SUMMARY OF THE KEY MESSAGES

The PPO fatal incident report, NHSE independent clinical review and clinical notes from SystmOne were obtained for 247 people who died in prison, or in hospital while detained. These data were reviewed by a group of clinicians including prison general practitioners, specialist nurses, consultants in palliative medicine, and consultants in psychiatry. In addition, an anonymous survey collected the views of healthcare professionals working in prisons.

Death was used as point of entry into the study, but the report focuses on the quality of healthcare in the preceding months.

The aim was to improve healthcare in prisons for current and future prisoners.

In conclusion: the report has **15 recommendations** and listed below are the **six primary areas for improvement.**

Examples of excellent care we found, particularly in mental health and end of life care, highlighting what can be achieved.

1 IMPROVE HEALTHCARE ASSESSMENTS AND THE MONITORING OF LONG-TERM CONDITIONS

26.9% of patients with **advanced chronic diseases** (e.g. heart failure) had the most overall **room for improved healthcare. 15.4%** in the **frequency of clinical review.**

44.2% of patients had **scope for improvement** in **health assessments**. Frequent areas for improvement were **history taking** for **physical health** problems, **mental health** conditions or **smoking, alcohol** or **drug misuse**.

2 RECOGNISE CLINICAL DETERIORATION AND USE NEWS2

68.0% of patients had evidence of **clinical deterioration prior to death**.

87.1% of patients had an **emergency transfer** to hospital due to **acute deterioration** in physical health.

NEWS2 was used to **assess 55.6%** of patients and to **monitor 40.5%**. The **use of NEWS2** could have been **improved** for **30.7%** of patients.

Clinical **deterioration** was **not managed appropriately** in **27.3**% of patients prior to emergency hospital transfer.

3 PLAN FOR EMERGENCY TRANSFER TO HOSPITAL AND IMPROVE COMMUNCATION AND HANDOVER

64.6% of patients required **emergency transfer to hospital** in the 12-months prior to their death.

13.5% of **transfers to hospital** were **preventable or avoidable.**

No clinical handover in **29.9%** of patients. **86.4%** of patients had a **discharge letter** and **8.8%** of them were **poor or unacceptable.**

Discharge from hospital back to prison was **not appropriate** for **19.8%** of patients.

4 PROVIDE CARDIOPULMONARY RESUSCITATION TRAINING

CPR was initiated in prison for **50 patients** (**31** who died of **natural causes** and **19** who died of **other 'non-natural' causes**). There was **room for improvement** for **22 patients**.

CPR training for **prison staff** was identified as an **important area for improvement**. In **6/22** patients, **immediate CPR could not be started due to lack of training** even though **prison staff were first on the scene**.

5 IMPROVE PALLIATIVE AND END OF LIFE CARE SERVICES

A **palliative or end of life care (EoLC) plan** was documented in **44.7%** of patients who died of a **natural** cause. Reviewers considered that **an additional 23.5%** of patients were **suitable for EoLC** planning.

The **EoLC process** could have been **improved** in **45.2%** of patients where death was from **natural causes**.

The **most common areas for improvement** were **involving the patient and family** (27 patients), and **advance care planning for end of life** (27).

6 LEARN FROM, AND SHARE THEMES FROM PPO / NHSE INDEPENDENT CLINCIAL REVIEWS

There was the **potential to learn from the NHS clinical review** in more than half of the cases. This applied to both the **natural deaths** where opportunities to learn were identified in **55.6%**, and **the 'non-natural' deaths** where they were identified in **57.1%**.