HMP Send
Health Needs Assessment Refresh 2012

NHS Surrey Public Health Team

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Executive Summary

Background

The NHS Surrey Public Health Team is undertaking a rolling programme of needs assessments and refreshes across the five Surrey prisons to inform the commissioning process. The health needs assessment is also a key component of several of the Prison Health and Performance Quality Indicators that are collected on an annual basis by the Department of Health and the Ministry of Justice. It is recommended that health needs assessments are refreshed annually, and the previous full health needs assessment was carried out at HMP Send in 2010.

HMP Send

HMP Send is a closed female training prison with accommodation for up to 260 prisoners (at the time of writing) including a resettlement unit, a substance misuse unit (RAPt) and a therapeutic community. There was a 40% decrease in the number of prisoners entering the prison in 2011- there were 214 new receptions.

Prisoners at HMP Send are mostly between 22-50 years old, although there were increases this year in prisoners aged 41-50 and 12.4% are over 50 years old. There is a high proportion of Black and Minority Ethnic prisoners (36%) although the number of foreign nationals has reduced to 9.6%.

Methods

The health needs assessment refresh was carried out between February and May 2012. Epidemiological data, information from the prison, healthcare and external providers has been used to determine an up to date picture of the health needs. The 2010 full Health Needs Assessment was used for comparison, where data was available. This health needs assessment refresh does not include a corporate health needs section (views from stake holders and service users)

Areas of Recommendation

Long term conditions

It was clear that many improvements had been made in the detection and management of long term conditions since the 2010 HNA. The production of Quality Outcome Framework scores provides a source of performance management that should be utilised more to ensure each patient is receiving the appropriate care for their condition. It is recommended that specific programme be set up to detect undiagnosed diabetes as this is a growing problem across the general population, and ethnic minorities are particularly at risk.

Communicable Diseases

These recommendations echo those of the 2010 HNA- the coverage of the Hepatitis B vaccination should be prioritised to ensure the coverage is above 80% every quarter, and more patients at risk of Hepatitis B and C should be offered testing.

Mental Health

It is recommended that the mental health provision should be reviewed to ensure that it is in line with the population needs. The service should monitor data on ethnicity and the outcomes of referrals. The QOF indicators for depression need auditing to ensure the right care is in place. Self-harm remains a problem, and should continue to be monitored to ensure services are in line with need.

Learning Disabilities

A learning disability liaison nurse is now in post and a screening tool is being used. This service should be monitored to ensure the most suitable tool is being used for this population, and that the tool is acceptable to prisoners.

Health Improvement

A successful Health Promotion Action Group is now in place and this should drive forward improvements in the health of prisoners at HMP Send. Smoking remains a problem with no service review having taken place since the 2010 HNA, and no data being submitted to the Surrey Stop Smoking Service. This should be a priority. More data on physical activity should be collected, and the new physical activity guidelines should be promoted. Some problems with screening are ongoing, with bowel screening coverage low and a high number of prisoners refusing breast screening. NHS Health Checks have been implemented successfully, and it is recommended that this programme continue.

1. Introduction

1.1 Background

The NHS Surrey Public Health Team is undertaking a rolling programme of needs assessments and refreshes across the five Surrey prisons to inform the commissioning process. The health needs assessment is also a key component of several of the Prison Health and Performance Quality Indicators that are collected on an annual basis by the Department of Health and the Ministry of Justice. It is recommended that health needs assessments are refreshed annually, and the previous full health needs assessment was carried out at HMP Send in 2010.

1.2 Health Needs Assessment

This health needs assessment (HNA) refresh is an assessment based on the health needs, health service provision and activities in HMP Send that impact on a prisoner's health. A HNA is a systematic method for reviewing the met and unmet health needs of a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities. Whilst assessing need is the primary focus of a health needs assessment, in reality consideration must also be given to ensuring that demand for and supply of health care is appropriate.

This HNA refresh also links in to other key drivers relevant to HMP Send:

- The Prison Health Performance and Quality Indicators are collected on an annual basis by the Department of Health and the Ministry of Justice
- The full Health Needs Assessment that was undertaken by NHS Surrey Public Health in 2010
- The Prison Health Delivery Plan.

1.3 Methods and Structure of this Paper

The health needs assessment refresh was carried out between February and May 2012. Epidemiological data, information from the prison, healthcare and external providers has been used to determine an up to date picture of the health needs. The 2010 full Health Needs Assessment was used for comparison, where data was available. This health needs assessment refresh does not include a corporate health needs section (views from stake holders and service users).

2. Prison Profile

There have been no significant changes to the number of prisoners (or capacity) in HMP Send since 2010, although there have been small changes in age, foreign nationals and sentence length. The demographic profile can change for a number of reasons and it should be monitored regularly to ensure services are meeting the needs of prisoners.

In May 2012 the population of HMP Send was 260, which is lower than at the last HNA (281) and lower than the certified normal accommodation (282). This is due to the closure of D wing for fire detection upgrade work. The 20 bedded wing has been closed for the last few months and will re-open shortly.

There were 214 new receptions into HMP Send in 2011, which is 40% decrease on the 352 reported in a 12 month period in the 2010 HNA indicating a more stable population.

Table 1: Summary demographic table

Demographic	Results in 2012	Changes from 2010
Total	260 prisoners (in May 2012)	281 prisoners in 2010
New receptions	214 new prisoners entering HMP Send in 2011	40% reduction in new receptions
Age	Around 30% each in 22-30, 31-40 and 41-50 Over 50s= 12.4% Over 60s= 3.4%	27% decrease in 22-30 17% decrease in 51-60 18% increase in 41-50
Ethnicity	Black and Minority Ethnic Prisoners= 36% (compared to 28% of all female prisoners)	No major changes
Foreign Nationals	9.6% of prisoners	30% reduction
Religion	Church of England 30% Roman Catholic 18% Muslim 4%	Less prisoners reporting no religion (could be due to changes in reporting procedures)
Disability	30% self-reported disability, of which 36% had more than one condition	Less prisoners reporting a disability (42% in 2010) More prisoners reporting progressive conditions and reduced mobility
Sexuality	19% gay/lesbian or bisexual	Increase from 14% in 2010
Sentence Length	Under 12 months= no prisoners 12 months- 4 years= 59% 4 years- 10 years= 9% Lifers and PPO= 32%	38% increase in 12 months-4 year sentences 8% increase in lifers

Source: See below under demographic categories

PHPQI 1.13 Equality and Human Rights states that health need assessments must include the six strands of diversity- age, gender, sexual orientation, disability, race and religion. Data, where available, is outlined below.

Age

The age of prisoners in HMP Send has changed since the 2010 HNA, with a 27% decrease in prisoners aged 22-30 (30 less prisoners) and an 18% increase in prisoners aged 41-50 (13 more prisoners). There was also a 14% increase in the over 60's, although this was only one prisoner more. This reflects national information indicating an ageing prison population[1].

[1] http://www.prisonreformtrust.org.uk/ProjectsResearch/Olderpeopleinprison

Table 2: Prisoners per age group in 2012, and compared to 2010

Age Group	2010	2012	Changes
18-21	0%	1.5% (n=4)	-
22-30	39% (n=109)	30% (n= 79)	27% decrease
31-40	29% (n=81)	30% (n= 79)	2% decrease
41-50	20% (n=56)	26% (n= 69)	18% increase
51-60	10% (n=28)	9% (n= 24)	17% decrease
61-70	2%* (n=7)	3% (n= 7)	14% increase
70+		0.4% (n=1)	

Source: SystmOne (total population 263) *= data previously grouped by over 60 only

Healthcare and the prison should work together to ensure that the needs of older prisoners are met, and to monitor the numbers to inform service planning.

Ethnicity

There have been no major changes in the ethnicity of the prisoners at HMP Send since 2010. There were minor changes in the three largest groups which changed from White British, Black Caribbean and White Other, to White British, White Other and Black Other. Categories with no prisoners have been removed. Nationally 28% of the female prison population is from BME groups and this is 36% at HMP Send.

Table 3: Prison population by ethnic group in 2012, compared to 2010

Ethnic Group	2010	2012
BME population	*34%*	*36%*
White- British	66%	62%
White- Irish	1%	2%
White- Other	6%	12%
Mixed- White and Black Caribbean	-	1%
Mixed- Other	3%	3%
Asian- Indian	2%	2%
Asian- Pakistani	2%	1%
Asian- Other	2%	1%
Black- African	4%	3%
Black- Caribbean	9%	6%
Black- Other	6%	8%

Source: Prison Diversity Lead

The way the data was received did not match to the Census 2011 categories, which now include 'White Gypsy or Irish Traveller' and 'Arab'. Therefore it is recommended that all ethnicity data is recorded according to these recognised categories.

Foreign Nationals

The most recent data available from the Ministry of Justice from December 2011, indicates a 30% reduction in the percentage of foreign national prisoners from 13% (37/281) in 2010 to 9.6% (26/272). This is likely due to HMP Downview being an identified foreign national centre, so prisoner are likely to be transferred there.

Religion

Compared to 2010, less prisoners reported that they had no religion (22% vs 52%)- it is not clear why this is the case, but it could be due to changes in reporting procedures. The largest groups in 2012 were Church of England (30%) and Roman Catholic (18%).

Table 4: Prisoners by religion in 2012

Religion	% of prisoners
Baptist	-
Buddhist	4%
Christian	8%
Church of England	30%
Church Of Scotland	-
Hindu	2%
Jehovah Witness	1%
Jewish	-
Methodist	1%
Muslim	4%
No Religion	22%
Orthodox (Greek/Russian)	1%
Other	-
Pagan	2%
Pentecostal	2%
Protestant	1%
Rastafarian	1%
Roman catholic	18%
Seventh Day Adventist	-
Sikh	2%
Spiritualist	1%

Source: Prison Diversity Lead

Disability

In 2012, 29.7% of the prison population in HMP Send stated that they have a disability. This is lower than 2010, when 42% of prisoners declared a disability; however this could be due to changes in the way disability is recorded.

Out of those that declared a disability, 36% declared more than one disability. The number of prisoners with progressive conditions and reduced mobility increased. This could also be due to the increasing number of older prisoners in HMP Send.

Table 5: Prisoner self-reported disabilities in 2012, and compared to 2012

Disability	2010	2012
Dyslexia	4%	4%
Hearing Difficulty	4%	4%
Learning difficulty	3%	3.5%
Mental Illness	13%	11%
Other Disability	3%	4%
Progressive condition	1%	4%
Reduced Mobility	4%	6.5%
Reduced Physical capacity	2%	1.5%
Speech Impediment	1%	1%
Visual Impairment	7%	3.5%

Source: Prison Diversity Lead

Sexuality

The Prison Diversity Lead was able to provide data on sexuality. Based on the prison population at the time of the health needs assessment, 11% of prisoners described their sexuality as gay/lesbian, 9% as bisexual and 17% did not wish to disclose their sexuality. This is higher than the 14% who declared themselves gay or bisexual in 2010.

Sentence Length

The length of prisoner sentences has changed since the full HNA. There are now no women with a sentence under 12 months, compared to 19% in 2010. The number of prisoners with a life sentence has increased by 8%, meaning there are around 6 more lifers at HMP Send. The number of prisoners with sentences above 12 months – less than 4 years has increased by 38%.

Table 6: Prisoner sentence lengths in HMP Send in 2012, compared to 2012

Sentence length	2010	2012	Changes from 2010
Less than 12 months	19% (n=54)	-	-
Above 12 months- less than 4 years	39% (n=110)	59% (n=152)	38% increase
4 years to less than 10 years	Data unavailable	9% (n=24)	-
Lifers and PPO	28% (n=78)	32% (n= 84)	8% increase

Source: HMP Send

Recommendations

1. The demographics of the prison population should be regularly reviewed to ensure services meet the needs of prisoners.
2. Healthcare and the prison should work together to ensure that the needs of older prisoners are met, and to monitor the numbers to inform service planning.
3. All recording of ethnicity should use the standards set out in the 2011 Census.
4. The prison and healthcare should ensure appropriate support and services are in place for women who are gay or bisexual, and women serving life sentences.

3. Physical Health Needs

3.1 Long term conditions

Table 7: Observed and expected prevalence for physical conditions in 2012, compared to 2010

	2010						2012			
	Expected		Observed				Expected		Observed	
Disease	**Overall prevalence**	**Expected no./281**	**Chronic Disease Register**	**Reception audit**	**Pharmacy data**	**Observed (range)**	**Overall prevalence**	**Expected no.**	**QOF/257 (19/03/2012)**	**Self-reported on reception/214 (2011 new receptions)**
Treated asthma (BTK)[2]	6.0%	5.7% (16)	4.3% (12)	22.9%	15.0%	12-64	6%	5.4% (14)	23.7% (61)	24.3% (52)
COPD (UK)[3]	0.8%	1.0% (3)	1.7% (5)	1.6%	-	5	1.6%	1.2% (3)	2.3% (6)	0.5% (1)
Epilepsy (BTK)	-	0.7% (2)	1.0% (3)	3.3%	3.2%	3-9	-	0.8% (2)	2.3% (6)	3.7% (8)
Diabetes (UK)[4]	0.8%	3	1.4% (4)	0.0%	-	0-4	5.3%	5.4% (14)	2.3% (6)	1.9% (4)
Hypertension (UK)[5]	28.0%	41	3.6% (10)	1.6%	-	4-10	29.0%	17.5% (45)	9.7% (25)	7.9% (17)
Ischaemic heart disease (BTK)	1.0%	2	-	-	-	Unknown	-	0.8% (2)	1.2% (3)	0.5% (1)
Pregnancy (BTK) *	3.0%	8	-	-	-	3	3.0%	8	-	-
Hepatitis B (BTK) *	12.0%	34	-	0.0%	-	0	12.0%	31	-	-
Hepatitis C (BTK) *	11.0%	31	0.0% (0)	3.0%	-	0-8	11.0%	28	-	5.6% (12)
HIV (BTK) *	1.2%	3	0.4% (1)	1.6%	-	1-4	1.2%	3	-	0.5% (1)

Sources in 2012: Expected prevalence= Birmingham Toolkit or National Data, Observed= SystmOne QOF, self-reported on entrance to prison

*BTK= Birmingham Toolkit UK= National UK data *= No age stratified data available*

[2] Marshal, T., Simpson, S. and Stevens, A. (2000). *Toolkit for healthcare needs assessment in prisons*. University of Birmingham.
[3] Public Health Intelligence Unit. *Model for Estimating the Prevalence of Chronic Obstructive Pulmonary Disease (COPD).* http://www.doncasterhealth.co.uk/PHIU/pdfs/QOF/COPDModel.pdf [Accessed July 2012]
[4] Diabetes UK. (2011). Diabetes in the UK 2011/2012: Key statistics on diabetes. http://www.diabetes.org.uk/Documents/Reports/Diabetes-in-the-UK-2011-12.pdf [Accessed July 2012]
[5] The Information Centre. (2010). *Health Survey for England.* http://www.ic.nhs.uk/hse [Accessed July 2012]

Methodology

The table above uses data either from the Birmingham Toolkit (uses data from a large group of prisoners or community data published at the time the toolkit was created) or from the latest general population data to estimate how many people we would expect to have certain medical conditions at HMP Send. Most of the data is age stratified which means we know the differences in prevalence for each age group and can apply those numbers to the age profile at HMP Send to get a more accurate prevalence estimate. All the data sources used have separate female data on each condition.

In 2010, the observed prevalence of diseases was taken from manually created and maintained paper registers. The 2012 prevalence of diseases is taken directly from SystmOne through QOF.

The Quality and Outcomes Framework (QOF) is a programme for all GP surgeries in England detailing practice achievement results, which has been implemented in prisons through the use of the SystmOne computer system. The prison QOF contains three components, known as domains: Clinical Domain, Organisational Domain and Additional Services Domain. Each domain consists of a set of achievement measures, known as indicators, against which points are scored according to their level of achievement. It is being used across the prisons as a tool for improving clinical practice.

N.B. The section below is presuming that SystmOne is providing accurate data. If correct clinical coding is not taking place, the data and recommendations may not be useful or accurate. However if this is the case, the replacement recommendation should be to ensure accuracy on SystmOne.

Asthma

2010 Expected	**2010 Observed**	**2012 Expected**	**2012 Observed**	
	Asthma Register		***QOF***	***2011 receptions reporting asthma***
5.7% (16/281)	4.3% (12/281)	5.4% (14/257)	23.7% (61/257)	24.3% (52/214)

Of the new receptions in 2011, 24.3% reported asthma as a current problem when they arrived at the prison. This is a similar prevalence to those on the QOF asthma register, which includes only those prescribed medication for asthma in the last 12 months. This is a much higher number than we would expect for this group of prisoners.

Self-reported asthma on reception was similar in the previous HNA (22.9%) to the 2011 receptions (24.3%), however the observed prevalence from the manually maintained asthma register (4.3%) and the pharmacy data (15%) in 2010 were much lower than the prevalence from the current QOF asthma register (23.7%).

Data from SystmOne indicates that 77% (46/60) of those diagnosed with asthma have had an asthma review in the preceding 15 months, and that 58% (28/48) were diagnosed and had measures of variability or reversibility. The first figure is very positive and suggests that those with a diagnosis are being monitored; however the second figure should be improved.

Accurate diagnosis is fundamental in order to avoid untreated symptoms as a result of under-diagnosis, and inappropriate treatment as a result of over-diagnosis. Given these high numbers, it is recommended that a programme of work is undertaken to review patients with asthma and the clinical pathways at HMP Send. This will then determine if this high number is accurate, and improve clinical care for these patients.

Chronic Obstructive Pulmonary Disorder (COPD)

2010 Expected	2010 Observed	2012 Expected	2012 Observed	
	COPD Register		*QOF*	*2011 receptions*
0.8% (3)	1.7% (5/281)	1.2% (3/257)	2.3% (6/257)	0.5% (1/214)

Of the new receptions in 2011, 0.5% reported COPD as a current problem when they arrived at the prison. This is a lower prevalence to the QOF COPD register (2.3%), which may indicate prisoners do not report they have the condition or that they are diagnosed whilst in the prison. The number on the QOF COPD register is higher than the expected number, though this is similar to the number reported on the paper register in 2010.

All patients with COPD should have their diagnosis confirmed by post bronchodilator spirometry- data from SystmOne indicates that this had not occurred (0/1 patients). NICE clinical guideline 101 recommends that FEV1 and inhaler technique should be assessed at least annually for people with mild/moderate/severe COPD (and in fact at least twice a year for people with very severe COPD) - data indicated this had not happened for any patients (0/5). No patients (0/5) with COPD had had a review of their condition within the last 15 months.

100% (6/6) of patients with COPD had received a flu vaccination in the preceding flu season (September-March) which is an excellent result.

Epilepsy

2010 Expected	2010 Observed	2012 Expected	2012 Observed	
	Epilepsy Register		*QOF*	*2011 receptions*
0.7% (2)	1.0% (3/281)	0.8% (2/257)	2.3% (6/257)	3.7% (8/214)

Of the new receptions in 2011, 3.7% reported epilepsy as a current problem when they arrived at the prison. This is a higher prevalence than the QOF epilepsy register (2.3%), which may indicate prisoners reporting epilepsy for drug seeking reasons or due to misdiagnosis in the past. The prevalence from the QOF epilepsy register (2.3%) is higher than the expected prevalence (0.8%) and the prevalence in 2010 (1.0%).

Data from SystmOne indicates that 100% (4/4) patients on the epilepsy register have a record of their seizure frequency taken in the last 15 months and 75% (3/4) were recorded as seizure free for 12 months, which indicates good management of medication. Only one patient was categorised as needing advice about contraception, conception and pregnancy advice, and this had not been provided. Although probably less relevant in a prison setting, this information is important for when leaving the prison, on temporary leave or when discharged.

Diabetes

2010 Expected	2010 Observed	2012 Expected	2012 Observed	
	Diabetes Register		*QOF*	*2011 receptions*
0.8% (3/281)	1.0% (3/281)	5.4% (14/257)	2.3% (6/257)	1.9% (4/214)

Of the new receptions in 2011, 1.9% (4/214) reported diabetes as a current problem when they arrived at the prison. This is a similar prevalence to the QOF diabetes register (2.3%). This is lower than the expected prevalence (5.4%), meaning there could be up to 8 patients with undiagnosed diabetes in the prison.

The expected number in this HNA is now based on the age-adjusted prevalence for England[6]. The Birmingham Toolkit used in the 2010 full HNA, is based on community data for 1996, and the prevalence of diabetes has increased greatly since then; for example overall from 3% in 2004 to 5.5% in 2011.

Also among women, diabetes is more than five times as likely among Pakistani women, at least three times as likely in Bangladeshi and Black Caribbean women, and two-and-a-half times as likely in Indian women, compared with women in the general population[6]. We may expect the prevalence to therefore be even higher given the high BME population at HMP Send (36% compared to 28% of female prisoners nationally); it is estimated that at least 9% (23/257) of prisoners at HMP Send are of an ethnicity with a higher risk of diabetes.

Of the 13 diabetes indicators for QOF on SystmOne, 10/13 had scores above 80% which is excellent. Only 40% (2/5) had a record of neuropathy testing in the preceding 15 months. Patients with diabetes are at high risk of foot complications. Inspection for vasculopathy and neuropathy is needed to detect problems. These checks should be carried out at an annual review. Only 66% (4/6) of patients' last measured total cholesterol within the preceding 15 months was 5mmol/l or less. 50% (2/4) of patients with diabetes had a blood pressure reading of 140/80 or less. Blood pressure (BP) lowering in people with diabetes reduces the risk of macrovascular and microvascular disease.

Cardiovascular Disease

Hypertension

2010 Expected	2010 Observed *Hypertension Register*	2012 Expected	2012 Observed	
			QOF	*2011 receptions*
28% (41/281)	3.6% (10/281)	17.5% (45/257)	9.7% (25/257)	7.9% (17/214)

Of the new receptions in 2011, 7.9% (17/214) reported hypertension as a current problem when they arrived at the prison. This is a lower prevalence to the QOF hypertension register (9.7%), which may indicate prisoners are being diagnosed with the condition in the prison. This is much lower than the expected prevalence (17.5%), meaning there could be up to 20 patients with undiagnosed hypertension in the prison. However, the prevalence has increased since the last HNA (3.6%) likely indicating an improvement in detection levels.

100% (25/25) patients on the register had had their blood pressure taken in the preceding 9 months and 64% (14/22) had a last blood pressure reading of 150/90 or less.

Heart Disease

2010 Expected	2010 Observed *Heart Disease Register*	2012 Expected	2012 Observed	
			QOF	*2011 receptions*
1% (2/281)	-	0.8% (2/257)	1.2% (3/257)	0.5% (1/214)

[6] Diabetes UK. (2011). Diabetes in the UK 2011/2012: Key statistics on diabetes. http://www.diabetes.org.uk/Documents/Reports/Diabetes-in-the-UK-2011-12.pdf [Accessed July 2012]

Of the new receptions in 2011, 0.5% (1/214) reported heart disease as a current problem when they arrived at the prison. This is similar to the QOF heart disease register (1.2%) and the expected prevalence (0.8%). There was no data available in the previous HNA.

Of the five coronary heart disease indicators for QOF on SystmOne, all had scores of 67%. This indicates excellent management of patients with heart disease in the prison.

CVD Primary Prevention

Data from SystmOne indicated that 18 patients were on the Cardiovascular Disease Primary Prevention register (recorded a new diagnosis of hypertension, excluding those with pre-existing CHD, diabetes, stroke and/or TIA). SystmOne showed that 0% (0/4) of patients on the register had received a face to face cardiovascular risk assessment at the outset of diagnosis and 77% (10/13) had received lifestyle advice.

Stroke, TIA and Atrial Fibrillation

Six patients were recorded as having a stroke or TIA at HMP Send, and no patients had a diagnosis of atrial fibrillation. Of the five Stroke/TIA indicators for QOF on SystmOne, all had scores of over 80%.

Other conditions

Table 8: Prevalence of other conditions

Condition	Prevalence (Number) at HMP Send
Dementia	None
Heart failure	None
Hypothyroidism - Prevalence of 1.9% in women in community	1.9% (5/257) *100% with thyroid function tests recorded in the preceding 15 months*
Sickle cell*	0.4% (1/257)
Cancer	None
Renal Impairment*	None
Chronic Kidney Disease	None

Data source: *Self-reported on reception screening or from QOF through SystmOne

Recommendations

5. Audit of clinical records to examine diagnoses of asthma patients against SIGN guideline 101[7].
6. Increase the percentage of patients who have a diagnosis with measures of variability or reversibility.
7. Audit of asthma reviews to ensure they cover the factors outlined in SIGN guideline 101.
8. Audit of asthma patients to ensure they all have an up to date asthma action plan in place.
9. Audit of all patients with COPD to ensure they have received a diagnosis confirmed by post bronchodilator spirometry, and a review of their condition including FEV1 and inhaler technique in the last 15 months.
10. A programme for detection of undiagnosed diabetes should be set up at HMP Send, including targeting prisoners of ethnic minorities who are at a higher risk of diabetes.
11. Audit of all patients on the diabetes register to ensure they have had neuropathy testing in the preceding 15 months.

[7] British Thoracic Society and the Scottish Intercollegiate Guidelines Network (2008, revised January 2012). British guideline on the management of asthma (101): a national clinical guideline. http://www.sign.ac.uk/pdf/sign101.pdf [Accessed July 2012]

12. Audit of patients with diabetes who have a total cholesterol over 5mmol/l and those with a blood pressure reading of 140/80 or more, to see if they would benefit from further treatment.
13. Audit of patients on the hypertension register who have a last blood pressure reading of 150/90 or more to see if they would benefit from further treatment.
14. Audit of those on the CVD register to ensure they have received a cardiovascular risk assessment.

3.2 Communicable Diseases

Hepatitis B

No prisoners entered HMP Send with a diagnosis of Hepatitis B in 2011, and no new diagnoses were made. We would expect 31 patients to have a diagnosis of Hepatitis B at HMP Send.

Hepatitis B Vaccination

All prisoners should be offered a Hepatitis B vaccination programme on arrival at HMP Send. The coverage rates for the vaccine are rated for the Prison Performance and Quality Indicators as <50% RED, 50-80% AMBER and >80% GREEN and are submitted to the Department of Health on a quarterly basis.

In the previous HNA, over one year, only two months of data were reported and the coverage rates recorded were only 6% and 8%. The table and graphs below show vast improvements in coverage since the last HNA and over 50 prisoners have been vaccinated in the last year. They also detail the percentage of prisoners who decline the vaccine, and the number who have not been offered the vaccine.

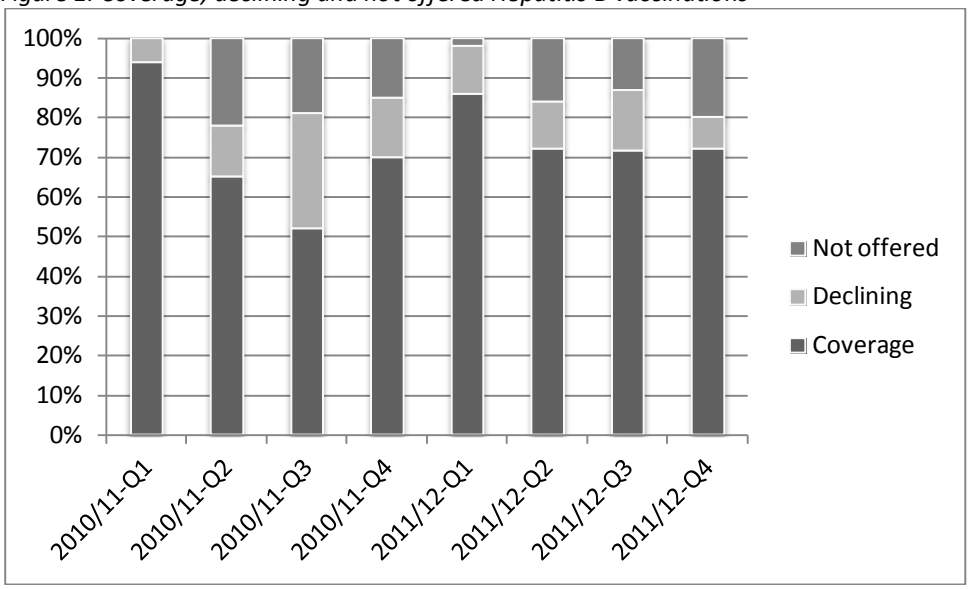
Table 9: Rating, coverage, declining and not offered for Hepatitis B vaccinations

Year and Quarter	Rating and Coverage	Declining	Not offered
2010/11-Q1	*Green* 94%	6%	0%
2010/11-Q2	*Amber* 65%	13%	22%
2010/11-Q3	*Amber* 52%	29%	19%
2010/11-Q4	*Amber* 70%	15%	15%
2011/12-Q1	*Green* 86%	12%	2%
2011/12-Q2	*Amber* 72%	12%	16%
2011/12-Q3	*Amber* 71%	15%	13%
2011/12-Q4	*Amber* 71%	8%	20%

Source: PHPQI website

The number of prisoners declining has been fairly static, therefore we could assume that if all prisoners were offered the vaccine the coverage rate would rise to above 80%. It is not clear why all prisoners are not being offered the vaccine.

Figure 1: Coverage, declining and not offered Hepatitis B vaccinations



Source: PHPQI website

Hepatitis C

Of the new receptions in 2011, 5.6% (12/214) reported a diagnosis of Hepatitis C, this is higher than the reception figures from the last HNA. No information was available on the current number of prisoners with Hepatitis C, although 3 were diagnosed while in the prison in 2011. We would expect to see 28 prisoners (11%) with a diagnosis of Hepatitis C. The data below indicates 71% (151/214) of new receptions were unaware of their Hepatitis C status, and 55% (83/151) of these prisoners were not offered a Hepatitis C test.

Hepatitis C Tests

Hepatitis C testing is now reported on quarterly as part of the Prison Health and Performance Quality Indicators (PHPQI 3.2). The graph below shows the percentage of new receptions who were tested for Hepatitis C in 2011 within 31 days of reception; 31 prisoners were tested over the year. The uptake rate of Hepatitis C tests was 21% (tested/total receptions not previously tested) and the coverage rate for new receptions was 44% (already tested + tested/total receptions).

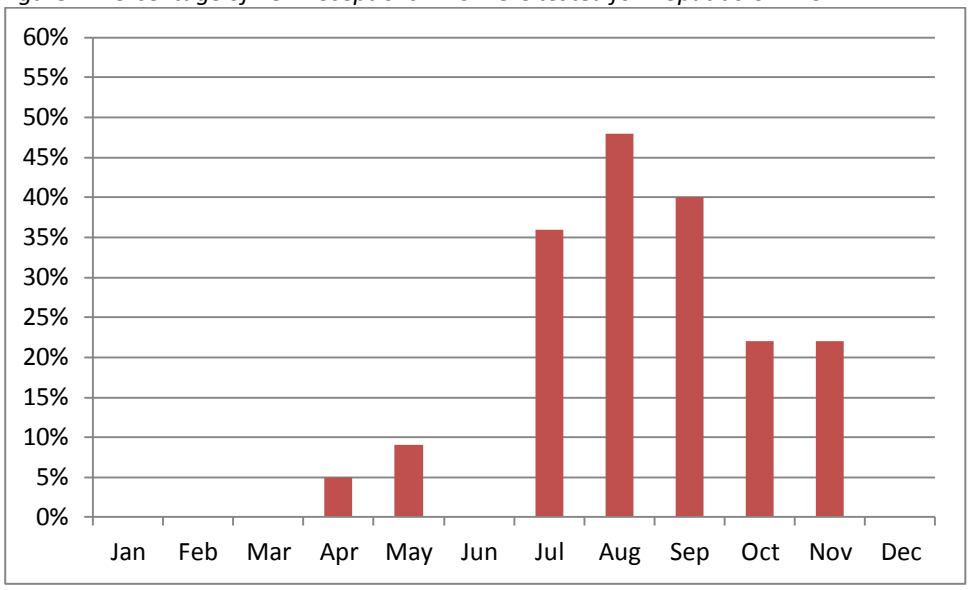
This data was not available in the previous HNA, although a recommendation was made for more testing to be carried out.

Table 10: Information on Hepatitis C tests for new receptions in 2011

Receptions	Declined	Already tested +ive	Already tested -ive	Tested	Uptake %	Declined %	Already tested %	Coverage %
214	37	12	51	31	21%	17%	29%	44%

Source: PHPQI website

Figure 2: Percentage of new receptions who were tested for Hepatitis C in 2011



Source: PHPQI website

HIV

Of the new receptions in 2011, data from SystmOne indicated that one patient (0.5%) reported a diagnosis of HIV- this is lower than the expected value of 1.2% (3/257).

No information was available on the current number of prisoners with HIV, although 1 was diagnosed while in the prison in 2011. Data from SystmOne indicated 39 patients accepted an offer of a HIV test on reception and 71 declined an offer of testing. 53 patients reported they had received a negative test result in the past. Data from SystmOne indicates 76% (163/214) of new receptions were unaware of their HIV status.

Tuberculosis

Of the new receptions at HMP Send in 2011, 3 prisoners reported they had had possible contact with someone with TB, 3 were screened and no cases were detected.

Prisons and other places of detention pose particular risks for the causes and transmission of infection, and challenges for control of communicable diseases due to:

- The nature of the environment: prison and detention establishments vary in their age, design, construction and healthcare facilities. Cell sharing is common. Staff levels and skill mix vary and access to healthcare services differ.
- The nature of the population: about 85,000 people are confined in prisons in England and Wales at any one time. Throughput and turnover are very high.
- The prevalence of disease: people in prison and detention often come from populations or groups at higher risk of certain infectious diseases e.g. blood-borne viruses, HIV and sexually transmitted infections and tuberculosis.

Due to the close living conditions within prison and the high prevalence of TB within BME communities outside prisons, the potential for an outbreak within a prison with a high proportion of BME groups is high.

NHS Surrey TB Strategy highlights the prevention, management and detection of TB within Prisons. When TB occurs in prison, one third of cases are drug resistant[8] so high quality case management is essential. Fewer prisoners complete TB treatment compared to others (48% vs 80%).

The management of TB in prisoners is complicated by the high rate of cases lost to follow up. This is due to homelessness rates after discharge leading to difficulties in providing adequate follow up to ensure ongoing treatment and the poor continuation of treatment after transfer to another establishment. It is essential that any prisoner that starts TB treatment has a plan in place to continue that treatment if they leave the prison or are transferred to a new establishment.

Some prisoners may enter the establishment with unrecognised active or latent TB infection. It is important that prisoners from TB high risk incidences countries are offered a BGC immunisation and screened for latent disease. It is therefore important that all prisoners have an awareness of TB.

Healthcare staff and prison staff should be educated to recognise TB symptoms in themselves and others and they should have an awareness of which communities are at higher risk of TB (including homeless and people from countries with high TB incidence).

For healthcare and prison staff it is important that at pre-employment occupational health assessment, new staff are screened for TB as part of their pre-employment process.

Recommendations

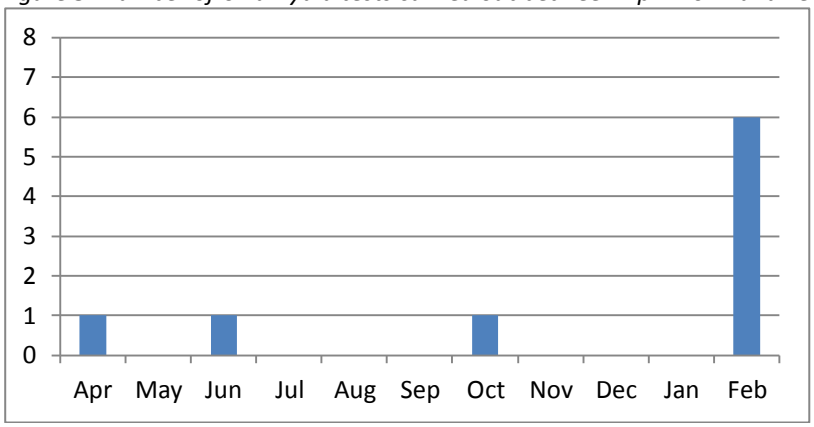
15. Develop a plan to improve the processes for Hepatitis B vaccination so all prisoners are offered the vaccine within 31 days of reception, and the coverage is over 80% every quarter. This plan should be reviewed after 3 months.
16. An audit should be carried out of all patients to ensure those ‘at risk’ were offered a Hepatitis C test on reception and later during their stay at HMP Send, and procedures put in place to ensure all new receptions ‘at risk’ are offered the test.
17. An audit should be carried out of all patients to ensure those ‘at risk’ were offered a HIV test on reception and later during their stay at HMP Send, and procedures put in place to ensure all new receptions ‘at risk’ are offered the test.

3.3 Sexual Health

Chlamydia Testing

Chlamydia is the most commonly diagnosed sexually transmitted infection (STI) in the UK, affecting both men and women. The National Chlamydia Testing Programme offers testing to all under 25s. Data from the Surrey Chlamydia Testing Programme showed that in 11 months a total of 9 tests were carried out. HMP Send has averaged 18 new receptions a month, so with the age profile outlined in the demographic section we would expect approximately 2-3 tests to be offered a month.

Figure 3: Number of Chlamydia tests carried out between April 2011 and February 2012



Source: Surrey Chlamydia Screening Programme

Compared with the data in the previous HNA, the number of tests carried out has declined. It is not know why this is the case, but it is likely due to testing not being prioritised.

Table11: Comparative number of Chlamydia tests carried out in two time periods

Time period	Number of Chlamydia Tests
April – October 2010	44
April – October 2011	3

Source: Surrey Chlamydia Screening Programme

It is recommended that there is an increase in the number of young women being tested. There is also a high positivity for Chlamydia in this population which indicates the programme is of value within the prisons.

Using data from April to November 2011, a target was estimated which would encourage improvement; for Send the target for 2012/13 is 56 tests. This target may now be too high given the changes in population at Send, and can be revised. It is recommended that the target be changed to 80% of new receptions under 25s, which is likely to equal around 25-30 tests over 12 months.

Recommendation

18. Develop a plan to improve the processes for Chlamydia testing so more young women are offered the test, and more tests are carried out. This plan should be reviewed after 3 months.

3.4 Oral Health

The *Strategy for Modernising Dental Services for Prisoners in England (2003)* and later the *Reforming Prison Dental Services in England Guidance (2005)*[8] focuses on improving the quality of dental care provided in prisons while raising awareness of the need for good oral health. A number of key good practice recommendations are made and include undertaking an oral health needs assessment, oral health promotion, improving access to treatment and improving quality of care.

Three key access standards to prison dentistry have been identified:

- Emergency care, for example severe facial trauma and severe bleeding, may require **immediate access** to an Accident & Emergency department in line with local health care provision and subject to local prison security policies.
- Urgent care for dental pain and minor trauma will require access to a dentist within **24 hours**.
- Appointments for routine care will not normally exceed **6 weeks** from the time of asking.

The prison dental services are provided by the same provider as the nursing service. In 2011/12 the service was under great challenge due to long term sickness and maternity leave among key members of staff and recruitment difficulties. Action has been taken to improve the situation.

Unfortunately dental sessions were lost as a result of these difficulties and a number of sessions have also been lost due to prison operational issues and IT system failure. All this together has resulted in an increase in the waiting times for treatment. This varies between the prisons as shown below. A plan has been put into place to replace the majority of the sessions lost due to staff shortages with the aim of reducing waiting times back to the standard of 6 weeks.

Data was not available for the first two months on 2011/12, but capacity in June appears to have been able to cope with demand. Send is the only prison in Surrey that seems to have been able to maintain a reasonable standard of patient waiting times over 2011/12:

- 87% of patients seen within 6 weeks of referral for routine care.
- 100% of patients referred for urgent treatment were seen within 24 hours
- No patients were referred for emergency treatment.

This is a significant improvement on waiting times reported in the 2010 HNA.

[8] Office for Public Management (2005) Reforming prison dental services in England. A guide to good practice.

4. Mental Health and Learning Disabilities

In Her Majesty's Inspectorate of Prisons unannounced inspection of HMP Send in December 2010, integrated mental health provision was described as 'reasonably good'. Women experiencing mental health problems and substance misuse issues are able to access primary and secondary mental health services.

Recommendations were made to have a dual diagnosis lead and dual diagnosis service supported by joint work with mental health and CARAT services to prevent gaps in the service. Following a death in custody in 2010, recommendations were made to ensure prompt and appropriate referrals from reception to the mental health team and that all staff in contact with prisoners should have mental health awareness training.

4.1 Prevalence of Mental Health

Questions about mental health history, treatment and self harm are routinely collected during the first reception screening on SystmOne.

Table 12: % of people answering yes to questions on mental health history during first reception on a snapshot day in 2011

Question Asked	% Answering yes
Prisoner has received treatment from a psychiatrist outside prison	24.12
Prisoner has stayed in a psychiatric hospital	28.40
Prisoner has had a psychiatric nurse or care worker in the community	9.73
Prisoner has received medication for mental health problems	40.08
Prisoner has tried to harm themselves (within prison)	22.96
Prisoner has tried to harm themselves (outside prison)	28.40
Prisoner feels like self-harming or Suicide	2.72

Source: SystmOne

40% of prisoners reported receiving medication for mental health problems. This is low when compared to national estimates that estimate 70% of female sentenced prisoners have at least one mental disorder[9]. This could be due to underreporting by prisoners or untreated mental health problems within this community.

4.2 Mental Health Provision

Staffing

- Service Manager 0.25 Whole Time Equivalent
- Community Psychiatric Nurse 0.8 Whole Time Equivalent
- Support Time and Recovery Worker 1.0 Whole Time Equivalent
- Counsellor 0.2 Whole Time Equivalent
- Movement Psychotherapy 0.2 Whole Time Equivalent
- Consultant Psychiatrist 0.1 Whole Time Equivalent
- Specialist Registrar 0.1 Whole Time Equivalent
- Consultant Psychotherapist 0.3 Whole Time Equivalent
- Social Worker 0.3 Whole Time Equivalent

[9] Prison Reform Trust (2011) *Bromley Briefings Prison Factfile*. London: Prison Reform Trust.

Number of Services a week

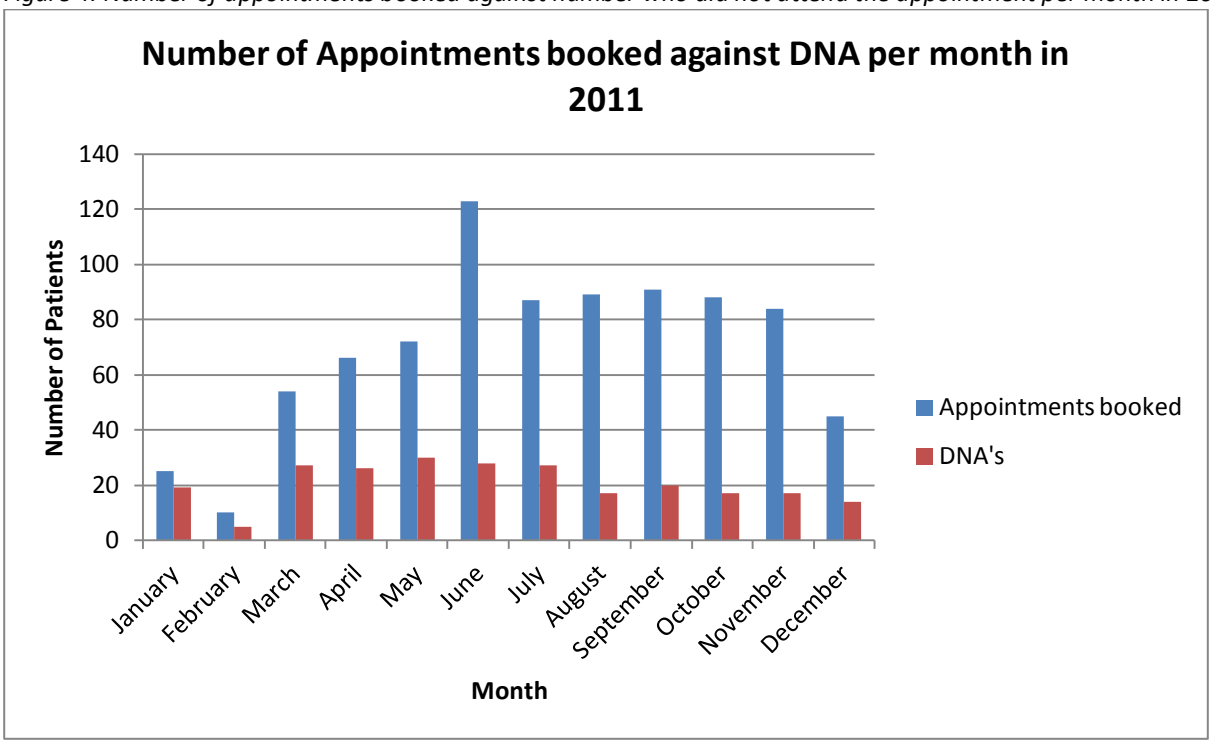
- 2 sessions of Movement Psychotherapy
- 1 Eating Distress Group
- 2 sessions of Psychotherapy
- 1 session of group Psychotherapy
- 8 sessions of counselling provided by volunteer counsellors.

There is a small waiting list for each service with the exception of counselling.

There was a significant waiting list for counselling. However since recruiting an additional volunteer counsellor, and starting to offer short term as well as long term therapy they have seen a reduction in the waiting list this year.

Number of Appointments

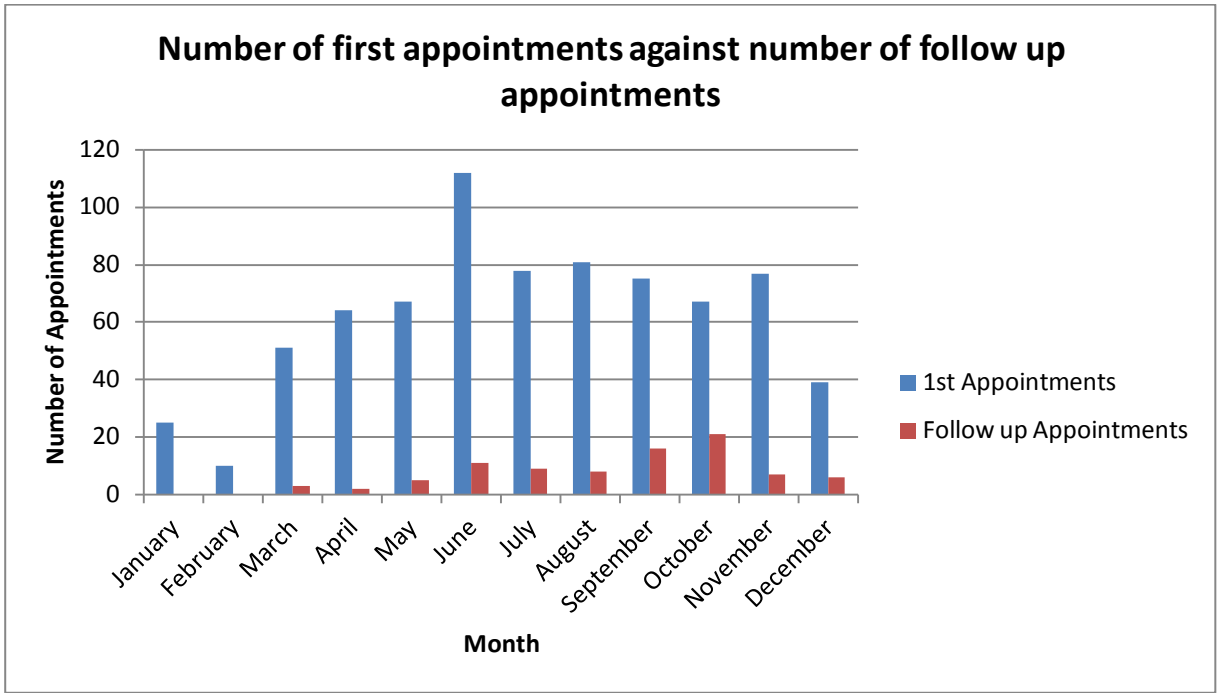
Figure 4: Number of appointments booked against number who did not attend the appointment per month in 2011



Data for January and February was low. This may have been due to poor reporting or changes in the In reach management.

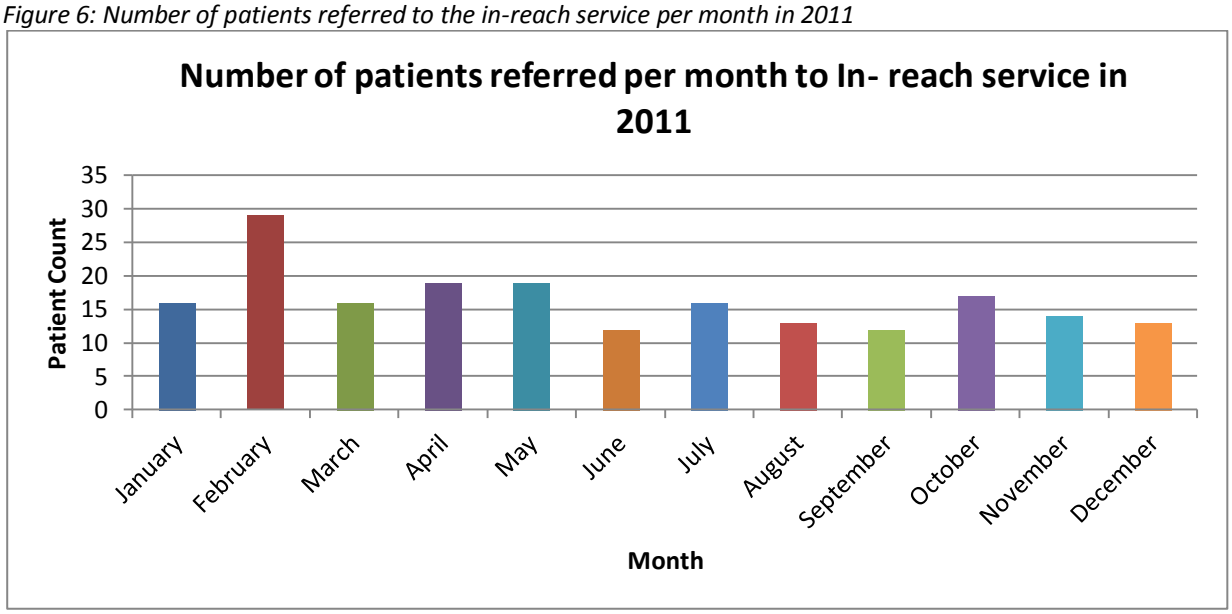
On average 35% inreach appointments were 'did not attends (DNAs) every month in 2011.In January there was the highest proportion of DNAs for 2011. 76% of appointments were not attended. In August the rate of DNAs was at the lowest rate at 19.1%.

Figure 5: Number of first appointments against follow up appointments per month in 2011



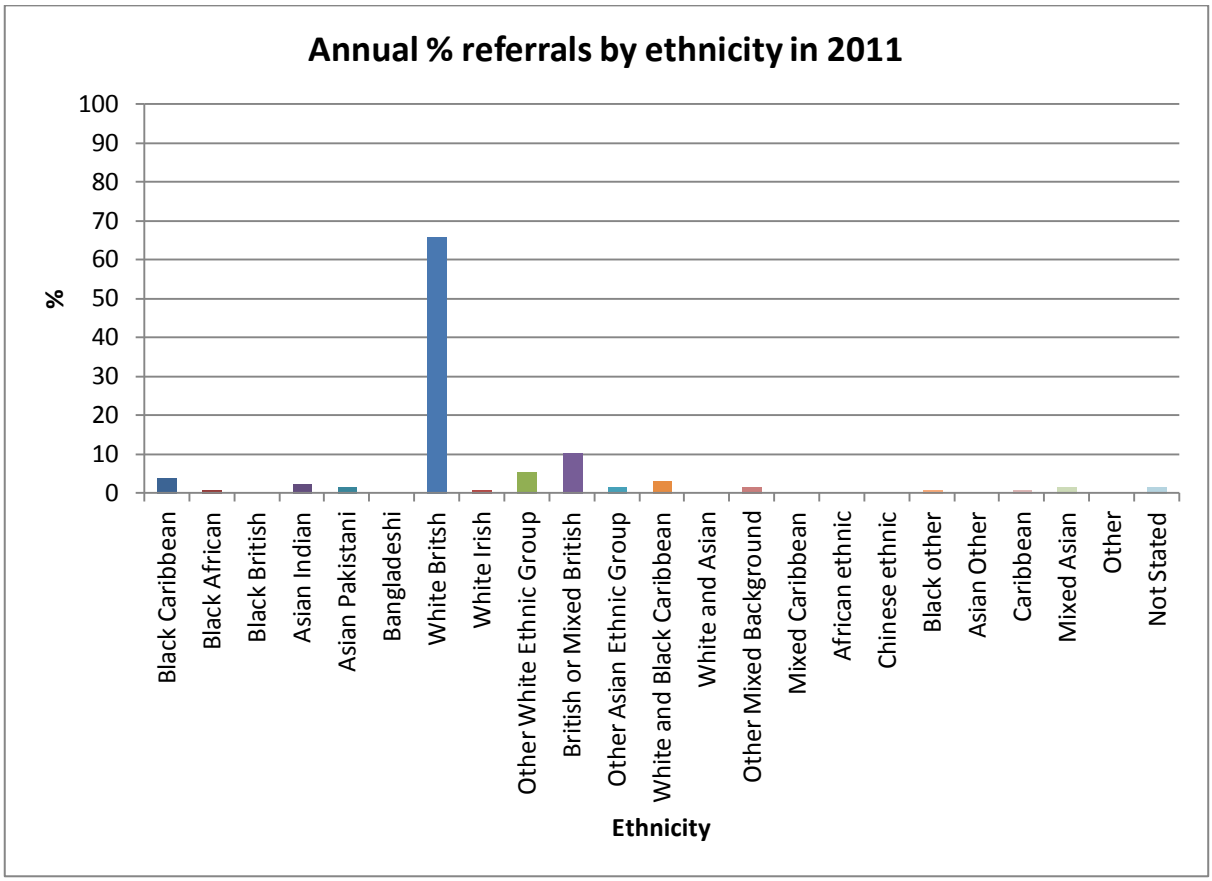
Referrals to Inreach

Figure 6: Number of patients referred to the in-reach service per month in 2011



On average 16 prisoners were referred to the In-reach service per month in 2011. The highest rate of referrals was in February (19). September and June had the lowest number of referrals (12).

Figure 7: Annual percentage referrals to in-reach by ethnicity for 2011

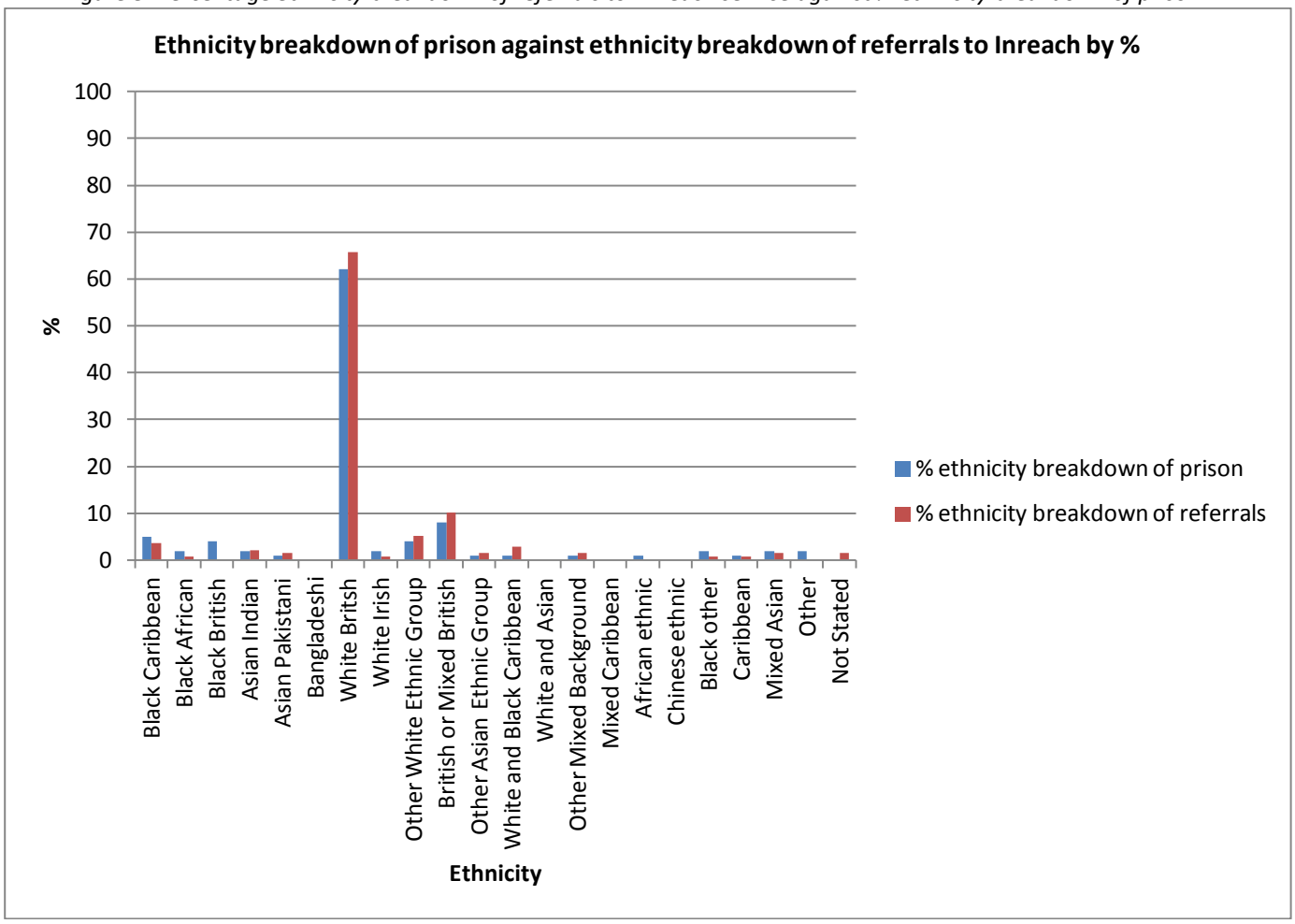


The five most common referrals were from prisoners from the following ethnic group:-

- White British (65%)
- British or Mixed British (10.22%)
- Other White Ethnic Group (5.11%)
- Black Caribbean (3.65%)
- White and Black Caribbean (2.92%)

There were no referrals from prisoner who described their ethnicity as Bangladeshi, White and Asian, Mixed Caribbean, African Ethnic, Chinese Ethnic and Other ethnic groups.

Figure 8: Percentage ethnicity breakdown of referrals to in-reach service against % ethnicity breakdown of prison



Prisoners from the White British ethnic group represented 65% of the referrals to in reach. This is relative to the proportion of that group in the prison (62%).

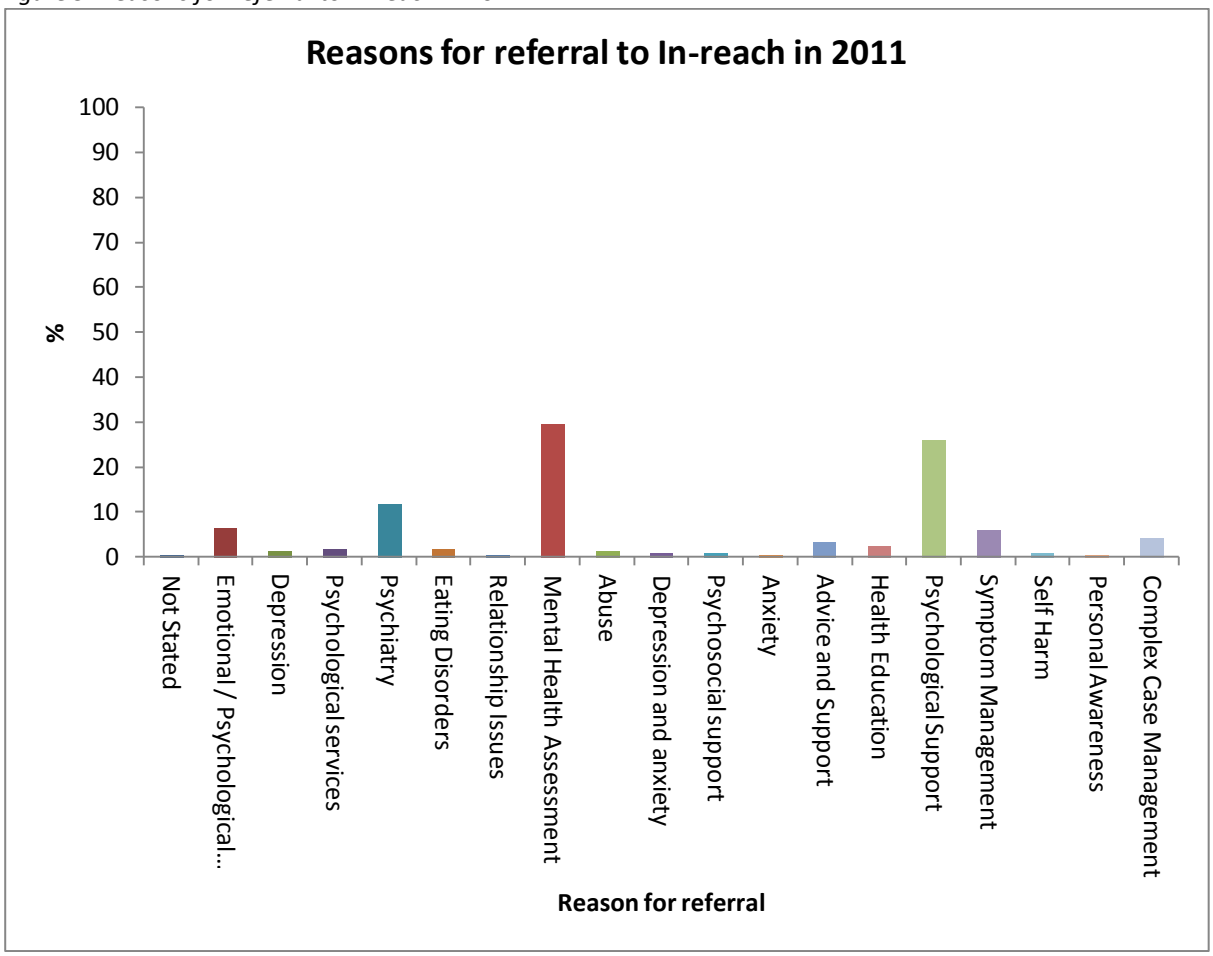
There is an over-representation of referrals to in-reach from prisoners who described their ethnicity as 'White and Black Caribbean' ethnic group- more than 50% of this population were referred to inreach.

There is underrepresentation of referrals to in-reach from the following groups. Less than 50% of these groups are referred relative to their proportion in the prison):

- Black African
- Black British
- Black Other
- White Irish

There are complex reasons for differences in prevalence of mental health problems and access to mental health services, and the data above should be regularly reviewed to ensure services are meeting the needs of prisoners from BME backgrounds.

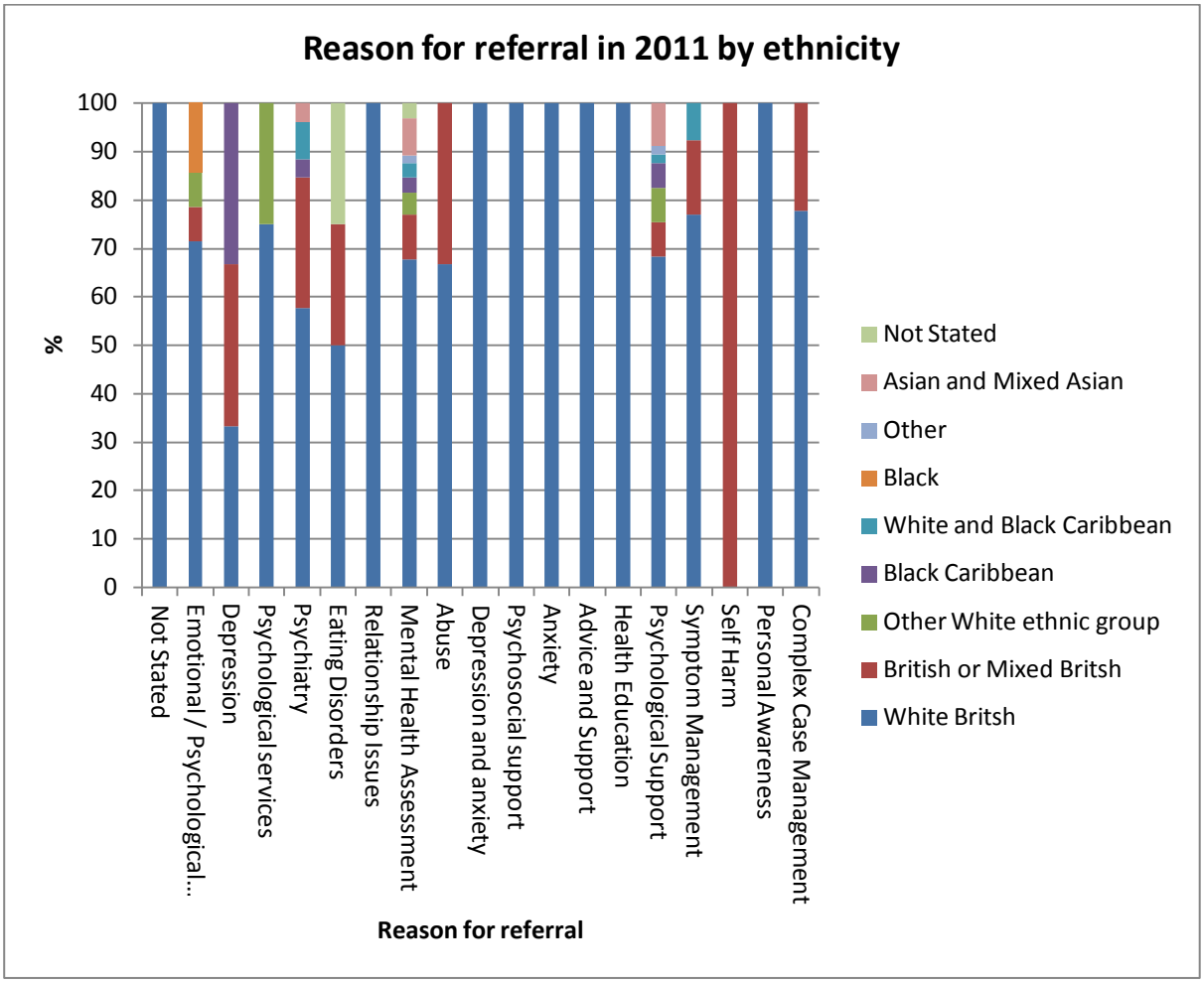
Figure 9: Reasons for referral to in-reach in 2011



The five most common reasons for referral to in-reach in 2011 were:

- Mental Health Assessment (29.55%)
- Psychological Support (25.91%)
- Psychiatry (11.82%)
- Emotional/Psychological Assessment and Therapy (6.36%)
- Symptom Management (5.91%)

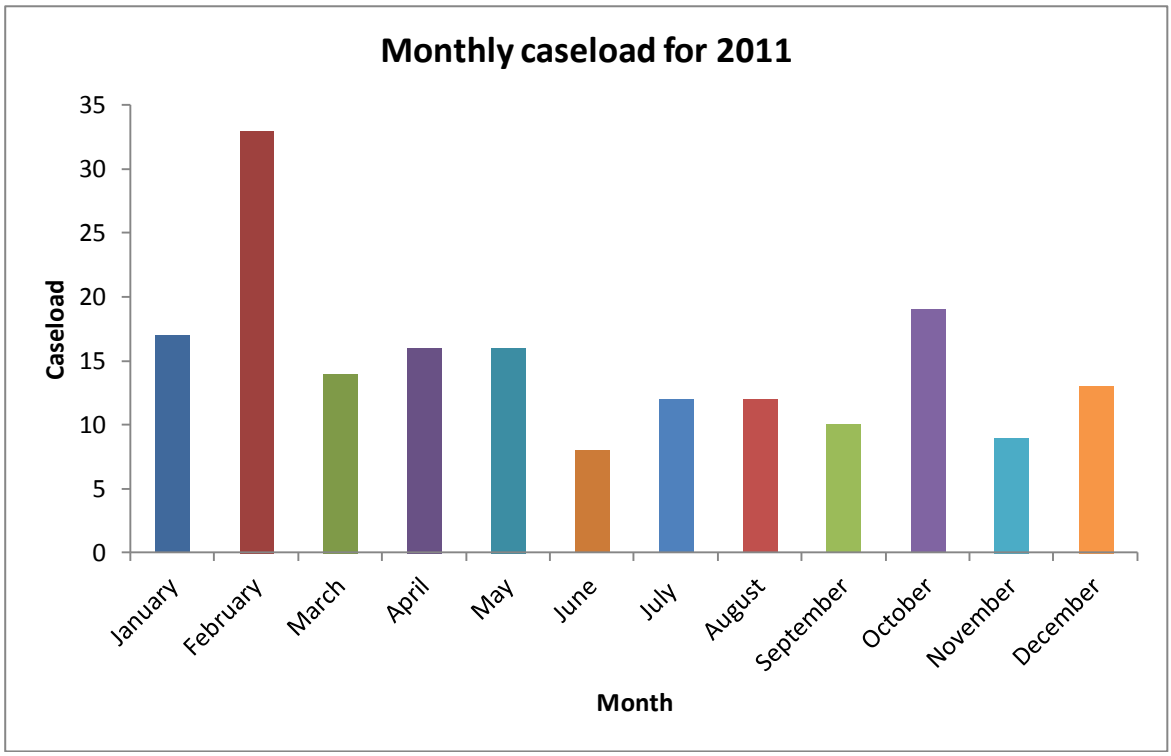
Figure 10: Reasons for referral to in-reach in 2011 by ethnicity



There is no data recorded by SystmOne on the number of referrals accepted or rejected and no information on the outcome of those not accepted by the service i.e. referred elsewhere. This information would be useful for analysing inappropriate referrals, and for planning alternative services to meet the needs that the In Reach Team cannot meet.

Inreach Caseload

Figure 11: Monthly caseload for 2011



The average monthly caseload of the inreach team was 15. The caseload was highest in February (33) and lowest in June (8)- this correlates with the relative number of referrals for those months

Table 13: Breakdown of caseload in 2011

Service	Annual caseload by % in 2011
Key worker	74.86
Psychiatry	18.44
Drop in	3.91
MHIR Wellbeing workshops	2.79

The majority of the caseload are seen by key workers (74.86%). The number of drop in clinic caseload and Mental Health Inreach Wellbeing workshops makes up the smallest caseload. The Mental Health Inreach Wellbeing workshops caseload could be low due to the criteria for attendance.

4.3 Primary Care Mental Health Data

A small amount of data was available on QOF from SystmOne related to depression, and physical health in patients with mental health problems. The information from March 2012 on depression showed:

- 37.5% (3/8) of patients on the diabetes and CHD disease registers have had active case finding for depression on one occasion in the last 15 months
- 15.1% (5/33) of patients with a new diagnosis of depression had an assessment of severity at the time of diagnosis with a recognised screening tool
- No patients (0/13) with a new diagnosis of depression, had received a follow up assessment of severity at 4-12 weeks

The information on physical health in those with a mental health diagnosis showed:

- 16 patients (6.2%) were on the mental health register (with a diagnosis of schizophrenia, bipolar disorder or other psychoses)
- 100% (15/15) had a comprehensive care plan
- 25% (3/12) had a record of alcohol consumption in the last 15 months
- 93.7% (15.16) had a record of their BMI in the last 15 months
- 100% (16/16) patients had a record of their blood pressure in the last 15 months
- 85.7% (6/7) patients had a record of their cholesterol and 100% (6/6) of their blood glucose in the last 15 months
- 100% (12/12) had had cervical screening in the past 5 years.

This information shows that although some areas are performing well, others require attention. It is recommended that an audit be carried out of the QOF scores for mental health and an action plan created to bring them up to 100% on all criteria.

4.4 Self Harm

Self Harm in HMP Send is managed through a care pathway by the prison safer custody, Inreach and healthcare. The role of Safer Custody team is to ensure that the local suicide prevention strategy is fully integrated and compatible with the local violence reduction strategy, that a self-harm management strategy is developed, and that all other local policies, procedures and strategies reflect the holistic nature of the wider safer custody strategy.

In 2010, Safer Custody developed incident packs containing instructions and paperwork. These are readily available in all areas. The packs have improved the management and reporting of self harm.

An Assessment, Care in Custody, and Teamwork (ACCT)[10] is used to help identify and care for prisoners at risk of suicide or self-harm. It is designed to provide more flexible multi-disciplinary support to prisoners at-risk of harming themselves. The plan encourages staff to work together to provide individual care to prisoners in distress, to help defuse a potentially suicidal crisis or to help individuals with long-term needs (such as those with a pattern of repetitive self-injury) to better manage and reduce their distress.

Table 14: % of people answering yes to a list of questions on self harm history during first reception on a snapshot day in 2011

Question Asked	% Answering yes
Prisoner has tried to harm themselves (within prison)	22.96
Prisoner has tried to harm themselves (outside prison)	28.40
Prisoner feels like self-harming or Suicide	2.72

In the last Health Needs Assessment conducted by NHS Surrey in 2010 the most common reason for referral to the Inreach team was for deliberate self-harm (20%). In 2011 only 0.91% of referrals were for self-harm. This is significantly low given the 2007 Corston Report[11] estimated that 37% of female prisoners self-harmed.

In 2011 there were 386 recorded incidences of self harm. The data from HMP Send safer custody team shows that on average 5.5% of the population at HMP Send self harm.

[10] Management of prisoners at risk of harm to self, to others and from others (Safer Custody). (2012). www.justice.gov.uk/downloads/offenders/psipso/psi-2011/psi-64-2011-safer-custody.doc [Accessed July 2012]
[11] Corston, J. (2007) The Corston Report, London: Home Office.

Table 15: Numbers of self harm incidences 2011 by month.

	Total self harm incidences	Number of women who self harmed
January	20	12
February	30	14
March	26	12
April	23	16
May	33	17
June	21	10
July	31	9
August	22	15
September	34	18
October	42	19
November	62	21
December	41	17

In 2011, on average 15 women self harmed a month and on average there are 32.1 incidences of self harm a month. The lowest number of self harm incidences occurred in January (5.2%). The lowest number of women reported as self harming was in July (9). The highest numbers of reported self harm incidences where in November (16%). In this month there was also the highest number of women reported as self harming (21).

There is no information on the type of self harm or how many reported incidents there are per person who is recorded as self harming.

A report from HMP Send about self harm stated that during 2010 and 2011 a minority of women were responsible for a large proportion of the self harm incidents.

Of the recorded self harm incidences, 9.5% (n=37) of incidences required hospital treatment. 1% (n=4) were classed as a serious incident- this is defined as those requiring resuscitation or remaining in hospital longer than the 24hrs due to severity of injury. This also includes a 'near miss' where serious injury or death would have been the likely result had the person not been found.

There were 4 self harm incidences recorded as actual 'suicide attempts'. There is no information on how many prisoners had self harm incidences recorded as actual 'suicide attempts'.

Table 16: % of Self harm incidents by length of sentence compared to % of sentence length

Sentence Length	% of self harm incidences	% of prisoners sentence length
0- 11 months	0%	-
12 months- 3yrs 9 months	15% (n=59)	59%
Over 4 years but indeterminate	30% (n=114)	9%
IPP	31% (n=120)	32%
Life sentence	24% (n=93)	

A report from HMP Send about self harm stated that during 2010 and 2011, long term sentence prisoners were responsible for the majority of incidents. In 2011, 55% of self harm incidences were by women on an IPP and those serving life sentences.

Dialectical behaviour therapy (DBT)

Dialectical behaviour therapy (DBT) is a system of therapy originally developed to treat people with borderline personality disorder (BPD). DBT combines standard cognitive behavioural techniques for emotional regulation and reality-testing with concepts of distress tolerance, acceptance, and mindful awareness.

The DBT service will be provided as a component of the wider Mental Health Inreach service provision, and will operate in HMP Send. The service will operate a structured treatment programme to women who self harm.

The service will be clinically led by a DBT trained forensic psychologist. In each prison there will be two additional qualified members of the MHIR teams who will be DBT trained. They will be skilled and trained to support women engaged in the DBT programme outside of their group and individual therapy sessions.

Recommendations

19. The mental health provision should be reviewed to ensure that it is in line with population needs, including primary mental health.
20. Data on ethnicity should be regularly reviewed to ensure services are meeting the needs of prisoners from BME backgrounds.
21. Information on referrals accepted or rejected, and the outcomes of those referrals rejected, should be collected and collated and shared with healthcare and the prison to inform staff and service planning.
22. The high rate of 'Did Not Attends' for mental health appointments should be investigated and an action plan put in place to improve this figure.
23. The QOF scores for mental health and depression should be audited and an action plan put in place to bring the scores up to 100% on each indicator.
24. Self-harm should continue to be monitored and trends mapped, so services can be regularly reviewed in relation to need.

4.5 Learning Disabilities

HMP Send was rated RED on this indicator in 2010 and 2011. A new Prison Learning Disabilities Nurse was appointed in May 2011, for the Surrey Prisons by SABPFT, to implement the standards of the indicator and GREEN was achieved in 2012.

A learning disability screening tool was implemented in September 2011. The screening tool being used is the Learning Disability Screening Questionnaire (LDSQ) developed by Karen Mckenzie and Donna Paxton[12]. The screening is undertaken by the Primary Health teams in each prison.

Between September 2011 and May 2012, 147 new prisoners were offered a learning disability screen. Of these, 100 people refused screening and 47 undertook the screening. No prisoners in HMP Send who undertook the screening were identified as having a learning disability.

Two prisoners were incorrectly identified as possibly having a learning disability.

Across the Surrey prisons, concerns about the screening tool have been raised. The predicted numbers of prisoners with a learning disability was 7% across the Surrey prison establishments (based on national data), however only 2% have been identified with a learning disability. The screening tool has also failed to identify prisoners who were already known to learning disability services in the community. The use of the screening tool is currently being reviewed.

Easy read/accessible information leaflets about the prison, how to access health services on release and various health complaints are now readily available in the prison. Templates of the Health Action plan templates were developed for use within the prison. Due to the lack of prisoners identified, no Health Action Plans or Health Passports have been used as yet.

An Information and resource pack has been developed and delivered to all departments in the prison. The Information and resource pack contains sections on:

- What is and what is not a learning disability
- Communication and tips on how to communicate effectively
- Autistic Spectrum Disorder (ASD)
- Attention Deficit Hyperactivity Disorder (ADHD)
- Useful websites and resources.

Learning disability awareness training has been delivered to seven members of the healthcare team and is available to all departments in the prison.

Recommendations

25. The prison learning disability liaison nurse to explore other learning disability screening tools.
26. The prison healthcare manager to explore why 68% of prisoners refused the screening tool and identify options to deliver the screening.

[12] http://www.gcmrecords.co.uk/gcm_records_latest_version_march_2012_007.htm

5. Substance Misuse and Alcohol

In October 2011 a joint substance misuse needs assessment was completed by Surrey Drug and Alcohol Action Team. Key finding from that assessment include:

- 47% of new receptions during 2010/11 were identified as needing substance misuse intervention
- The most prevalent drug of choice is heroin, followed by crack, cannabis and cocaine.
- Benzodiazepines were the second most popular secondary drug choice for CARAT clients
- When the main drug of choice is unavailable some prisoners self medicate with prescription medication.

Since the 2010 HNA, Alcohol Use Disorders Identification Test (AUDIT) has become a widely used alcohol screening tool. Developed by the World Health Organisation it used around the globe to help identify drinking behaviours that may cause damage to health. The AUDIT tool is routinely used as part of the reception screening. AUDIT scores were available for 70% of HMP Send prison population.

Table 17: Information on AUDIT scoring at reception on a snapshot day in 2011

AUDIT Score	Category	Count	%
0-7	Sensible drinking / Low Risk	131	72%
8- 15	Hazardous Drinking / Increased risk	22	12%
16- 19	Harmful Drinking / High Risk	5	3%
20+	Dependent drinking	23	13%

Research by MacAskill et al [13] found that 73% of prisoner AUDIT scores were over 8 indicating hazardous, harmful or dependent drinking. In HMP Send 72% of the population that undertook the AUDIT assessment had audit scores of 0-7 indicating sensible/ low risk drinking. AUDIT has its limitations as the assessment is based upon current drinking patterns and current perceptions of alcohol use.

As HMP Send is a sentenced prison some questions might not be relevant to the prisoner. An alcohol assessment tool that asks about alcohol use prior to sentencing might enable a better understanding and inform alcohol health promotion and intervention to support rehabilitation.

No information was provided on alcohol services at HMP Send.

Recommendation

27. An audit should be undertaken to cross-reference the AUDIT scores with other information (past history of alcohol misuse, information from prisoner) to ensure that AUDIT is picking up those people who would benefit from alcohol interventions, even though they may not have had access to alcohol for a long period of time.

[13] MacAskill et al. (2011). Assessment of alcohol problems using AUDIT in a prison setting: more than an 'aye or no' question. BMC Public Health. http://www.biomedcentral.com/content/pdf/1471-2458-11-865.pdf [Accessed July 2012]

6. Health Improvement

6.1 Smoking

Around 21% of the adult population in England are smokers[14]. In comparison the smoking prevalence in HMP Send is more than double this. Based on the reception screen, 49% (n=126) of prisoners in HMP Send reported a smoking status. From this, 59% (n=62) were given smoking cessation advice during the reception screening.

In 2011 21% (n=27) of the prisoners who reported a smoking status were referred to a smoking cessation clinic. No data has been provided on the number of prisoners that set a quit date and successfully stopped smoking, and no data is reported to the Surrey Stop Smoking Service.

Recommendations

28. A service review should be completed to ensure current support is implemented in line with NICE best practice guidance. This should include routine brief advice on smoking to all smokers, as well as referral to Stop Smoking Support if appropriate.
29. Data should be collected, monitored and reported to the Surrey Stop Smoking Service on referrals to Stop Smoking, quit dates and outcomes.
30. An action plan should be put in place to increase the number of quits achieved per year.
31. A targeted approach should be adopted for 'at risk patients' such as those with asthma and COPD.

6.2 Obesity

Data from SystmOne indicated that 22% (n=57) of women were on the QOF obesity register, indicating that they have a Body Mass Index of over 30. This is lower than the national average of 26% of women in the United Kingdom[15]. Data from the 2010 HNA indicated that around 15% (n=40) of prisoners at HMP Send were obese. This increase is either due to an increase in data collection, or an increase in obesity in this population- it is not clear why this is lower than the general population.

There was no information provided on the number of prisoners who were overweight or underweight, and in 2010 the prevalence was higher than the national average.

6.3 Physical Activity

New UK-wide physical activity guidelines were released by the Department of Health in July 2011[16]. To stay healthy, it is recommended that adults aged 19-64 should try to be active daily and should do:

- At least 150 minutes (2 hours and 30 minutes) of moderate-intensity aerobic activity such as cycling or fast walking every week and
- muscle-strengthening activities on 2 or more days a week that work all major muscle groups (legs, hips, back, abdomen, chest, shoulders and arms).

OR

[14] The Information Centre. (2011). Statistics on Smoking: England, 2011. http://www.ic.nhs.uk/webfiles/publications/003_Health_Lifestyles/Statistics%20on%20Smoking%202011/Statistics_on_Smoking_2011.pdf [Accessed July 2012]

[15] The Information Centre. (2012). Statistics on obesity, physical activity and diet: England, 2012. http://www.ic.nhs.uk/webfiles/publications/003_Health_Lifestyles/OPAD12/Statistics_on_Obesity_Physical_Activity_and_Diet_England_2012.pdf [Accessed July 2012]

[16] Department of Health (2011). Physical Activity Guidelines. [Accessed July 2012] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127931

- 75 minutes (1 hour and 15 minutes) of vigorous-intensity aerobic activity such as running or a game of singles tennis every week, and
- muscle-strengthening activities on 2 or more days a week that work all major muscle groups (legs, hips, back, abdomen, chest, shoulders and arms).

OR

- An equivalent mix of moderate- and vigorous-intensity aerobic activity every week (for example 2 30-minute runs plus 30 minutes of fast walking), and
- muscle-strengthening activities on 2 or more days a week that work all major muscle groups (legs, hips, back, abdomen, chest, shoulders and arms).

No information on prisoners levels of physical activity was available.

Recommendation

32. Information on prisoners levels of physical activity should be collected and monitored.
33. Ensure prisoners are aware of the new physical activity guidelines and how they can apply them in the prison.

6.4 Health Promotion Action Group (HPAG)

PSO 3200 Health promotion and the Prison Health Performance and Quality Indicators state that health promotion should be managed using a whole prison approach with a specific focus on:

- Mental health promotion
- Healthy lifestyles including sexual health and relationships
- Healthy eating and nutrition
- Substance misuse
- Smoking cessation
- Drugs and alcohol.

This is also reflected in the Prison Health Performance and Quality Indicators, and a rating of Green was awarded in 2011/12.

6.5 Screening

The screening data below is taken from SystmOne for October-December 2011.

Table 18: screening data October-December 2011

Bowel Screening	Number of Eligible Patients	9
	Number offered Screening	0
	Number of completed screenings	0
	Number refusing Screening	0
	% Coverage	0%
Breast Screening	Number of Eligible Patients	23
	Number offered Screening	23
	Number of completed screenings	6
	Number refusing Screening	15
	% Offered	100%
	% Coverage	26%
Diabetic ROP Screening	Number of Eligible Patients	4
	Number offered Screening	4
	Number of completed screenings	3
	Number refusing Screening	0
	% Offered	100%
	% Coverage	75%
Cervical Screening	Number of Eligible Patients	26
	Number offered Screening	0
	Number of completed screenings	0
	Number refusing Screening	0%
	% Coverage	0%

Of the 9 prisoners of bowel screening age, none had received screening. It is vital that prisoners have access to this screening programme.

The data above indicates that 65% (15/23) of prisoners offered breast screening have refused to have it. This information is concerning and action should be taken to understand why this is the case.

Data taken from SystmOne on the 19th March 2012 indicated that 83% (5/6) of patients with diabetes had received retinopathy screening, which is an improvement on the previous figures above.

The data above on cervical screening does not appear to give an accurate picture as data taken from SystmOne on the 19th March 2012 indicated that 96.5% (193/200) of patients had had cervical screening in the previous 5 years.

Recommendations

34. All prisoners eligible for bowel screening should be offered it, and the coverage rate should be increased to 60%.
35. The high number of prisoners refusing breast screening should be investigated, and action taken to improve the uptake to 70%.

6.6 Health Checks

The aim of an NHS Health Check[17] is to help lower the risk of the four common but often preventable diseases: heart disease, stroke, diabetes and kidney disease through early interventions and detection. People aged 40- 74 are eligible for a check.

Based on the current prison population, 101 prisoners are eligible and in 2011/12 HMP Send carried out 86 health checks.

Recommendation

36. NHS Health Checks should be continued to be offered to all prisoners aged 40-74.

[17] http://www.nhs.uk/Planners/NHSHealthCheck/Pages/NHSHealthCheckwhat.aspx

7. Full List of Recommendations

Prison Profile (demographic changes)

1. The demographics of the prison population should be regularly reviewed to ensure services meet the needs of prisoners.
2. Healthcare and the prison should work together to ensure that the needs of older prisoners are met, and to monitor the numbers to inform service planning.
3. All recording of ethnicity should use the standards set out in the 2011 Census.
4. The prison and healthcare should ensure appropriate support and services are in place for women who are gay or bisexual, and women serving life sentences.

Long term conditions

5. Audit of clinical records to examine diagnoses of asthma patients against SIGN guideline 101[18].
6. Increase the percentage of patients who have a diagnosis with measures of variability or reversibility.
7. Audit of asthma reviews to ensure they cover the factors outlined in SIGN guideline 101.
8. Audit of asthma patients to ensure they all have an up to date asthma action plan in place.
9. Audit of all patients with COPD to ensure they have received a diagnosis confirmed by post bronchodilator spirometry, and a review of their condition including FEV1 and inhaler technique in the last 15 months.
10. A programme for detection of undiagnosed diabetes should be set up at HMP Send, including targeting prisoners of ethnic minorities who are at a higher risk of diabetes.
11. Audit of all patients on the diabetes register to ensure they have had neuropathy testing in the preceding 15 months.
12. Audit of patients with diabetes who have a total cholesterol over 5mmol/l and those with a blood pressure reading of 140/80 or more, to see if they would benefit from further treatment.
13. Audit of patients on the hypertension register who have a last blood pressure reading of 150/90 or more to see if they would benefit from further treatment.
14. Audit of those on the CVD register to ensure they have received a cardiovascular risk assessment.

Communicable Diseases

15. Develop a plan to improve the processes for Hepatitis B vaccination so all prisoners are offered the vaccine within 31 days of reception, and the coverage is over 80% every quarter. This plan should be reviewed after 3 months.
16. An audit should be carried out of all patients to ensure those 'at risk' were offered a Hepatitis C test on reception and later during their stay at HMP Send, and procedures put in place to ensure all new receptions 'at risk' are offered the test.
17. An audit should be carried out of all patients to ensure those 'at risk' were offered a HIV test on reception and later during their stay at HMP Send, and procedures put in place to ensure all new receptions 'at risk' are offered the test.

Sexual Health

18. Develop a plan to improve the processes for Chlamydia testing so more young women are offered the test, and more tests are carried out. This plan should be reviewed after 3 months.

[18] British Thoracic Society and the Scottish Intercollegiate Guidelines Network (2008, revised January 2012). British guideline on the management of asthma (101): a national clinical guideline. http://www.sign.ac.uk/pdf/sign101.pdf [Accessed July 2012]

Mental Health

19. The mental health provision should be reviewed to ensure that it is in line with population needs, including primary mental health.
20. Data on ethnicity should be regularly reviewed to ensure services are meeting the needs of prisoners from BME backgrounds.
21. Information on referrals accepted or rejected, and the outcomes of those referrals rejected, should be collected and collated and shared with healthcare and the prison to inform staff and service planning.
22. The high rate of 'Did Not Attends for mental health appointments should be investigated and an action plan put in place to improve this figure.
23. The QOF scores for mental health and depression should be audited and an action plan put in place to bring the scores up to 100% on each indicator.
24. Self-harm should continue to be monitored and trends mapped, so services can be regularly reviewed in relation to need.

Learning Disabilities

25. The prison learning disability liaison nurse to explore other learning disability screening tools.
26. The prison healthcare manager to explore why 68% of prisoners refused the screening tool and identify options to deliver the screening.

Alcohol

27. An audit should be undertaken to cross-reference the AUDIT scores with other information (past history of alcohol misuse, information from prisoner) to ensure that AUDIT is picking up those people who would benefit from alcohol interventions, even though they may not have had access to alcohol for a long period of time.

Smoking Cessation

28. A service review should be completed to ensure current support is implemented in line with NICE best practice guidance. This should include routine brief advice on smoking to all smokers, as well as referral to Stop Smoking Support if appropriate.
29. Data should be collected, monitored and reported to the Surrey Stop Smoking Service on referrals to Stop Smoking, quit dates and outcomes.
30. An action plan should be put in place to increase the number of quits achieved per year.
31. A targeted approach should be adopted for 'at risk patients' such as those with asthma and COPD.

Physical Activity

32. Information on prisoners levels of physical activity should be collected and monitored.
33. Ensure prisoners are aware of the new physical activity guidelines and how they can apply them in the prison.

Screening

34. All prisoners eligible for bowel screening should be offered it, and the coverage rate should be increased to 60%.
35. The high number of prisoners refusing breast screening should be investigated, and action taken to improve the uptake to 70%.

Health Checks

36. NHS Health Checks should be continued to be offered to all prisoners aged 40-74.