



Health Services Safety
Investigations Body

Investigation report

Healthcare provision in prisons: data sharing and IT

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Emergency care, Communication and decision making, Continuity of care

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A note of acknowledgement

We would like to thank the patients and healthcare and prison staff who engaged with the investigation for their openness and willingness to support improvements in this area of care.

About this report

This report is intended for healthcare and justice organisations, policymakers and the public to help improve patient safety in relation to data sharing and IT for patients detained in prison.

Executive summary

Background

This investigation focuses on data sharing and IT within prisons and prison healthcare departments, specifically looking at how the interaction between digital systems and continuity of healthcare records may impact on the care delivered to patients. The investigation focused on two main areas:

- the ability of the different IT systems used for prison operations/security and for healthcare to share information (referred to as 'interoperability')
- General Medical Services (GMS) registration in prisons (the registration of patients with a prison GP practice) and the impact of this on patients and the issues different patient groups may encounter.

The investigation explored how IT systems in prisons were used and how information was shared between the operational/security side of the prison and the prison healthcare side. The lack of interoperability between the two systems, and the impact this had on the safety of patients, staff and other patients within the prison, was explored. In addition, the investigation looked at how this affected time and resource management of both prison and healthcare staff.

The investigation also looked at how GMS registration has been rolled out to the prison healthcare departments, and the approaches prisons across the country were taking. A focus of this area was the impact that GMS registration, or patients choosing not to register, impacted on the safe delivery of their care. The investigation also considered different patient groups, specifically the challenges relating to patients who are detained on remand, compared to those who have been sentenced.

This is the third of a series of HSSIB reports on the theme of healthcare provision in prisons. The first report explored [emergency care response](#), the second explored [continuity of care](#) and a further report will explore patient safety concerns and common themes found across all areas of healthcare provision in prisons.

These investigations were launched after discussions with 26 national organisations across the healthcare and justice systems, through which HSSIB gained knowledge of their concerns about healthcare in prisons.

Through a patient engagement group, HSSIB engaged with over 120 patients and people being detained to understand their experiences of receiving primary and secondary healthcare in prison. The investigation also engaged with stakeholders from across the prison healthcare system to gather evidence about primary and secondary patient care from their perspectives.

Findings

- Prison operational IT systems (the Prison National Offender Management Information System and the Digital Prison Service) and the prison healthcare IT system (SystemOne) are not able to automatically share information between each other.
- Important patient information, such as risks they pose to themselves or others, is not readily available to healthcare staff when seeing patients.
- Prison healthcare department admin staff have to duplicate medical appointments onto both the healthcare and the prison IT systems. This can amount to thousands of appointments per month, expending time and resource, while also creating multiple opportunities for user input error.
- The prison healthcare IT system has been adapted in readiness to receive and exchange information with the prison IT systems. The prison IT systems have not been adapted and there is currently no plan to adapt them.
- Patients who are detained on remand for short periods of time may have their continuity of care in the community negatively impacted by being GMS registered with the prison GP, and therefore de-registered from their community GP.
- Patients are given information about GMS registration during the prison reception process, when they are asked to consent to the sharing of their medical records. There is limited time for patients to consider the information or ask any questions and understand what they are consenting to, during what HM Prison and Probation Service describes as a 'stressful experience'.
- There is variability across prisons in the understanding prison healthcare staff have about the GMS consent and registration process, resulting in different processes. This causes difficulties in maintaining continuity of care for some patients.

- Prisons housing remand prisoners experienced much lower GMS registration rates due to remand patients expressing concern about the impact on them of registration if they are released from remand.
- Each prison healthcare department is viewed by the NHS as an independent GP practice; however, for the purposes of GMS registration, all prison healthcare departments are viewed as surgeries under a single prison GP practice. This has led to confusion at all levels in healthcare, from national leaders to provider staff, about the consent process for the transfer of medical records.
- Some patients are being asked to re-consent to GMS registration when they move to a new prison. This is creating inconsistencies in the way consent is sought and gaps in patients' medical records, making continuity of care difficult as patients move between prisons and to the community.
- Patients who do not consent to GMS registration do not automatically appear on national screening programmes, such as the breast screening and bowel screening programmes.

HSSIB makes the following safety recommendations

Safety recommendation R/2025/067:

HSSIB recommends that NHS England/Department of Health and Social Care ensures that the General Medical Services registration process, for patients in prison, is designed using informed consent principles, providing patients sufficient time, advice and support to understand what registration means for them. This is to ensure patients are making informed decisions about their healthcare provision, therefore improving patient safety.

Safety recommendation R/2025/068:

HSSIB recommends that NHS England/Department of Health and Social Care, working with healthcare service providers and their healthcare teams at prisons which hold remand prisoners, reviews and amends the process for GMS registration of patients on remand.

This is to ensure a consistent approach to GMS registration across the prison estate, which acknowledges the potential negative impact short-term changes in care provision may have on the continuity of care for patients who have been remanded in custody.

Safety recommendation R/2025/069:

HSSIB recommends that HM Prison and Probation Service ensures that the development of the Digital Prison Services system includes interoperability with healthcare IT systems. This will ensure that information which does not impinge on the confidentiality requirements of either system, relevant to the safety and wellbeing of staff, patients and other prisoners, is available at the point of need.

Safety recommendation R/2025/070:

HSSIB recommends that NHS England/Department of Health and Social Care includes within its healthcare IT procurement system specification the need to support interoperability between the operational prison IT systems and any future prison healthcare IT system. This will ensure that information which does not impinge on the confidentiality requirements of either system, relevant to the safety and wellbeing of staff, patients and other prisoners, is available at the point of need.

Local-level learning

HSSIB has identified local-level learning for prison healthcare providers and teams, who can improve patient safety by:

- aligning local policies, in relation to consent for GMS registration, with NHS England guidance on informed consent principles
- assisting staff to adapt their approach to consent discussions with patients in recognition of the stressful reception environment.

HSSIB has identified local-level learning for prison healthcare providers and teams, who can improve patient safety by adopting processes to avoid patients who are GMS registered within the prison system being automatically asked to re-consent when transferring to a different prison.

HSSIB has identified local-level learning for prison healthcare providers and teams, who can improve patient safety by supporting patients to pre-register with community GPs as part of release planning.

HSSIB has identified local-level learning for prisons who can improve patient safety by adopting a mechanism for healthcare providers and teams to highlight patients who may not be medically suitable for release on temporary licence (ROTL) and, where appropriate, being involved in the decision process.

1. Background and context

1.1 Introduction

1.1.1 This investigation focuses on data sharing and IT systems in the context of patients in prison. This means:

- how prison and healthcare IT systems share information about patients in prison
- to what extent that information informs either the operational aspect of the prison about a patient's healthcare needs, or the healthcare department about necessary security and risk aspects relating to a patient.

The investigation considered the registration of patients with prison GP services, including how these systems link with community GP systems.

1.2 Ministry of Justice

1.2.1 The Ministry of Justice (MoJ) is the government department responsible for the justice system.

1.2.2 The justice system includes:

- courts
- prisons
- probation services
- attendance centres (Ministry of Justice, n.d.a).

1.2.3 There are over 100 prisons and 300 courts within the justice system in England and Wales (Ministry of Justice, n.d.a).

1.3 HM Prison and Probation Service

1.3.1 HM Prison and Probation Service (HMPPS) is an executive agency sponsored by the Ministry of Justice. It works with partner organisations to enable the sentences of the courts to be carried out, either in custody or the community.

1.3.2 Within England and Wales, HMPPS is responsible for:

- running prison and probation services
- rehabilitation services for ex-offenders leaving prison
- making sure support is available to stop people re-offending
- managing contracts for private sector prisons and services such as the Prisoner Escort and Custody Service and Electronic Monitoring Service.

1.3.3 Through HM Prison Service it manages public sector prisons and the contracts for private prisons in England and Wales.

1.3.4 Through the National Probation Service it oversees probation delivery in England and Wales including through community rehabilitation companies.

Prison categories

1.3.5 Prisons are categorised according to the risks associated with the prisoners they hold. There are four categories of prison for male prisoners:

- 'Category A
These are high-security prisons. They house male prisoners who, if they were to escape, pose the most threat to the public, the police or national security.
- Category B
These prisons are either local or training prisons. Local prisons house prisoners that are taken directly from court in the local area (sentenced or on remand), and training prisons hold long-term and high-security prisoners.
- Category C
These prisons are training and resettlement prisons; most prisoners are located in a category C. They provide prisoners with the opportunity to develop their own skills so they can find work and resettle back into the community on release.
- Category D – open prisons
These prisons have minimal security and allow eligible prisoners to spend most of their day

away from the prison on licence to carry out work, education or for other resettlement purposes.’ (Ministry of Justice, n.d.b)

1.3.6 There are two categories of prison for female prisoners: open or closed. High-risk female prisoners are classed as ‘restricted status’ and are housed in closed prisons (Ministry of Justice, n.d.b).

1.4 Prison healthcare

Equivalent care

1.4.1 The House of Commons Health and Social Care Committee report on prison health states that:

‘Prison health and care services should be delivering standards of care, and health outcomes, for prisoners that are at least equivalent to that of the general population.’ (House of Commons Health and Social Care Committee, 2018)

1.4.2 The Royal College of General Practitioner’s definition of equivalence reads:

“‘Equivalence’ is the principle by which the statutory, strategic and ethical objectives are met by the health and justice organisations (with responsibility for commissioning and delivering services within a secure setting) with the aim of ensuring that people detained in secure environments are afforded provision of or access to appropriate services or treatment (based on assessed need and in line with current national or evidence-based guidelines) and that this is considered to be at least consistent in range and quality (availability, accessibility and acceptability) with that available to the wider community in order to achieve equitable health outcomes.’ (RCGP, 2018)

Prison healthcare commissioning

1.4.3 In 2012 the Health and Social Care Act directed that healthcare services, in prisons in England, should be commissioned by NHS England. This responsibility was transferred to NHS England in 2013. NHS England commissions services through specialist regional teams.

1.4.4 NHS England health and justice commissioning teams use the principle of equivalence when commissioning healthcare in prisons. This means that people who are detained by the justice system should receive an equivalent level of health service to the rest of the population.

1.4.5 NHS England, through its regional specialised commissioning teams, is also responsible for quality assurance within the commissioned services, which aims to ensure services meet their contractual obligations and deliver services to the required standards.

1.4.6 During the investigation it was announced that NHS England was being abolished and elements were being merged into the Department of Health and Social Care. At the time of writing it is unclear how this will affect commissioning arrangements.

Prison healthcare departments

1.4.7 Each prison has a healthcare department that provides medical services to patients within the prison.

1.4.8 Healthcare departments provide different levels of cover depending on the commissioning requirements of the prison and its population. Most departments are nurse-led with GP-run clinics. Some departments provide 24/7 care, while others only provide daytime cover and some have no cover at weekends.

1.5 Prison IT systems

Offender management

1.5.1 In 2004 the Prison National Offender Management Information System (p-NOMIS) was introduced as a single prison service IT system, by the National Offender Management Service which is now HMPPS. It was designed as the single database used by prisons, covering all aspects of a prisoner's management except for healthcare.

1.5.2 The Digital Prison Service (DPS) was launched in 2021 as the successor to p-NOMIS. DPS is a modular system allowing HMPPS to roll it out incrementally across the prison system, replacing elements of p-NOMIS, while not losing any functionality of the existing system during replacement. DPS will add functionality and improve each area as it is initiated. It is anticipated that the roll-out of DPS will be completed by 2027.

Healthcare

1.5.3 Offender Health IT (OHIT) was rolled out in 2009/10 and was a major transformation for healthcare delivery in prisons. While this was a 'closed' system, it was the first step in moving to digital records from paper records. The Health and Justice Information System was then introduced in 2013 and focussed on connectivity between prison electronic health records and the Spine.

1.5.4 SystmOne is the clinical computer system which enables healthcare staff to record patient information securely in an electronic format. This information can then be shared with other healthcare professionals so that everyone caring for the patient is fully informed about their medical history, their current medical status, what medication has been prescribed and any allergies the patient may have.

1.5.5 SystmOne is widely used in GP practices, child health services, community services, prisons, hospitals, urgent care and out-of-hours services, palliative care services and many other settings.

1.5.6 SystmOne is the only patient care record system used within English prisons, although it varies slightly in its functionality in the prison system compared to the version used in the community.

Interoperability

1.5.7 This report includes technical language and specifically refers to interoperability. This is the ability of IT systems to work with other IT systems without special effort to enable communication of information within/between care providers or different organisations, such as healthcare departments and HMPPS.

1.6 General practice registration

General Medical Services and GP2GP

1.6.1 General Medical Services (GMS) registration is the registration of patients with a GP practice. This happens in the community and within prisons and enables the GP2GP service, which allows patients' electronic health records to be transferred directly, securely and quickly between their old and new GP practices (NHS Digital, 2025). Registration allows for continuity of care between GP practices with a patient's medical records being transferred between them when a patient changes GP practice. (North of England Care System Support, n.d.a)

1.6.2 Prison healthcare departments are recognised as GP practices and therefore, with consent, a patient's record can be transferred to their place of detention from their community GP, or between places of detention when transfers occur.

1.6.3 NHS England, via the North of England Care System Support (NECS), is responsible for the implementation of GMS registration within prisons and other places of detention (the detained estate). NECS provides training, guidance, advice and support for healthcare teams in prisons, helping them to roll out and integrate GMS registration in their prisons.

NHS Spine

1.6.4 The NHS Spine allows clinicians to access patient medical records such as summary care records, prescription history and demographic information.

1.6.5 Spine joins together clinical IT systems across the country ensuring that clinicians are treating patients with up-to-date information. NHS England (2025) states that 'Spine supports the IT infrastructure for health and social care in England, Wales and Isle of Man, joining together over 44,000 healthcare IT systems in 26,000 organisations. Up to 500,000 health professionals use it daily and 43 million messages are supported every day'.

Primary Care Support England

1.6.6 Primary Care Support England supports 'front line primary care provision in England by providing key services to GPs, Optometrists, Dentists and Pharmacists.' It delivers 'transformed solutions, using digital innovation and service improvement to improve provider and patient experiences' (Primary Care Support England, n.d.).

1.7 Release on temporary licence

1.7.1 The MoJ 'Release on temporary licence (ROTL) policy framework' states:

'Release on Temporary Licence (ROTL) facilitates the rehabilitation of offenders, by helping to prepare them for resettlement in the community once they are released. This includes, among other examples, finding work and rebuilding family ties. It is intended that this will lead to reduced reoffending in the long-term.' (Ministry of Justice, 2022)

1.7.2 Types of ROTL include:

- resettlement day release
- resettlement overnight release
- childcare resettlement licence
- special purpose licence.

2. Analysis and findings

This section describes the investigation's findings in relation to data sharing and IT within prisons. The findings are grouped into two main themes, as identified by the investigation's analysis of the evidence. The themes are as follows:

- prison GP registration and transfer of clinical information
- data sharing between clinical and non-clinical IT systems.

This section includes extracts from a report by patient engagement group ABL Health, commissioned by HSSIB, which collated the experiences of 120 patients and people being detained.

More information about the investigation's evidence gathering and analysis can be found in the appendix.

2.1 Prison GP registration and transfer of clinical information

Reception and information provision

2.1.1 When a patient first arrives at a prison they go through a reception process, which includes:

- identity and detention check
- identification of immediate security needs
- search and scan
- assessment of healthcare needs by the healthcare provider.

2.1.2 The HM Prison and Probation Service (HMPPS) reception guidance, Prison Service Instruction (PSI) 07/2015, states that 'The reception-in procedure can be a stressful experience for prisoners' (HM Prison and Probation Service, 2024). The reception area and process were described by healthcare staff as "not a calm environment".

2.1.3 The aim of the healthcare element of reception, completed by the healthcare providers, is to establish the patient's healthcare needs, which may include:

- physical health issues
- substance misuse identification
- mental health issues
- existing medication requirements.

2.1.4 PSI 07/2015 lists at least 15 topics that people going through the reception process should be given information about, relating to prison rules or services that are available to them. These topics do not include healthcare-specific information, such as the healthcare regime, what appointments and checks they must have and the healthcare registration process. This information, provided by healthcare staff, is in addition to the topics mandated by HMPPS.

GP registration and informed consent

2.1.5 All prisons visited during the investigation discussed with patients the transferring of registration from their community GP to the prison GP. This discussion took place during the reception process in line with each prison's local procedures.

2.1.6 If a patient consents to General Medical Services (GMS) registration the prison healthcare GP becomes their registered GP. This de-registers them from their community GP, if they have one. It allows the patient's community health record to be electronically transferred to the prison healthcare GP via the GP2GP service (see 1.6).

2.1.7 Prison healthcare teams told the investigation that patients may choose not to consent to GMS registration with the prison GP for many reasons, including:

- not wanting their GP to know they have been in prison
- being suspicious of how their information may be used
- as an act of rebellion
- a feeling of being able to maintain control of something.

2.1.8 Regardless of whether or not a patient chooses to consent to GMS registration, they are able to access healthcare while at their place of detention. If a patient chooses not to be GMS registered their healthcare registration is classified as 'secure estate healthcare registration only' (North of England Care System Support, n.d.b.).

2.1.9 Prison healthcare staff described risks associated with patients choosing not to be GMS registered, such as the prison healthcare GP potentially not being able to view their full medical history. This impacted on GPs' ability to provide care, especially for patients with long-term health conditions. In addition, when a patient who was not GMS registered with the prison healthcare GP was released, their community GP would not have automatic access to information about the care and treatment they had received while in prison.

2.1.10 Prison healthcare staff told the investigation that they had concerns that patients did not understand what GMS registration was, or the impact on their healthcare provision if they did or did not consent. Most patients were presented with the GMS information during the reception process, which some healthcare staff described as a point of "information overload" for patients. Patients were presented with multiple pieces of paper that they had to sign and the GMS registration was just another one.

2.1.11 There was limited time available to staff to describe the benefits of being GMS registered, or for patients to ask questions and clarify their understanding. This resulted in patients either not consenting to registration, or consenting but not fully understanding what they had consented to. Healthcare staff raised concerns that patients were not being given the

opportunity to sign with informed consent, especially due to the stressful environment and processes, in addition to being given large amounts of information upon arrival at the prison. One senior healthcare leader described it as “trauma informed consent”.

2.1.12 The investigation found that the reception process and environment made it difficult to comply with NHS England’s consent principles. Healthcare staff told the investigation that the noise and stress affected patients’ ability to process information. In addition, the speed of the process gave limited time to support patients in their decision making, therefore complicating the task of applying consent principles. The four consent principles, out of seven, that were specifically affected are:

- ‘right to be involved and supported
- focus on meaningful dialogue, i.e. specific to the individual
- right to be listened to and given information, time and support
- what matters to patients’. (NHS England, n.d.a)

2.1.13 Patients who did not consent to GMS registration also fell outside of national screening programmes (such as breast cancer and bowel cancer screening) for automatically being called for screening, the e-referral system (e-RS) was not available to them, and could mean a potential gap of years in a patient’s medical history when they were released from prison and discharged from the prison GP into the community. Healthcare staff said that when they talked to patients these potential healthcare impacts were not well understood. During consultation the investigation was informed that all prison healthcare teams work with their regional screening hubs to provide the screenings regardless of GMS registration status. This was not reflected in discussions with prison healthcare teams who said patients not being on national screening programmes due to not being GMS registered was a concern.

2.1.14 An example of a method used to gain consent from patients was described to the investigation. This involved patients being told that if they did not sign the GMS consent form they would not be able to use the gym facilities. The patient was told that this was due to the healthcare staff being unable to review their medical history and therefore being unable to sign them off as fit to exercise. Several national stakeholders stated that this was not an example of informed or freely given consent.

2.1.15 In addition, the healthcare staff who were present at the reception process were nurses; however, the investigation was told that the staff who had the better understanding of the details of GMS registration were the healthcare admin staff, who were not present at the reception process. This meant that the staff who were best placed to answer questions and explain GMS registration were not available to patients at the point they were being asked to consent and

register. However, senior staff within a national organisation stated that nurses were supposed to have the knowledge of GMS registration, so they could have the conversation about the “clinical benefit” of GMS registration with patients.

2.1.16 Some prisons had adapted their processes to change the point at which patients were either presented with the information, or asked to make the decision about, GMS registration. An example that was shared with the investigation was where two prisons had removed GMS registration from the reception process and moved it to the following day. One prison gave patients the information sheet to take away with them and then asked them to go to the healthcare department to sign the GMS registration document with their decision. At the other prison, members of the healthcare admin team visited patients on the wings and explained what GMS registration was and how it affected their care while they were in prison and upon release. Both prisons had seen an increase in patients signing the forms, and described patients being able to make informed decisions about their healthcare.

2.1.17 There was confusion among patients about GMS registration and what it meant for them, in terms of GP registration in the community and for the transferring of medical records.

‘Several of the prisoners were already registered with a GP prior to coming to prison and said that they would think they would still be registered but were unsure if this was the case.’ (ABL Health, 2024)

2.1.18 The concerns about patients not making informed consent decisions centred on them refusing GMS registration despite having long-term medical conditions. This had been seen to impact on the care the healthcare teams were able to provide. Healthcare providers acknowledged that patients needed to be able to understand GMS registration and what it offered them in terms of healthcare delivery. Therefore, time to take in the information, ask questions and understand it was essential from both an informed consent perspective, and a patient safety perspective.

HSSIB makes the following safety recommendation

Safety recommendation R/2025/067:

HSSIB recommends that NHS England/Department of Health and Social Care ensures that the General Medical Services registration process, for patients in prison, is designed using informed consent principles, providing patients sufficient time, advice and support to understand what registration means for them. This is to ensure patients are making informed decisions about their healthcare provision, therefore improving patient safety.

Local-level learning

HSSIB has identified local-level learning for prison healthcare providers and teams, who can improve patient safety by:

- aligning local policies, in relation to consent for GMS registration, with NHS England guidance on informed consent principles
- assisting staff to adapt their approach to consent discussions with patients in recognition of the stressful reception environment.

Maintaining continuity of care and care records

2.1.19 The investigation learned that GP clinical systems include the option to “share” out information, which enables information to be viewed by other providers who may be delivering healthcare to their patients, for example a community hospital. This sharing of information would have formed part of the consent process during registration with the community GP. If a patient’s community GP uses the same clinical system as the prison (SystemOne), and sharing out has been turned on, then the prison healthcare GP can view the patient’s community GP record. The investigation was told this sharing of information occurred regardless of whether the patient had consented to GMS registration or not, as they had previously consented to the sharing of their community GP record. However, this way of sharing patients’ information only enabled the information to be viewed, not added to. To make additions, the prison (by way of the healthcare team) would need “ownership” of the record, which would require the patient to be GMS registered with the prison healthcare GP.

2.1.20 Prison healthcare teams were not aware this was the case but did explain that they could see some patients’ records straight away, but were unsure of the reason for this. The investigation acknowledges the complexity of the way in which information may or may not be shared, and how this complexity has led to different understandings by prison healthcare teams.

2.1.21 Where a patient did not give consent to GMS registration, their community GP record would be “merged” into a secure estate healthcare registration only record, enabling the prison healthcare GP to see the patient’s medical history, although this did not include information such as; past letters and screening results. However, on the patient’s release their prison healthcare record would not be electronically available to any subsequent community GP, as the information on their care and treatment (while in prison) was held in a “vacuum” outside of their GMS record. This would create a gap in the patient’s medical history for the period that they were detained.

2.1.22 The investigation learned that the visibility of community GP information for patients who were not GMS registered was unique to where the same clinical system was being used (SystmOne – see 1.5.3). Where the community GP used any other clinical system, no information would pull through to the prison without the patient’s consent to GMS registration. In this situation the healthcare team would contact the community GP and request a GP summary (a high-level care note similar to a hospital discharge letter). The investigation was told these varied in detail. In addition, the prison healthcare team could access the patient’s summary care record through the NHS Spine (North of England Care System Support, n.d.b.).

2.1.23 Visited prisons stated that on release, a patient who had not consented to GMS registration, and whose prison healthcare record was therefore not available to the community GP, would be provided, with printouts of their care and treatment. This was done so that they could pass the information to their community GP, although the prison healthcare teams would not know whether this happened or not.

Transfer between prisons

2.1.24 When patients transferred between prisons, access to their healthcare information from their previous prison was transferred with them to their new prison, regardless of whether they were GMS registered or had a secure estate healthcare registration only record (see 2.1.8). This enabled the receiving prison’s healthcare team to have awareness of any healthcare needs the patient may have had, any ongoing treatment and any medication requirements. However, patients stated that this was not always the case and there were risks with information not following them or being at the new prison in time.

‘The prisoners said that a lot of the information comes from them personally during the reception process regarding their health care needs, as opposed to this coming from the previous establishment, in their experience. The prisoners said that when transferring, it can be difficult as especially when they [are] waiting for several appointments, these rarely, if at all, are picked up by the new prison.’ (ABL Health, 2024)

2.1.25 NECS explained that within the detained estate it was “once GMS, always GMS”, meaning that once a patient had agreed to GMS registration this remained the case for the duration of their stay in prison, regardless of any transfer between prisons. NECS described having produced eLearning, sent emails and distributed service bulletins detailing this concept. Some of these were shared with the investigation and spanned 2023 to 2025.

2.1.26 The investigation heard that despite the efforts listed above, knowledge of the ‘once GMS, always GMS’ concept was variable across the prison estate. One healthcare team the investigation engaged with described their understanding as being if a patient did not re-consent on transfer to a different prison then the new prison “will have access to some information but not all”. Another team stated that while they were aware additional consent was not required they asked for this anyway on transfer “out of politeness”. However, one prison stated that asking a prisoner who had previously not consented would give them the opportunity to consent, or have the information explained to them again.

2.1.27 NECS explained they were aware of the variability and that this remained despite training and information being provided. The turnover of healthcare staff within prisons was said to be a factor in this variability.

2.1.28 The investigation was told there was a significant risk associated with patients being asked to re-consent on transfer because if they refused, having previously consented, then they would be de-registered and have no registered GP either in the prison or in the community. This “flip flopping” between being GMS registered and not would mean when patients were released there would be a gap in their medical record and their summary care record. There would also be an instant impact during their stay in prison as they would not be able to access some services such as e-referrals into secondary care and healthcare screening programmes.

2.1.29 NECS explained that each prison GP service being viewed by Primary Care Support England (see 1.6.6) as an individual practice, rather than one practice with multiple sites, meant that there needed to be a process of registering people on arrival at a prison, whether GMS or a local process.

2.1.30 The investigation learned of another issue created by the way GP practices are recognised. This related to patients who are transferred from a prison to a secure hospital. Once admitted to the secure hospital the patient’s GP registration with prison healthcare ends. Primary care provision within secure hospitals is not recognised as a GP practice, although GPs are employed to provide primary physical healthcare services. Therefore, patients are unable to be registered while there. This means that patients do not have a registered GP and the GP2GP system cannot be used to obtain the patient’s medical history. The investigation was told this had resulted in delays in identifying past diagnoses including asthma, diabetes and cancer. It also led to the same consequences for patients who declined GMS registration.

2.1.31 The challenges of secure hospitals not being registered as GP practices were identified during discussions for this investigation but were not explored further as secure hospitals are outside of the scope of this investigation. This issue of electronic patient records in mental health secure units was also identified in HSSIB's (2025) investigation '[Mental health inpatient settings: creating conditions for the delivery of safe and therapeutic care to adults](#)'.

Local-level learning

HSSIB has identified local-level learning for prison healthcare providers and teams, who can improve patient safety by adopting processes to avoid patients who are GMS registered within the prison system being automatically asked to re-consent when transferring to a different prison.

Remand prisoners

2.1.32 The investigation learned that when GMS was first rolled out in prisons, concerns were raised in relation to the GMS registration of patients who were on remand. The length of time prisoners may be on remand varies significantly. Some are in prison for a relatively short period before being released back into the community, sentenced or transferred; others are on remand for more than 6 months. According to government data, there were:

- '87,919 prisoners in England and Wales as at 31 March 2025
- 18,090 first receptions into prison between October and December 2024
- 73,717 individuals were received into custody as first receptions in 2024
- 17,582 remand prisoners as at 31 March 2025.' (GOV.UK, 2025)

2.1.33 A parliamentary question was asked on 10 February 2022 about the number of people being held on remand for longer than 6 months. The answer stated that:

- '2,475 people were held on remand for 6 months to less than 1 year
- 1,230 people were held for 1 year to less than 2 years
- 480 people were held on remand for greater than 2 years.' (UK Parliament, 2022)

2.1.34 Guidance was produced by NECS on when patients could and should be registered, including those on remand. It states:

'Any new arrival could apply for GMS registration on arrival into a Place of Detention (PoD):

- regardless of sentence length or sentence/remand status

- regardless of medical history.

Any new arrival should apply for GMS registration on arrival into a Place of Detention (PoD) who:

- has a likely stay of 1 - 4 weeks or more, whether remand or sentenced
- has a medical history including, but not limited to:
 - substance and/or alcohol misuse issues
 - ongoing mental health problems
 - prescribed regular medications
 - any long-term conditions or ongoing medical care or investigations with the community GP (especially regarding QoF [Quality and Outcomes Framework] domains)
 - any ongoing medical care under specialist care in a hospital or has sustained any recent injuries
 - has transferred from a secure mental health hospital following a period of Section (S47 or S48).’ (North of England Care System Support, n.d.b.)

2.1.35 During site visits it was observed that there was variability in the awareness of this guidance and further variability in adherence to it. The latter was due to the uncertainty for this patient group and healthcare teams not wishing to GMS register patients who were then promptly released. In addition, healthcare teams described remand patients as reluctant to register due to:

- losing their community GP (with whom they may have a longstanding relationship)
- potential difficulty in re-registering on release
- not wishing their current GP to be made aware of them being on remand.

2.1.36 One reception prison (a prison that receives and holds prisoners on remand or convicted but unsentenced) told the investigation it did not routinely register remand prisoners with GMS, as remand prisoners are released from court rather than being released from the prison. This stance had developed following a series of “high-risk near misses”, where patients on remand with a medication need had completed GMS registration and then been released from court, without the opportunity for release planning. This meant that on release they were no longer registered with their GP in the community, with potential implications for their ongoing healthcare needs. These incidents had been raised with NHS England as a safeguarding concern and had led to the development of local prison processes.

2.1.37 If a remand patient's records were needed for their care, a copy was requested from their community GP rather than the patient being GMS registered, and this would be used alongside the summary care record. In addition, where remand patients had complex healthcare needs the healthcare teams would explain how GMS registration enabled access to their records. They would talk about the risks if they were to be released and not registered with a community GP and then agree with the patient whether the GMS registration should take place or not.

2.1.38 While these processes were not in line with the published NHS England guidance they had been developed following discussions with NHS England safeguarding colleagues. The investigation was also made aware that multiple reception prisons had independently developed similar processes to each other within their healthcare departments. These processes had been developed without engagement with the NHS England Health and Justice team.

2.1.39 One prison healthcare team described receiving an email from "NHS England" stating not to register patients who were on remand or a short sentence. There was confusion between the prison healthcare team that received the email and the intent of the email from NECS, who stated the email was "to do with coding in the records and is not informing the prisons not to register remand patients". The full email from NECS was shared with the investigation. It states:

'... the Secure estate healthcare registration code should not be added to any patient records who are on remand or a short sentence without them having completed a GMS and SCR [summary care record] Information and Consent Form.'

Email from NECS to a prison healthcare team

2.1.40 There was no consistency of approach to GMS registration across all the reception prisons the investigation engaged with. Prison healthcare teams at reception prisons all described challenges for patients on remand which they felt had not been recognised. They also described "pressure" during commissioning review meetings to increase the number of GMS registered patients, which they described as unrealistic for reception prisons.

2.1.41 The initial roll-out of GMS in the prison system required every prison to capture consent or non-consent from all patients across the country. However, now that the initial roll-out is complete, future registrations should only happen in reception prisons that receive prisoners who are on remand or are newly sentenced.

HSSIB makes the following safety recommendation

Safety recommendation R/2025/068:

HSSIB recommends that NHS England/Department of Health and Social Care, working with healthcare service providers and their healthcare teams at prisons which hold remand prisoners, reviews and amends the process for GMS registration of patients on remand.

This is to ensure a consistent approach to GMS registration across the prison estate, which acknowledges the potential negative impact short-term changes in care provision may have on the continuity of care for patients who have been remanded in custody.

Category D open prisons

2.1.42 The investigation learned that there were specific challenges for open prisons in relation to GMS, which commonly occurred in two scenarios:

- Where patients needed to visit a GP in the community when away from the prison and in the process registered with that GP, not realising that doing so would prompt their registration to transfer from the prison healthcare GP. This meant that the prison healthcare team, who managed the healthcare needs of the patients in prison, would not be aware of the treatment provided by the community GP, including any prescribed medications or referrals made. Additionally, the patient would be removed from the prison's internal appointment ledgers and waiting lists, and any active medication prescriptions would be ended. This means medication would need to be re-prescribed before it could be administered by the prison healthcare staff.
- Patients who had not GMS registered with the prison healthcare GP maintained a community GP within their home area. This meant that they could be receiving healthcare, including prescriptions, from two GPs, each of whom may be unaware of the treatment provided by the other. This created a risk of being prescribed medication that should not be prescribed if the patients full record was known, duplicative medications, or medication which was prohibited within the prison system (such as pregabalin), as described to the investigation by healthcare teams during site visits.

Other approaches to GMS registration and consent

2.1.43 The investigation was informed that a different approach to GMS registration was being taken in Scotland. Instead of asking patients to consent to registration, they were automatically registered if they were sentenced for more than 6 months. Patients who were on remand but

exceeded the 6-month timeframe were also automatically registered. Patients were still asked to sign a GMS consent form, although this was more of a formality as registration would take place in the patient's best interests if consent was not given.

2.1.44 In cases where patients had ongoing care needs that required the healthcare teams to see the patients' records, to enable them to deliver the best and safest care to all patients, they were automatically registered regardless of their sentence length or remand status. This ensured that all patients in the Scottish prison system who had been detained for more than 6 months were being treated with full visibility of their healthcare record.

2.1.45 For healthcare teams to make and assess patients' care plans in line with previous care, in the first 6 months of patients being detained, they were reliant on:

- the emergency care summary (similar to the summary care record in England)
- information requested from a patient's GP
- the Clinical Patient Management system, allowing them to see care delivered in custody (GOV.UK, n.d.).

2.1.46 One national stakeholder the investigation engaged with compared the GMS system with the national organ donation programme, which has run on an opt-out basis since May 2020 (NHS Blood and Transplant, n.d.). This means that people are considered to be part of the national donor programme unless they opt out of it. In relation to consent, the GMS and donor systems are run in different ways, with the organ donation programme more in line with the approach to GMS registration in Scotland.

Pre-registration with community GP

2.1.47 As part of release planning the prison healthcare team meets with the patient to plan how their healthcare requirements are to be met in the community. NHS England has developed guidance for prison healthcare teams to support patients in planning their transition into the community (NHS England, 2022).

2.1.48 The guidance includes identifying a GP practice with availability for those patients who are GMS registered and therefore no longer have a community GP, completing the registration form and sending this with a covering email to the GP practice. Registration with GPs in the community is now commonly done online, although a paper form is still available and can be used. In the detained estate, online registration cannot be used as such registrations are processed straight away and cannot be delayed. As pre-registering is part of the release planning, immediate transfer of the GMS ownership of a patient's record to the new community

GP would mean a gap in the record of any care provided by the prison healthcare GP up until the patient's release. The paper form is therefore used for the purpose of pre-registration as part of release planning.

2.1.49 NECS explained that it had developed a template email for use by prison healthcare teams to send to prospective GP practices when arranging for the registration of patients on their release. This email had been specifically developed to alleviate the problems which can occur in arranging GP community registration for release from prison. Such problems were described as:

- refusal by the GP practice to take on the patient as they were not currently within their area
- the GP practice registering the patient immediately on receiving the registration form. This de-registered the patient from the prison GP, preventing continuity of the healthcare record up to their release.

2.1.50 HM Inspectorate of Probation told the investigation that on release, the probation service acted as a failsafe and ensured that registration with a GP took place; this was echoed by healthcare staff. Prison healthcare staff told the investigation they gave the patient a list of GPs they could register with but did not routinely assist them with the registration.

'Others [patients] who said they had not accessed a GP before coming into prison said that they were not provided with information but said that they thought it would be helpful for this to be given as many of them have not accessed a GP for a number of years and the thought of having to do this can be daunting.' (ABL Health, 2024)

2.1.51 This demonstrated a mismatch between the expectations of NHS England (work as imagined) and the role being undertaken by prison healthcare teams (work as done). This investigation has not explored the actions of the probation service in relation to the registration of patients with GPs. However, what is perceived by healthcare and probation staff to be a safety net appears to be the usually adopted process.

2.1.52 During consultation the investigation was told that the NHS England commissioned RECONNECT service should be offered as standard to patients due to leave prison. RECONNECT is a 'care after custody service that seeks to improve the continuity of care of people leaving prison..... with an identified health need. This involves working with them before they leave to support their transition to community-based services... Whilst not a clinical service, RECONNECT offers liaison, advocacy, signposting, and support to facilitate

engagement with community-based health and support services' (NHS England, n.d.b). Prison healthcare teams visited during the investigation did not speak about the RECONNECT service when discussing pre-release planning and GP registration.

Local-level learning

HSSIB has identified local-level learning for prison healthcare providers and teams, who can improve patient safety by supporting patients to pre-register with community GPs as part of release planning.

2.2 Data sharing between clinical and non-clinical systems

2.2.1 The Healthcare Safety Investigation Branch (2019) report on the [management of chronic health conditions in prisons](#) identified that 'the two key IT systems in use in prisons have no direct interoperability'. The systems in place at the time of that investigation were the offender management system p-NOMIS (see 1.5.1), and the clinical healthcare system, SystmOne (see 1.5.3).

Manual prisoner information download

2.2.2 This investigation learned that the Digital Prison Service (DPS) has been launched (see 1.5.2) and was being used alongside the p-NOMIS system during its development and implementation cycle. Healthcare teams and admin staff told the investigation that they predominantly used the p-NOMIS system due to the lack of functionality currently available in the DPS.

2.2.3 Prison healthcare teams told the investigation they have to complete a manual download of information from p-NOMIS, which is then uploaded into SystmOne. The download updates information such as prisoner cell location and transfers between prisons and is vital for prison population management. This download had to be completed at least once a day due to the frequency of changes.

2.2.4 Information downloaded from p-NOMIS did not always match records held on SystmOne. The reasons for mismatches between the data included the incorrect spelling of names and errors with dates of birth within the p-NOMIS system. This was because p-NOMIS was populated with information taken from the custodial warrant, whereas SystmOne was populated with data supplied by the patient. One prison shared data with the investigation which showed an error rate of 8%; nearly half the errors were incorrect name spellings. Because of this,

healthcare staff had to complete a validation check of the information for each download. These same errors continue because the p-NOMIS information must reflect the custodial warrant and cannot be adjusted locally.

2.2.5 NECS described situations where the validation of this information into SystmOne had been confirmed incorrectly and where the wrong download had been selected and then uploaded into SystmOne. In these instances patients had been removed from the prison healthcare system, and their registrations amended on the Spine. This required significant work to correct, by NECS and Spine teams, and impacted on patient care, for example by causing delays to GP and outpatient appointments, and referrals. DPS functionality is currently not forecast to bridge this gap.

Creating and amending healthcare appointments

2.2.6 Healthcare staff who are required to access both systems must access these via individual terminals with respective accounts for each system. Healthcare appointments must be added to SystmOne and DPS individually for scheduling the patient medically and operationally. While staff described the process as simple the concern was the amount of time it took due to the number of appointments being entered. One example given was a healthcare department which booked approximately 400 appointments per week, with each appointment taking approximately 1 minute to enter on DPS. This equated to more than 6.5 hours of work per week. Other prisons could have significantly more appointments, with one reporting to the investigation that they routinely booked more than a thousand appointments per week.

2.2.7 In addition to the resource used for the creation of appointments, any cancellations or amendments also needed to be duplicated across the two systems. One prison told the investigation that when an on-site health screening service was cancelled it took admin staff approximately 8 hours to make the required amendments.

Risk information

2.2.8 SystmOne holds information about clinical risks to patients, including any emerging or escalating healthcare risks. p-NOMIS holds security and safety risk information associated with prisoners, including any risk they may pose to others. One example given was that certain prisoners should not be seen by female staff on a one-to-one basis. Such risks may emerge at any time and so healthcare staff would not know a change in risk status had occurred without checking p-NOMIS, a system commonly accessed by healthcare admin staff but not by staff providing care. As these systems do not share information these risks are held separately, which impacts their visibility for prison and healthcare staff, thus increasing the risk to staff, patients and other prisoners. One prison healthcare team described this as them operating “blind to risk”.

2.2.9 There was variability in how prisons mitigated this risk, with some using a morning “wing brief” attended by prison and healthcare staff to share information relevant to the appointments scheduled for that day. Others had no visibility without accessing the individual records on p-NOMIS.

2.2.10 While healthcare staff can access p-NOMIS, prison staff cannot access SystmOne and therefore only have visibility of healthcare risks flagged on p-NOMIS, such as suicide risk and medical hold (where a patient’s transfer to another prison or location is put on hold for health reasons). The currency and therefore relevance of this information is often unclear.

2.2.11 The investigation was told that while information on clinical risk may be relevant to whether patients could be released on temporary licence (ROTL), healthcare teams were not routinely engaged when ROTL was being considered. One example provided was a patient who had been authorised for ROTL by the prison staff but whose medication requirements had not been considered. Healthcare staff became aware of the ROTL via the patient and following discussions the ROTL was cancelled as there was no ability to administer the time-sensitive medication the patient needed. The cancellation of ROTL impacted on the relationship between the patient and healthcare team.

Local-level learning

HSSIB has identified local-level learning for prisons who can improve patient safety by adopting a mechanism for healthcare providers and teams to highlight patients who may not be medically suitable for release on temporary licence (ROTL) and, where appropriate, being involved in the decision process.

Progress on interoperability

2.2.12 The Healthcare Safety Investigation Branch report (2019) contained the following recommendation:

‘It is recommended that the National Prison Healthcare Board for England oversees work to implement interoperability between SystmOne and the Prison National Offender Management Information System, enabling sharing of essential information across the prison service which does not impinge on the confidentiality requirements of either system.’

2.2.13 The following response was received:

'The National Prison Healthcare Board for England recognises the value of enabling interoperability between the prison health database (SystemOne) and the custodial services system (p-NOMIS).

NHS Digital has been working with the Ministry of Justice and the prison health database provider to explore technical solutions to enable information sharing, with due regard for patient confidentiality. Currently, we expect to be able to test new approaches in information sharing across the two systems from Autumn 2020. If initial tests are successful, this could enable the joined-up approach to be used across the whole prison estate in England from April 2021.

In the meantime, further work will take place across organisations between clinical teams and prison staff to support effective information sharing.'

2.2.14 The National Prison Healthcare Board for England has been split into two separate boards, the National Health, Care and Justice Strategic Partnership Board for England and the National Health Care and Justice Operational Delivery Board for England. NHS England told the investigation the actions it had taken to progress this work. NHS England had worked with the SystemOne vendor to provide the functionality needed to support interoperability with p-NOMIS. HMPPS did not invest funding to develop p-NOMIS to be interoperable with SystemOne, in part due to the procurement of DPS. The investigation was told by HMPPS that there is still no funding to develop interoperability with the healthcare IT system.

HSSIB makes the following safety recommendation

Safety recommendation R/2025/069:

HSSIB recommends that HM Prison and Probation Service ensures that the development of the Digital Prison Services system includes interoperability with healthcare IT systems. This will ensure that information which does not impinge on the confidentiality requirements of either system, relevant to the safety and wellbeing of staff, patients and other prisoners, is available at the point of need.

2.2.15 NHS England is in the process of re-procuring the healthcare IT system for use in prisons. Capturing the requirement to ensure interoperability between any future healthcare system for use in prisons and DPS is essential.

HSSIB makes the following safety recommendation

Safety recommendation R/2025/070:

HSSIB recommends that NHS England/Department of Health and Social Care includes within its healthcare IT procurement system specification the need to support interoperability between the operational prison IT systems and any future prison healthcare IT system. This will ensure that information which does not impinge on the confidentiality requirements of either system, relevant to the safety and wellbeing of staff, patients and other prisoners, is available at the point of need.

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4. Appendix

Investigation Approach

The investigation report '[Management of chronic conditions in prisons](#)' (Healthcare Safety Investigation Branch, 2019) identified areas of healthcare which were out of scope for that investigation that would likely warrant an investigation. To identify topics for investigation within the healthcare provision in prisons theme, the investigation reviewed intelligence from service and professional regulators, national reports, academia and research. Discussions also took place with a large number of national stakeholders to understand their concerns in this area.

Evidence was collated and analysed to identify common areas across the stakeholders which were directly related to patient safety concerns. These areas were then placed into a hierarchy based on the number of stakeholders that mentioned it, the breadth of the concern across the prison estate, whether it affected male and female prisons and the estimated seriousness of the concern. As a result of this work the investigation was formally launched in February 2024 looking at three main topics:

- emergency care response
- continuity of care
- data sharing and IT.

Evidence gathering

The investigation undertook a programme of visits that was designed to be as efficient as possible and to account for all aspects of the prison estate, covering all three topics. All evidence was grouped into the different topic areas for analysis.

The investigation's site visits covered:

- category A to D prisons (male) and closed prisons (female)
- prison buildings of a range of ages (1800s to 2020s)

- four geographical areas across England (south-east, midlands, north-west, north-east)
- three prison operators
- four prison healthcare providers.

The investigation engaged with:

- prison officers and security staff
- prison management
- national and local commissioners
- healthcare staff and healthcare provider management.

All evidence collection was carried out using standardised question sets for each visit and interview, enabling a like-for-like analysis of healthcare provision across prisons in England. Evidence was coded into key lines of inquiry and subject areas. Once coded the evidence was thematically analysed by the investigation team, ensuring strength and breadth of evidence was assured. The analysis was independently reviewed to ensure the evidence directly led to the findings and safety recommendations reflected in the report.

Stakeholder engagement and consultation

The investigation engaged with stakeholders to gather evidence and check for factual accuracy, and for overall sense-checking. The stakeholders contributed to the development of the safety recommendations based on the evidence gathered.

Table A Investigation stakeholders

National organisations	Other organisations
HM Prison and Probation Service	Observations at 13 prisons and engagement with an additional 3
NHS England	Acute trusts
Ministry of Justice	Prison healthcare providers
North of England Care System Support	ABL Health

