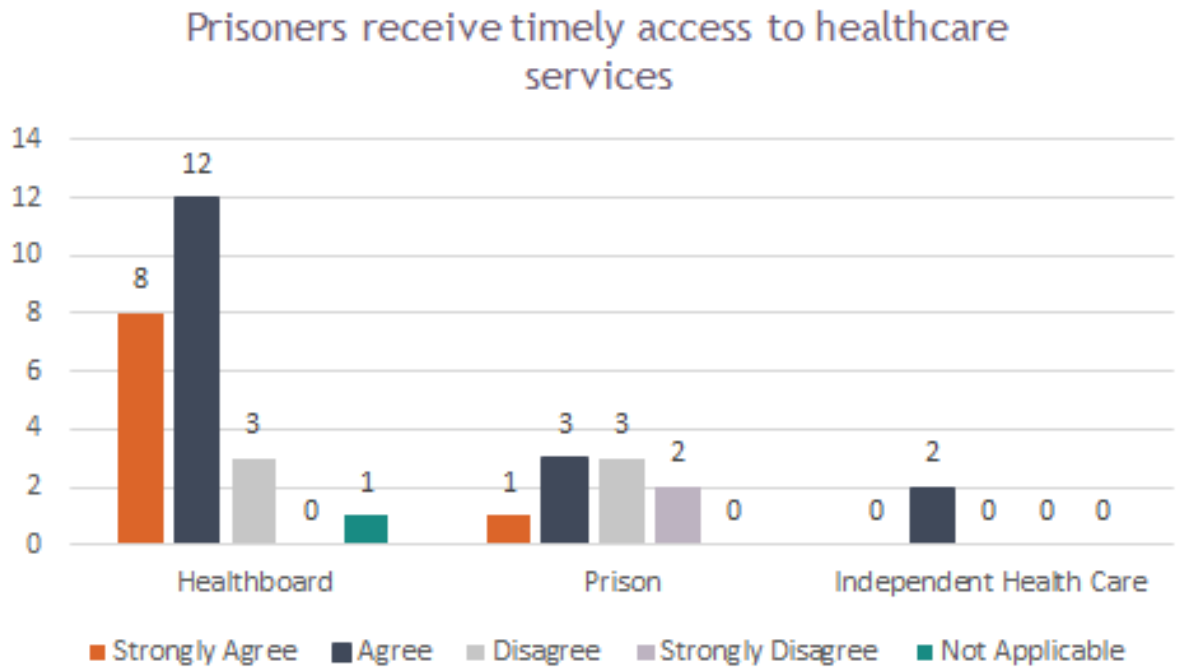
The health board and prison partnership board should consider commissioning a further health needs assessment to establish what clinical pathways should be in place at the prison.

Access to healthcare services

As part of our review, we conducted a patient survey for the prison residents. Our survey highlighted difficulties in patients accessing various healthcare services, and the results are highlighted in the table below:

Whilst overall it appears that access to substance misuse services is the easiest for those who require the service, the access to other healthcare services is mostly regarded as 'not easy'. Access to dental services appears to be the most difficult for the prison residents. Further exploration around the healthcare services provided within the prison are continued later in the report. We also engaged with staff through our survey and asked them whether they felt prisoners receive timely access to healthcare services.

The table below highlights the responses:



We found that 74% of all respondents thought that prisoners received timely access to healthcare services. However, this is reflective of the positive responses from health board and independent health care staff. Prison staff opinion was more evenly split between agreement and disagreement with this statement.

The following comment was made relating to timely access to healthcare:

"Access to healthcare can be an issue in the fact individual wings are brought down one at a time due to the covid rules (and not mixing). This unfortunately can cause some delays to clinic time"

GP services and access to appointments

We considered the arrangements in place for the provision of GP services within the prison, and it was positive to find that the health board has been working on plans to improve the provision in this area.

A new GP service model was introduced to HMP Swansea in January 2020, with a team of salaried GPs supported by a practice nurse to provide GP services five days a week to the prison residents. During our review, we attended an online presentation within the PCTQC, which outlined the new model for the provision of GP services at the prison.

Prior to the introduction of the new GP service model, the prison was supported by locum GPs providing a sessional service.

There were numerous operational issues with this model, and sometimes difficulty with staffing this role. The model was changed to provide stability and continuity of the service and patient care. However, it is too soon to make a judgement on the impact and effect of this new GP service model.

Our interviews noted that GPs can access the Welsh Clinical Portal to source individual health records wherever possible. However, this information is not always readily available, and summaries must be requested from GP surgeries from a prisoner's previous community setting to ensure up to date health records, continuity of care, and prescribing. We were told that this often presents difficulties in the sharing of and obtaining confidential information in a timely manner.

It was positive to find that weekly sessions are also available for prison residents who require support with substance misuse. In addition, plans have been made to introduce sessions to support prisoners with chronic disease management. However, the GPs did acknowledge that with a high turnover of men in and out of the prison, it can be difficult to manage this effectively.

Requests for a GP consultation are triaged daily, and the men are prioritised as appropriate. Prisoners who are unwell are usually seen in person, whilst others may receive a telephone consultation through the in-cell telephony system. We found that appointment capacity can vary and is dependent on the numbers of new prisoners arriving and needing GP services, and the resources available within the prison staff teams, to escort patients to the GP consultation rooms.

Respondents to our patient survey for the prison residents highlighted more than half of patients found it difficult to access GP services, except for Substance Misuse.

We received some comments within our patient survey highlighting the difficulties with accessing a GP appointment. These include:

"*Sometimes you are waiting to see a doctor for weeks*".

"*Difficult to get to see the doctor even when submitting [requesting] multiple appointments*".

"*Easier GP access [is needed]*".

Recommendation 14

The health board must explore how individual health records can be accessed by GPs working within the prison, to ensure timely and an up-to-date history of patients is available, and to also provide timely health care and prescribing for prison residents.

Dental services

We considered the process in place for prisoners to access dentistry care. Dental services within HMP Swansea are provided through an SLA with the dental service 'Time for Teeth'. However, on reviewing the SLA it appears not to have been signed by the health board or dental provider, despite contract services being delivered from 1st July 2021. The delay in signing the SLA indicates a lack of timely review and oversight by the health board. However, this issue was later rectified during the course of our review.

Senior PCT service group staff told us that Time for Teeth dental service had fulfilled its contractual obligations throughout the pandemic, with only a few occasions when they were not able to go into the prison due to an outbreak of COVID-19. The PCT teams confirmed they were kept fully informed of these occasions and the dental provider increased their appointments in the following weeks, to ensure patient disruption was minimised.

In contrast to this, our interviews with the prison staff highlighted that only one dental clinic was provided at the prison each week during the pandemic, and there were 80 men on the dental appointment waiting list.

This was substantiated by comments received in our patient survey for the prison residents, which included:

"My root canal has been put off 3 times and I've been in pain for 2 months with it".

"I have been waiting 3 months for a dentist appointment, I've been in pain and taking paracetamol and ibuprofen every day".

"*The dentist is almost impossible to see*".

Whilst we acknowledge the constraints of a secure environment, it is not appropriate for someone to suffer with pain for a period of two or three months whilst awaiting dental treatment. It is likely that if a member of the community was in the same predicament, they would be reviewed much sooner, or at least through an emergency dental service.

The health board must note the comments made by prison staff and prison residents regarding the availability of the dental service. It should consider these views in assessing whether the dental provider is maintaining its contractual obligations.

Recommendation 15

The health board should take steps to consider and monitor the service provided by the dental provider 'Time for Teeth', to ensure its contractual obligations are meeting the needs of the prison residents.

Eye care services

We reviewed the accessibility and provision of eye care services at the prison and were disappointed to find that the prison residents were not being provided with an acceptable opportunity to receive care and/or treatment for their eyes.

We noted that an agreement had been in place with an optician service, however, this had been withdrawn at the beginning of the pandemic. This therefore meant that for almost two years, the health board was not meeting the eye care needs of men at the prison. During our interviews with prison staff, it was highlighted to us that around 60 men were on the waiting list for eye care during the review, due to the lack of service between March 2020 and January 2022.

In the CHC report *A prisoner's view*, the prison residents at HMP Swansea reported concerns to the CHC relating to eye care services and expressed their dis-satisfaction with the lack of services available to them. The recommendations in this report were reported to QSN, however, as noted earlier in this report, there was no evidence this issue had been escalated, discussed or actioned.

This issue was further substantiated in our patient survey, where almost 65% of respondents felt it was not easy to obtain optometry care, and some of their comments included:

"We need an optician because I am getting migraines straining my eyes reading or watching TV. I need glasses".

"Need optician badly, raised issue and complained and still waiting and I really need them".

Since our fieldwork, the health board has taken steps to address this gap in eye care provision and secured a contract with the Prison Optician Trust and was implemented in January 2022. Senior managers within the health board PCT service group informed us that there is a plan in place to ensure that all patients currently waiting for an assessment, will be reviewed by the end of March 2022.

Recommendation 16

The health board must consider the impact on the prison population as a result of the prolonged period without access to eye care services, and how it can mitigate against the risk of this occurring in the future.

Pharmacy services

In September 2021, a new pharmacy delivery model was introduced to the prison. The model provides two on-site pharmacists, one of which can prescribe medications (within their scope of practice). They are managed by the lead on-site GP and have professional accountability to the health board's Pharmacy and Medicines Management division, within the Neath Port Talbot Singleton Service Group.

During our interviews with the pharmacy team, it was highlighted that NHS Wales has recently introduced a new electronic pharmacy stock control, called *WellSky*. This system is designed to improve the accuracy of computerised dispensing and medicines stock management, and staff were hopeful this would maintain efficient medicines management within the prison. However, the pharmacists highlighted that training was not yet complete for the use of *Wellsky*, and since 'going live', there had been a lack of information technology support from DHCW (Digital Health and Care Wales) for the system.

We explored the pharmacists' understanding of the HMIP *Scrutiny Visit* reports, and the recommendations highlighted within them in relation to medicines management. However, they were not aware of the recommendations of the report and had not been included in any of the plans to implement actions for the recommendations.

As highlighted earlier, our review noted that the health board did not at the time of our review hold the necessary Home Office license to possess and dispense CDs in HMP Swansea. We were told that when healthcare services were repatriated to the health board in 2016, the health board did not supply CDs to HMP Swansea, and instead the prison received stock CDs directly from a pharmaceutical wholesaler. It was therefore established following legal advice obtained by the health board in conjunction with contact with the Home Office, that HMP Swansea required a license to possess and dispense CDs. This resulted in an action being set for the prison to apply for a Home Office licence to possess and dispense CDs.

However, in June 2020, the health board was notified by one pharmaceutical wholesaler which supplied CDs to HMP Swansea, that it required a copy of a Home Office CD license in place for the prison, to continue the supply of CD medication. The wholesaler agreed to a grace period until the end of 2020 to allow the prison to continue ordering and receiving CDs. By January 2021, a licence was not in place, one wholesaler therefore ceased the supply of CDs to the prison.

As a result, in January 2021, a decision was made that whilst the health board would seek a meeting with the Home Office to clarify the issues of Home Office CD licenses, it would apply for a Home Office CD license to possess and dispense CDs at HMP Swansea.

The health board did not have a Home Office licence in place to possess and administer CDs within HMP Swansea at the time of the fieldwork. Whilst we have subsequently received assurance that a licence was granted in May 2022, the delay to obtaining this licence was compounded by the fact that the health board initially sought legal advice to clarify appropriate 'ownership' and appropriate naming on the application, and there was a Home Office suspension to onsite visits due to the COVID-19 pandemic, to review the environment. The prison residents who require CDs continue to receive them as prescribed, through the health board hospital department and through the remaining pharmaceutical wholesalers.

Recommendation 17

The health board must take appropriate action to address any issues arising as part of the implementation of the new electronic pharmacy system, and to ensure all staff are adequately trained, and that appropriate support is always available to staff if required.

Recommendation 18

The health board must ensure that the pharmacy team based at the prison are made aware of the latest HMIP report findings, and that any actions set by the health board as a result are shared with them to ensure improvement.

Recommendation 19

The health board must undertake a prompt review of its governance arrangements to ensure it is compliant with all medication licensing requirements.

Recommendation 20

The health board must provide HIW with an update regarding the progress of the CD license application, and when it has been granted.

Mental health services

We explored mental health support for prison residents. Our healthcare staff interviews noted that a Mental Health Crisis Team has been introduced within HMP Swansea to provide prompt support to the men when required and includes substance misuse support. The team has been in place for approximately two years, and is supported by a nurse manager, four senior staff nurses and a group therapy practitioner.

We found that the health board also provides a Mental Health In-Reach Team (MHIRT) service to the prison. This service is shared between HMP Swansea and HMP Parc[26], which is a privately owned category B prison and Young Offenders Institution located in Bridgend.

Our interview with staff from the MHIRT highlighted that the team did not attend HMP Swansea throughout the pandemic, and instead completed virtual assessments. This was to reduce the footfall within the prison to maintain good infection prevention and control. However, this impacted on the ability to provide the required level of service to the prison residents. This was also highlighted in our interviews with prison staff, who raised concerns around the limited MHIRT services, and the fact that appointments were virtual assessments and consultations.

We found this issue raised by prison staff was also highlighted within the health needs assessment report dated January 2021. That report identified that:

'the majority of the resources in the in-reach team are absorbed into HMP Parc, due to the sheer size and demand'.

The report recommended:

> *'There may be benefit in ring-fencing the proportion for the in-reach team that should be available to HMP Swansea, to ensure that needs are met and that any demands in HMP Parc do not result in a reduced service in HMP Swansea'.*

It was not clear from our review as to what actions have been taken in line with the recommendation above, and how the health board has considered it to ensure the appropriate service is delivered to HMP Swansea.

Through our interviews with MHIRT staff, we identified that the staff establishment had not been reviewed for quite some time, particularly since HMP Parc had increased in population, and its demand for mental health services has increased. Our discussions highlighted that the resources available did not meet the demand.

Whilst some on site MHIRT services have now resumed at HMP Swansea, we believe that the health board should review the team's establishment, to understand whether the MHIRT is adequately resourced to meet demand.

[26] HMP Parc

The issues regarding potential unmet demand at HMP Swansea, were corroborated by our patient survey respondents for the prison residents with nearly 60% saying it was not easy to access mental health services. This is a concern, since 71% of respondents said they have mental health needs.

Some comments included in our survey from the prison residents include:

"Mental health is a big issue in here and should be treated as a priority".

"Not having to wait months for appointments. I'm still waiting 3 months to see a mental health worker".

"I suffer with PTSD and ADHD, and I have not received no help from mental health at all even though I was promised help".

"Better mental health support the MH services here are shocking".

In contrast to the prisoner comments within our survey, senior health board staff expressed their view that they were satisfied that the service provided by the In-Reach team had been sufficient during the pandemic. In addition, that the model of delivery was in line with that of other services provided across the health board during the pandemic.

We were unable to confirm whether the level of MHIRT services received by HMP Swansea had been sufficient, and whether the addition of the MHIRT service being provided to HMP Parc was detracting from that provided to HMP Swansea. However, based on the feedback we received from prison staff, prison residents and the conclusions of the health needs assessment report, more attention is required to ensure that the men at HMP Swansea have timely access to the appropriate level of mental health support.

Recommendation 21

The health board must review the current staffing establishment of MHIRT, to ensure the resources available meet the demand of mental health services, in both HMP Swansea and HMP Parc.

Recommendation 22

The health board must consider how the performance of its MHIRT service is monitored, to ensure it is meeting the needs of the HMP Swansea residents. In addition, it should consider how it can obtain regular patient feedback from the prison's residents in order to shape service provision.

Health Therapies

We considered the need of those who may require therapy services, such as occupational therapy, physiotherapy, and dietetics. We held interviews with staff and learned that any occupational therapy assessments which are required for applicable prison residents, are provided through secondary care mental health services.

It is positive to note that discussions have taken place, exploring the option to provide physiotherapy services directly to the prison. Whilst these discussions have taken place, we were not provided with the outcome or what plans if any, will be made for this service at the prison.

Through our interviews with staff, we also identified that the health board does not currently provide nutrition and dietetic services directly into the prison. We were told if this service were to be implemented, additional resources would be required. This also includes resource to offer greater range of services relating to nutrition and dietetics, such as gastroenterology, weight management, nutrition support, nutrition supplementation, food behaviours and any nutrition related concerns. At present patients can access these services through primary care or secondary care referral.

Health promotion

We considered the health promotion information available to the prison residents. It was disappointing to learn from all staff groups that very little health promotion is offered to prisoners. This is not in line with the vision outlined in the Partnership Agreement for Prison Health in Wales (2019), to drive improvements in the health and wellbeing of people held in Welsh prisons. In addition, neither does it align to the objective to promote good health and well-being for everyone, as highlighted in the Welsh Government Strategy *Prosperity for All: The National Strategy*.

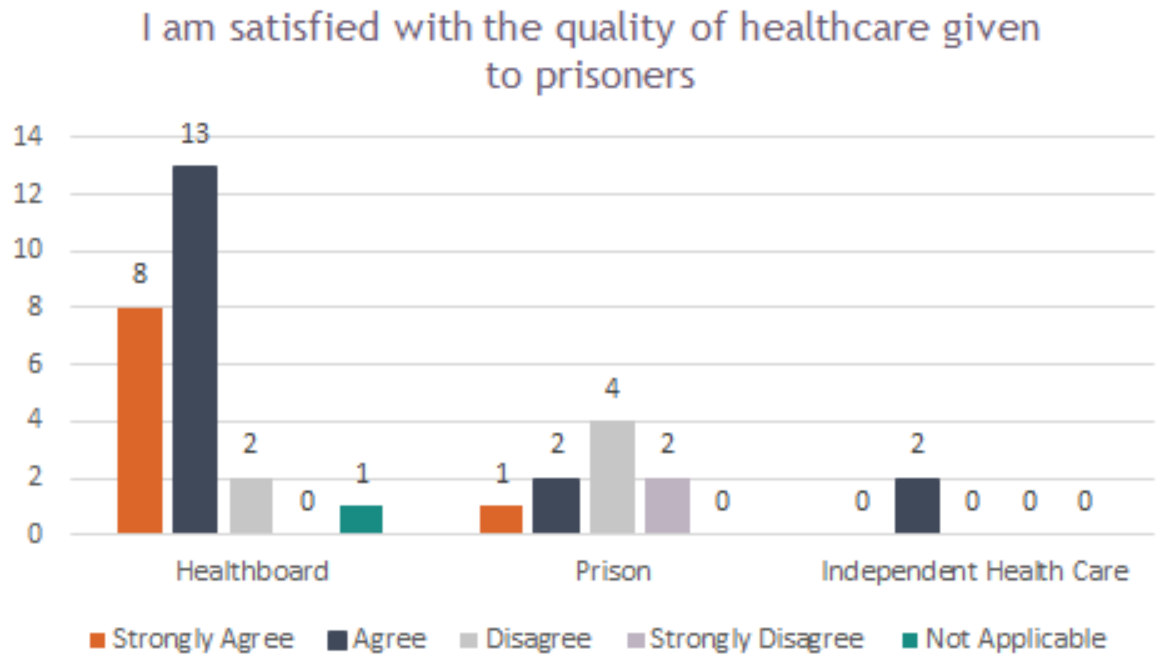
During our staff interviews, we were told that a Health Promotion Steering Group had previously been in place. However, this was discontinued and had not met since 2016, which appears to coincide with the TUPE of prison healthcare staff to the health board in 2016. This was also the same for the Prison Health Improvement Group, which had been a forum for discussion and policy change in relation to health improvement.

Recommendation 23

The health board must consider how a strengthened approach can be implemented for health promotion within the prison, with a view to promoting the health of prisoners and addressing health inequalities.

We identified several governance issues around the healthcare services provided at the prison, and in our staff survey we asked whether staff were satisfied with the quality of healthcare provided to prisoners.

The table below highlights their responses:



From a healthcare staff perspective, it was positive to note that most respondents were satisfied with the quality of healthcare given to prisoners. However, responses from the prison staff reflected more negatively, with the majority disagreeing with this.

The following prison staff comments were made relating to quality of healthcare:

"Healthcare team in HMP Swansea provide excellent standards of care within the limitations imposed on them by appalling availability of resource (primarily labour hours). I've spent years watching healthcare team members work in very difficult conditions providing the best levels of care within their abilities".

"The whole healthcare provision at Swansea needs to be evaluated as currently it nowhere near provides adequate care for prisoners. The mental health provision at Swansea is woefully short and leaves staff and prisoners vulnerable. The staff try to do a good job but suffer from poor management and shortages".

In view of our findings regarding governance issues for healthcare services provided at the prison, it is concerning to note that healthcare staff appear to be content with the services provided, particularly when this is in contrast with prison staff and prison resident feedback.

Work is required by the health board to understand how or why its staff reflect positively on the services provided to HMP Swansea, as compared with the views of others set out within our review. The health board must consider whether key information is appropriately being conveyed through its quality governance framework and is being addressed at the appropriate level. This is to gain an understanding of the disparity of opinion between staff groups and prison residents on the quality of healthcare services provided to the prison. In addition, the health board should consider how it can obtain and learn from ongoing prison staff and prison resident feedback, in relation to services available and provided to HMP Swansea.

Recommendation 24

The health board PPB must consider:

a. The disparities between staff groups and prisoner perceptions of prison healthcare services and whether key information is appropriately conveyed through its quality framework.

b. How it can obtain and learn from regular prison staff (non-healthcare) and prisoner (patient) feedback, in relation to services available and that provided to HMP Swansea, and act accordingly on the feedback.

Workforce and culture

The prison healthcare staff establishment

We reviewed the healthcare staff establishment within the prison. The healthcare team provides 24-hour care, and is managed and led by a Lead Nurse, who is responsible for 20 whole time equivalent substantive members of staff.

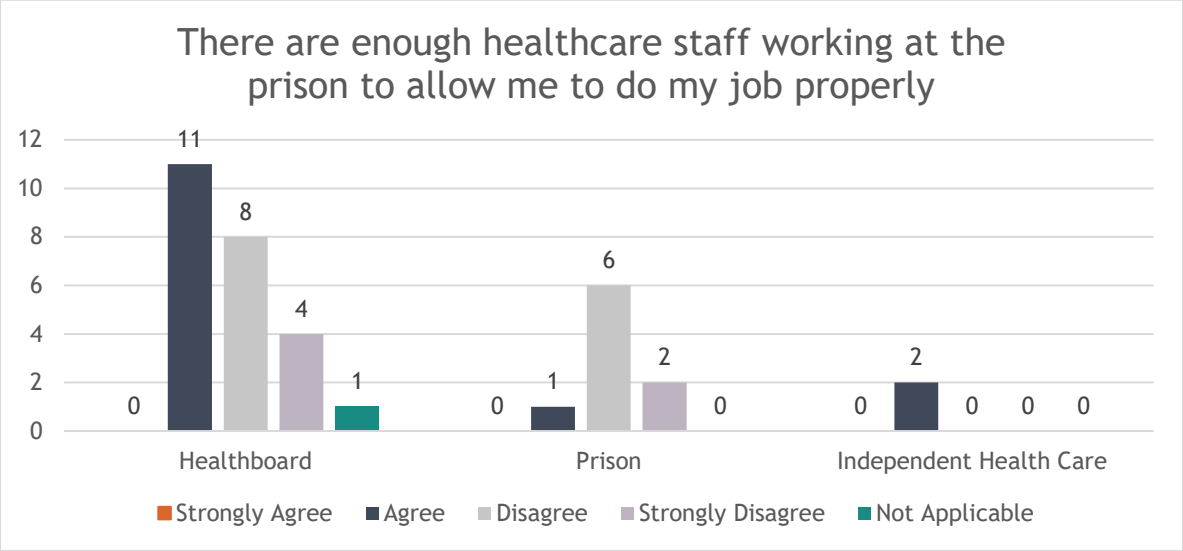
During our interview with the Lead Nurse, we were informed that the establishment contains numerous long-standing members of staff, which offers some continuity to the healthcare services provided at the prison. However, there has also been a high turnover in some posts, with some leaving after just two years.

Following discussion with senior nurse managers, and our review of the prison healthcare team establishment, we learned it had not been reviewed since the TUPE of staff to the health board in 2016. We found there were several vacancies, and that coupled with staff short term absences, the team were reliant on bank and agency staff to fulfil the rota.

The staffing numbers were noted by some prisoners within our patient survey:

"A few more Nurses [are needed] as the ones here are always very busy so this limits the time they can spend with each case".

To explore the staff perception on staffing levels further, within our survey we asked whether there are enough staff to carry out their role properly. The table below highlights the results:



Over half of respondents thought there were not enough healthcare staff at the prison, to allow them to do their job. Health board staff were divided in their opinions, with 46% suggesting enough, and 50% suggesting not enough staff. Most negative responses came from prison staff, with 89% citing not enough staff.

The following comments were made relating to healthcare staffing:

"We appear to be short of staff compounded by absences with insufficient healthcare Staff to enable them to do normal duties such as two nurses moving controlled drugs. Healthcare staff do not have enough staff to send one to reception of the morning as they do not have the resources. We have not had an optician for nearly 20 months with little ambition to address this need".

"There are not enough medical staff to meet the needs at Swansea. Treatments often overrun as the healthcare staff are pulled from wings to cover reception. The profiling of healthcare staff is inadequate to meet the needs. Services are sporadic and cancelled short notice, we have been waiting approximately 2 years for an optician, and this is unacceptable. Medical escorts are sent out without a proper examination usually by advice given from the on call doctor over the phone. This places huge strain on staffing within the prison often having to curtail regimes to facilitate".

"The management of the healthcare department at Swansea [prison] is questionable and either support or action plans for improvement need to be in place".

"The interface between Secondary care Mental Health and the Crisis team have improved, however what is not clear is the work being done by the Primary care Mental Health Team and this may be due to lack of staff in that area of Mental Health Service provision".

"Often there are not enough healthcare staff available to fully meet the needs of the prison".

Whilst many negative comments were received, in numerical terms, opinion around staffing was more balanced, with around half of healthcare staff feeling there are enough staff and the other half not.

Recommendation 25

The health board must review the adequacy of the prison healthcare nursing establishment, to ensure it is sufficient to meet the current level of demand for health care services in HMP Swansea.

Service culture

We explored the culture of the prison healthcare service. Within our staff survey, most healthcare staff felt that the work they do is recognised and valued positively by the health board. Whilst half of prison employed staff did not find this statement applicable to them, for the remaining staff only half responded positively that the work they do is recognised and valued. Whilst we cannot be certain that their responses were reflective of the prison as the employer, the Prison Governor should consider its staff's responses.

It was positive to note that most staff felt their department encouraged teamwork and was consistent across all staff groups.

When considering staff management support, the consensus amongst all healthcare staff was that their department manager was supportive, although a quarter of prison staff disagreed with this in their line of work. The following comment was made by healthcare staff:

"I feel valued and there is a great relationship between myself and my management team, they have been supportive and have helped me achieve my goals and aims as highlighted in my PADR".

Most staff believed there was a culture of openness and learning in their department, with most healthcare staff, and just under two-thirds of prison staff in agreement with this.

Staff also indicated a good working relationship between healthcare staff and prison staff. Although, this feeling was greater within healthcare staff groups than within the prison staff, where just over a third disagreed with this.

Most staff indicated that their managers acted on staff and prisoner feedback, and staff told us they felt safe in providing and supporting healthcare services at the prison.

Incidents and concerns

We considered the culture around reporting and managing incidents and concerns within the prison healthcare services and asked about this in our survey of staff.

The majority of staff indicated they were actively encouraged to report incidents or concerns, and they knew how to do this. Staff were also aware of whistleblowing procedures and indicated they were treated fairly if they were involved in an incident or a concern, with only one person in disagreement with this.

One comment included:

"I feel confident and competent in raising any concerns if and when they arise".

However, the following comment was made by a member of staff who said:

"When raising issues, confidentiality is not maintained and who whistle blow's identity is not protected".

We found that when incidents or concerns are reported, most healthcare staff feel that action is taken to help ensure that they do not happen again. However, whilst this was reflected positively by healthcare staff, only half of prison staff agreed with this.

Healthcare staff told us that learning from incidents and concerns is shared with staff, however, only half of prison staff agreed with this, and a quarter disagreed with the remaining feeling this was not applicable to them.

We do, however, have concerns over the rigour of recording and capturing concerns raised by prisoners, and expand upon this later in the report.

Staff Training and Personal Appraisals

We considered whether staff were able to undertake training and received regular appraisals of their performance at work.

We asked staff whether they were able to attend statutory or mandatory training. It was positive to find that most staff groups answered positively with this.

We also asked if staff had received an appraisal or performance and development review of their work in the last 12 months. It is encouraging to note that this was reflected positively by healthcare staff, however, only half of prison staff agreed with this.

We received some comments in our survey around appraisals, performance, and development, which included:

"I strongly agree that my learning and development needs are well catered for, and I am supported to attend courses that will help me deliver better service outcomes and deliver excellent and safe patient care".

"Prior to becoming bank [nursing] staff, I was a substantive member of the team at HMP Swansea and was offered appraisals and PADR regularly and consistently during that time".

Staff health and wellbeing

In our survey, we considered the health and wellbeing of staff, and asked if they felt their managers took positive action on their health and wellbeing, and if they were offered full support in the event of challenging situations. It is reassuring to note that most staff responded positively to this, particularly since they were working within a secure prison environment.

In addition, most healthcare staff were aware of the occupational health support services which are available to them through the health board. However, only 63% of prison staff indicated an awareness of this service being available to them.

We received some comments from healthcare staff in relation to wellbeing, with one comment including:

"I am aware of services available to me such as the wellbeing and Occupational Health service that can be easily accessed if required. I also feel I have an excellent work life balance, and I feel well supported by management team in my workplace".

Patient Experience

One of our key objectives for the review was to understand the overall experience of the prison population who have healthcare needs. Throughout our review, we identified a poor focus on obtaining and acting on patient experiences at HMP Swansea.

The patient experience at HMP Swansea

There was minimal evidence of the health board providing the opportunity for prison residents to express their experience of using healthcare services within the prison in order to identify any trends or concerns and use this to improve services. We were informed that the prison facilitates a weekly prisoner forum, where representatives of the prison residents can raise and discuss current matters, issues arising and concerns.

These are attended by a member of the healthcare team. However, the health board does not provide any specific prison healthcare forums.

We found no evidence of patient experience within the prison population being fed into and considered by, the health board, or of any plans in place to gather such feedback. This represents a missed opportunity for the health board to demonstrate that it listens to the views of the prison population and uses this to inform improvement. It also suggests a lack of priority for prison healthcare from a health board perspective.

The health board's Patient Experience Team acknowledged that improvement is required around gathering patient experience from the prison residents, to gain an understanding around the quality and safety of services provided to the men, and to supporting service improvement.

Recommendation 26

The health board must consider how it can obtain regular patient experience feedback from the prison residents at HMP Swansea, and to consider these findings in line with how this is considered regarding people within the health board's other communities.

Management of concerns

We explored the process for dealing with patient concerns raised within the prison.

During our interviews with healthcare staff, we identified that any healthcare concerns raised by the prison residents were managed differently in the prison as compared with health board corporate procedures for complaints or concerns.

The prison healthcare team had adopted a procedure entitled *HMP Swansea Healthcare Complaints Pathway*, which is an amended version of the health board's *Putting Things Right*[27] Policy. The procedure presents a complaint handling process tailored for the prison environment.

Its aim is to encourage prisoners to verbalise their concerns with healthcare staff, with a view for immediate resolution where possible.

The pathway requires all 'on the spot' concerns to be documented and logged as informal concerns on the health board's incident reporting system 'Datix'. However, we were told by senior nurse managers that such concerns were not routinely recorded on Datix. This limits the ability of the health board to monitor patient concerns, identify learning from these and to help make improvements.

The PCT service group teams informed us that a concerns overview report is presented to the PPB, however, as highlighted earlier, the PPB had not met during the pandemic. Regular PPB meetings have now resumed, however, there has been a lack of scrutiny of concerns over the past two years because of the pandemic.

[27] See: Health in Wales | Putting Things Right

There is a need now to ensure that the information on concerns reported to the PPB is accurate, and that Datix is being used appropriately.

In our interviews with prison staff, we learned that the NHS Wales *Putting Things Right* process was not readily advertised to prisoners. This was echoed in our patient survey for the prison residents, where almost half the respondents indicated they were unaware of how to make a complaint about healthcare services. As noted earlier, the prison complaints pathway's aim is to resolve complaints in the first instance where possible. However, if prisoners wish to complain about healthcare services formally, then they need to be aware of the *Putting Things Right* process, to help them with this.

Our interviews highlighted that healthcare staff do not routinely discuss with prison staff concerns raised by prisoners about their healthcare. In addition, we found that prison staff would welcome regular dialogue to allow them to contribute to addressing concerns wherever possible, in order to make improvements. This is clearly an area that requires attention and strengthening.

Recommendation 27

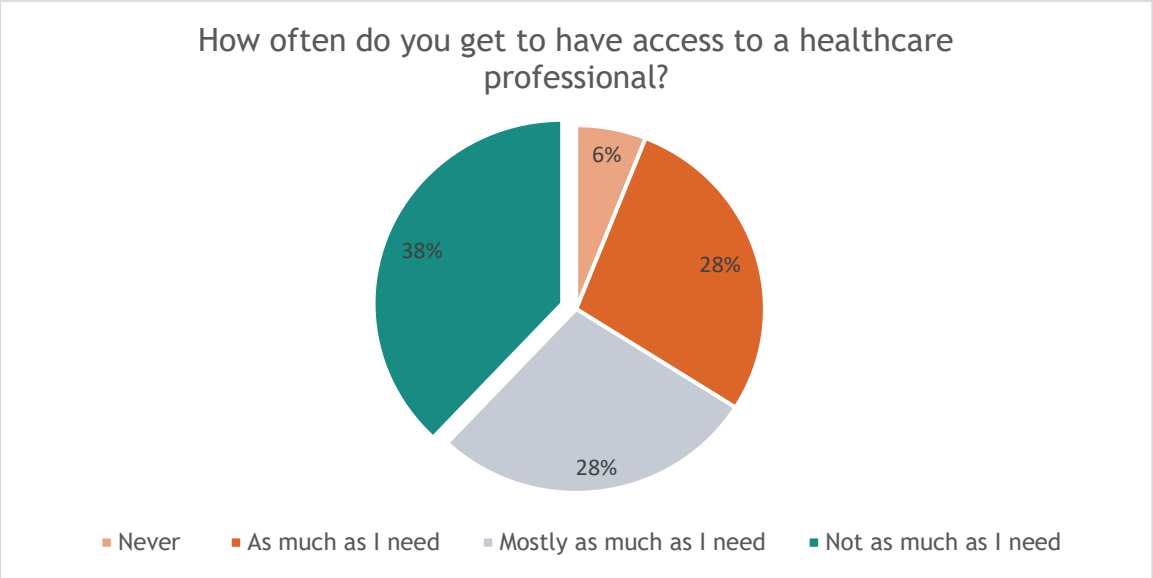
The health board must ensure that its prison healthcare staff are recording prisoner concerns as highlighted within the HMP Swansea Healthcare Complaints Pathway. In addition, that these are accurately reported to the PPB for monitoring and action planning as appropriate.

Recommendation 28

The health board must ensure the prison residents have access to information relating to NHS Wales Putting Things Right process and are provided with information on how to raise a concern regarding healthcare.

Patient access to healthcare

We asked the prison residents how often they can access healthcare if/when required, the responses are reflected in the chart below:



Just over half said they had access to healthcare professionals mostly, or as much as they needed. The remaining residents felt they could not access a healthcare professional as much as they needed, with 6% stating they never have access when needed.

We received several comments relating to the timeliness of access to healthcare, which were highlighted earlier in the report. We also asked the respondents how healthcare services could be improved. Some responses included the following comments:

"Get back to people in a timely manner. Personally, I have been waiting over 4 weeks to be seen about my requests".

"Faster response times to healthcare appointments and listen to inmates about our problems".

More than half of patients said they found access difficult to all services, except for substance misuse. The services that were most difficult for patients to gain access to be the dentist, optician and GP, which has been discussed earlier in the report.

Patient engagement with healthcare staff

It is reassuring to note that most patients within the prison felt that staff treated them with dignity and respect, and that their healthcare was explained to them in a way that they understood.

A positive comment was shared by a prison resident as follows:

"Thank you for the help towards a better future for me and my problems I face, it means a lot to me and I appreciate the work you all do at health care, thanks".

However, when we asked the prison residents in our survey whether they were involved in decisions about their healthcare treatment, around half of those who responded felt they were not involved.

We received comments in relation to this, which included:

"If they listened to us instead of thinking what they think is right, then they just sign off because they think they're always right".

Timely medication prescriptions

For patients who required medication prescriptions, 70% said that it was received in a timely manner, however, some negative comments were made in relation to the distribution of medication:

"Automatically re-order prisons medication so there aren't missed days".

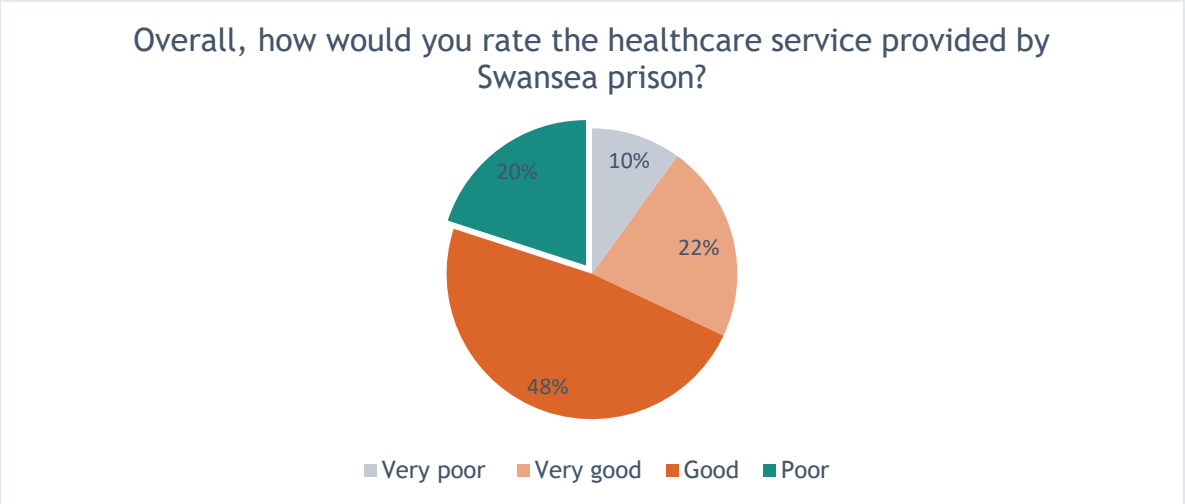
"The alcohol detox programme they put you on don't last long enough. I still get withdrawals".

"Involve you more in the treatment required, also the hatch where medication is provided is slow and you're only allowed to the hatch at certain times".

Overall patient experience of prison healthcare

In response to our question to patients regarding how they rate the healthcare services provided to them, the majority felt this was good or very good.

This is reflected in the table below:



We received several comments in relation to the healthcare services from the patients, and these include:

"Think they do a fantastic job as understand it can't be the easiest place to work and I feel there is more compassion here for me and my problems so thanks to all healthcare staff"

"I don't think they need to as I find they are brilliant compared to Berwyn & Parc & Cardiff, much better and they are all genuine here"

"The care I have received since being in HMP Swansea has been top notch".

Overall, our survey identified a number of positive findings in relation to patient experience. However, there is an opportunity and need for the health board to ensure that engagement with prisoner feedback is prioritised to drive service development and improvement.

It is also important that the residents at HMP Swansea receive feedback regarding our review report, and what action will be taken in response to the report's recommendations.

Recommendation 29

The health board must inform HIW how it will work with the Prison Governor to share the findings of our review with the prison residents. This must also consider how the report's recommendations will be responded to.

Is the quality and safety of prison healthcare services understood at Board level within the health board, and are any concerns and issues arising adequately acted upon in line with corporate procedure?

Throughout our review, we considered the quality governance arrangements in place across the health board, with further scrutiny over the healthcare arrangements for HMP Swansea. Having done so, we wanted to understand how well sighted the Board is on the quality and safety of prison healthcare services, in particular of the operational delivery issues identified by our review.

We held interviews with senior members of the health board and independent board members. All had a sound understanding and knowledge of the principles of the health board's corporate quality and safety governance framework, and regarding the provision of healthcare services to the prison. However, not all were aware of the local governance arrangements in place within the prison or that the PPB had not met between December 2019 and August 2020.

Through our discussions with independent members of the Board, it was evident that HMP Swansea was of low priority within the health board's governance framework and was not in the line of sight of the Board from a quality governance perspective. Our interviews identified concerns that Board members had not been in receipt of any reports relating to inspection or assurance work within the prison. This included DIC reports, and they expressed concerns that action taken in response to DIC recommendations was not being appropriately triangulated through the governance framework.

Several PCT directors and independent board members were not aware of the publication of the Senedd report by the HSCSC dated March 2021[28]. As highlighted earlier, this committee report outlines agreed priorities between Her Majesty's Prison and Probation Service (HMPPS) in Wales, the Welsh Government, Local Health Boards and Public Health Wales to drive improvements in the health and wellbeing of those held in Welsh prisons. We were informed that the PPB would take direct responsibility for the delivery of improvements noted in the report, however, as noted by our review, the PPB had not met for some 20 months.

In addition to the lack of oversight of reports, some independent board members had not seen and were not aware of any patient experience information from prison residents regarding healthcare services within the prison. Furthermore, we were told that any concerns information escalated through the PCT governance framework to the QSC or Board meetings, did not include any issues related to prison healthcare.

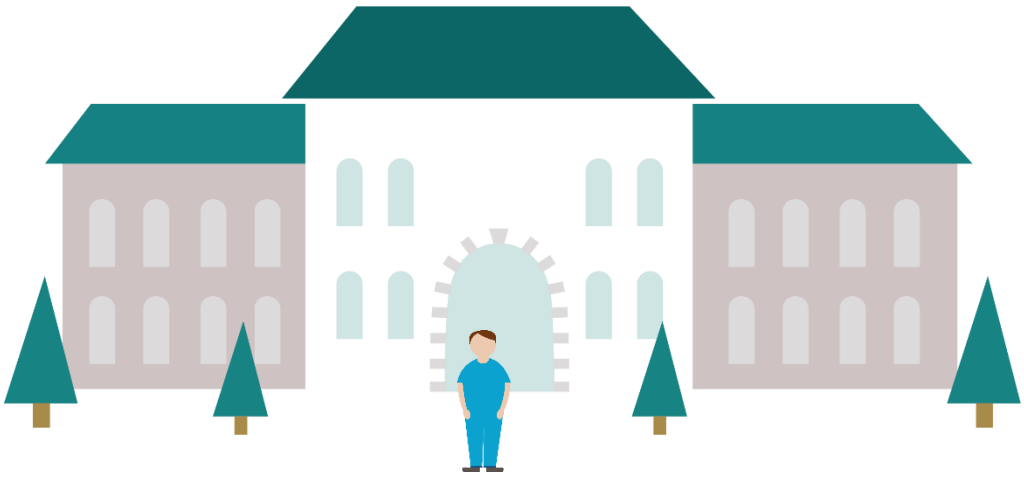
[28] See: Health and social care provision in the adult prison estate in Wales (senedd.wales)

Our interviews identified that some independent members had never received any information relating to risks associated with the prison, which is consistent with our other findings, with no risks relating to prison healthcare services captured on the health board risk register.

We were informed that independent members have requested more assurance relating to action taken and mitigation of risks across the health board. This was also highlighted by Service Group Nurse Director, who indicated there was work required with more attention needed on the risk register, and for those who should access it.

Along with senior staff within the PCT service group, very few Board members had visited the prison to date. Whilst we have already acknowledged the issues with the constraints associated with visiting a secure custodial environment, it is important the health board recognises the need to develop an improved programme of engagement and visibility with the prison. However, our interviews with independent members indicated that they were keen to see improvements in the quality governance arrangements associated with the prison healthcare services.

The senior health board staff we interviewed were accepting of our findings that the collection and reporting of key performance indicators for the prison healthcare services, was inconsistent with other services provided by the health board, and work is required to develop and improve this area.



Conclusion

It is clear from our review that those working within the prison healthcare services strive to provide the best care possible to patients at HMP Swansea, particularly within the challenges and constraints of a secure custodial environment.

Whilst we recognise the challenges faced by the health board and prison service during the pandemic, improvements are required to strengthen healthcare quality governance arrangements for the healthcare services provided at HMP Swansea.

Our review has highlighted that prison healthcare does not feature prominently on the health board's agenda. This requires attention and action, as we are not assured that key quality information is being reported, escalated, and acted upon appropriately, posing a potential risk to the safety of the prison population.

The health board needs to strengthen oversight of prison healthcare services, and ensure it takes timely action in response to internal and external assessments and reviews, and that these actions are monitored effectively.

The health board, in partnership with the prison, must also do more to seek and engage the views of the prison population, to inform service design and improvement. Whilst our surveys have highlighted positive experiences for some when accessing support for their mental health or substance misuse needs within the prison, we also heard frustration about the timeliness and ease of access to other services, particularly for dental and optometry services.

Overall, we consider the quality governance arrangements in place for prison healthcare are not robust enough to ensure appropriate Board oversight of any issues or concerns. This includes a limited oversight of key quality performance indicators for prison healthcare, which in turn are not scrutinised in the same way that other healthcare services are throughout the health board.

Action is required on the part of both the health board and prison to make improvements and strengthen partnership working in order to ensure the quality of healthcare services provided at HMP Swansea is maintained and improved.

What Next?

We expect the health board and prison partnership board to carefully consider the findings from this review and act upon the 29 recommendations set out within the report and listed within Appendix A.

We hope that this review will be used to improve prison healthcare services being provided not only to HMP Swansea, but also to help the health board consider the robustness of its governance process in place for other services throughout the organisation.

The health board will be required to submit an improvement plan in response to the review's recommendations. This is to ensure that the matters raised by our review are being addressed.

It is our expectation that the health board, alongside the prison, will ensure that the prison residents have an opportunity to receive and understand the findings from our review.

We will publish the report and ensure it is shared directly with other health boards in Wales who have a responsibility for delivering healthcare to Welsh prisons. This is to ensure learning is shared, and to allow other health boards to consider the robustness of their governance arrangements for healthcare services provided to their respective prisons.

The findings throughout our review and highlighted in the report will enable us to consider what further work HIW will undertake.

Appendix A - Recommendations

As a result of the findings from this review, we have made the following recommendations in the table below.

	Recommendations
1	The health board and prison partnership board must consider how they gain assurance, that any reports or recommendations relating to prison healthcare published by both Welsh Government and Senedd committees, are identified, received and disseminated to the appropriate individuals throughout the health board and prison. In addition, that action is taken to ensure appropriate membership and attendance of the Prison Health Oversight Group.
2	The health board and prison partnership board must ensure that recommendations made in the report, Health and Social Care provision in the Adult Prison Estate in Wales, are reviewed and considered, and take action where necessary.
3	The health board and PPB must ensure there are clear lines of reporting and escalation into the PPB terms of reference, to ensure robust governance arrangements are in place for the management of healthcare services at the prison.
4	The health board and PPB must promptly address the outstanding recommendations made in the Tamlyn Cairns Partnership health needs assessment report and implement any actions and monitor as appropriate.
5	The Health Board must ensure that it has a clear strategy and plan for the commissioning and delivery of healthcare services, and for the wellbeing and improvement of prisoner health.
6	The Prison Partnership Agreement must be reviewed and updated promptly by the health board and HM Prison Service. This must reflect current arrangements for commissioning and accountability for the delivery of healthcare services at HMP Swansea.
7	The health board must ensure quality and safety matters arising from HMP Swansea are defined, reported, and escalated appropriately through the governance framework. In doing so, it must: a. Ensure that the appropriate groups within the quality and safety governance framework scrutinise and monitor actions taken to address recommendations made in all external inspection reports. b. Ensure that all outstanding recommendations made within the HMIP Scrutiny Visit reports, CHC report, and DIC report recommendations, are considered robustly, and any actions taken should have regular review to ensure appropriate and timely actions are implemented.
8	The health board must ensure adequate arrangements to identify, escalate, record, manage, and mitigate risks in relation to healthcare services at HMP Swansea.

9	The health board must improve visibility and oversight of clinical audit, and ensure this activity is reported to relevant governance groups for monitoring and scrutiny for prison healthcare services.
10	The health board and prison must consider how it can address the issue identified around staff safety, and the availability of 'panic alarms' within the healthcare environments at the prison.
11	The health board and prison must review and update the memorandum of understanding to ensure that there is clarity around responsibility and accountability for repair of premises and healthcare equipment.
12	The health board should review the clinical pathways used to deliver care to the prison population to ensure they are appropriate to the secure environment. Consideration should be given to the variety of patient needs, and to ensure appropriate and up to date guidance is available to both substantive and temporary healthcare staff.
13	The health board and prison should consider commissioning a further health needs assessment to establish what clinical pathways should be in place at the prison.
14	The health board must explore how individual health records can be accessed by GPs working within the prison, to ensure timely and an up-to-date history of patients is available, and to also provide timely health care and prescribing for prison residents.
15	The health board should take steps to consider and monitor the service provided by the dental provider 'Time for Teeth', to ensure its contractual obligations are meeting the needs of the prison residents.
16	The health board must consider the impact on the prison population as a result of the prolonged period without access to eye care services, and how it can mitigate against the risk of this occurring in the future.
17	The health board must take appropriate action to address any issues arising as part of the implementation of the new electronic pharmacy system, and to ensure all staff are adequately trained, and that appropriate support is always available to staff if required.
18	The health board must ensure that the pharmacy team based at the prison are made aware of the latest HMIP report findings, and that any actions set by the health board as a result are shared with them to ensure improvement.
19	The health board must undertake a prompt review of its governance arrangements to ensure it is compliant with all medication licensing requirements.
20	The health board must provide HIW with an update regarding the progress of the CD license application, and when it has been granted.
21	The health board must review the current staffing establishment of MHIRT to ensure the resources available meet the demand of mental health services, in both HMP Swansea and HMP Parc.
22	The health board must consider how the performance of its MHIRT service is monitored, to ensure it is meeting the needs of the HMP Swansea residents. In addition, it should consider how it can obtain regular patient feedback from the prison's residents in order to shape service provision.

23	The health board must consider how a strengthened approach can be implemented for health promotion within the prison, with a view to promoting the health of prisoners and addressing health inequalities.
24	The health board PPB must consider: a. The disparities between staff groups and prisoner perceptions of prison healthcare services and consider whether key information is appropriately transported through its quality framework. b. How it can obtain and learn from regular prison staff (non-healthcare) and prisoner (patient) feedback, in relation to services available and that provided to HMP Swansea, and act accordingly on the feedback.
25	The health board must review the adequacy of the prison healthcare nursing establishment, to ensure it is sufficient to meet the current level of demand for health care services in HMP Swansea.
26	The health board must consider how it can obtain regular patient experience feedback from the prison residents at HMP Swansea, and to consider these findings in line with how this is considered regarding people within the health board's other communities.
27	The health board must ensure that its prison healthcare staff are recording prisoner concerns as highlighted within the HMP Swansea Healthcare Complaints Pathway. In addition, that these are accurately reported to the PPB for monitoring and action planning as appropriate.
28	The health board must ensure the prison residents have access to information relating to NHS Wales Putting Things Right process and are provided with information on how to raise a concern regarding healthcare.
29	The health board must inform HIW how it will work with the Prison Governor to share the findings of our review with the prison residents. This must also consider how the report's recommendations will be responded to.