Health Needs Assessment

HMP Downview

July 2010

List of abbreviations

ACCT	Assessment, Care in Custody, and Teamwork (form for self harm to monitor patients at risk)
AED	Automated external defibrillator
CARATs	Counselling Assessment Referral Advice and Through-care
CHD	Coronary heart disease
CNA	Certified normal accommodation
CPA	Care programme approach
CSU	Care and support unit – 'segregation'
DH	Department of Health
DNA	'Did not attend'
DSH	Deliberate self-harm
DV	HMP Downview
F213SH/F2052SH	Form to record self harm, now replaced by ACCT
HCA	Healthcare assistant
HMIP	Her Majesty's Inspectorate of Prisons
HNA	Health needs assessment
IDTS	Integrated Drug Treatment System
IMR	Inmate Medical Record
IRC	Immigration removal centre
JBU	Josephine Butler Unit
LD	Learning disability
MAPPA	Multi-agency public protection arrangements
NOMS	National Offender Management Service
OPG	Orthopantomogram (dental X-ray view)
PALS	Patient Advice and Liaison Service
PEEP	Personal emergency evacuation plan
PHDW	Public Health Development Worker (NHS Surrey)
PHPQI	Prison Health Performance and Quality Indicator
PSO	Prison Service Order
RGN	Registered General Nurse
RMN	Registered Mental Health Nurse
ROTL	Release on temporary license
SABP	Surrey & Borders Partnership – the Mental Health Provider
STR worker	Support time recovery
TOP	Termination of pregnancy
WTE	Whole time equivalent

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EXECUTIVE SUMMARY

Baroness Corston's 2007 report[1] highlighted the need for a woman-specific approach for incarcerated women, given that their unique health and social needs which are distinct from men.

Health needs assessments allow commissioners to make plans for healthcare, based on a sound understanding of current service provision and patient needs.

This HNA for Downview was carried out from mid - February to June 2010. The HNA for the Josephine Butler Unit (YOI on the grounds of Downview) is the subject of a separate report.

This paper describes the prison, the methods for the HNA, and the results (service descriptions, comparison with similar prisons, epidemiological descriptions of disease burden, and corporate work). The results have been synthesized to build a picture of health needs, then and recommendations for action with suggested ownership.

This health needs assessment was carried out at unique point, as a new electronic case management system in prisons (SystmOne) was in the process of being implemented, which provided early data to triangulate with data from traditional sources.

Key facts

- HMP Downview is a closed women's training prison with an operational capacity of 358, with women accommodated in four wings;
- The prison population is young - with the majority of women aged 25 to 34 years;
- The largest ethnic groups are White British (44.3%), followed by Black or Black British (36.1%);
- Foreign national women form 22% of the prison population, higher than the national female prison average of 19%.

Key findings and recommendations for Downview from HNA, with suggested ownership

The recommendations from the health services work, corporate work, and disease-specific work has been synthesised under headings to give a thematic view of recommendations, together with the source of the recommendation (eg corporate work). Any recommendations which also relate to PHPQIs are highlighted accordingly.

Thematic area	Sub-heading	Recommendations	Source	PHPQI	Suggested Ownership
STRUCTURE	**Environment**	Install mixer taps in healthcare areas on C wing	Health services	1.2	Healthcare
	Environment	Ensure that all clinical and waiting areas are cleaned adequately and regularly to meet NPSA and NHS standards.	Corporate	1.2	Healthcare, prison
	Environment	Review regulation on wearing kitchen uniforms around the prison, and check whether food kept in 'bains-marie' meets food hygiene requirements	Corporate	1.2	prison

[1] Corston Report (2007) A report by Baroness Jean Corston of a review of women… in the criminal justice system

	Relationships	Relationships between healthcare and unified staff should be improved, with continuation of the joint handover sessions in order to foster improved relationships.	Corporate	N/A	all
	Training	Ensure that resources exist for a nurse to deliver nurse-led cardiac rehabilitation after a heart attack.	Health services	1.38	healthcare
		All prison staff must ensure that when discussing health issues with prisoners they maintain confidentiality.	Corporate	1.7	Prison
	Staff support	Providing post incident support for prison officers who have cared for women who self harm.	Health services	1.26	Prison
	Service delivery	NHS Surrey to prepare colposcopy cost minimisation analysis with Screening Leads and prison to decide on future service provision.	Health services	1.16, 1.24	NHS Surrey and all
	IDTS	Ensure that all women requiring IDTS review are referred promptly to assess need.	Corporate	1.19	Healthcare, prison
	Emergency response	Ensure safe emergency response in hours and out of hours, by: ensuring sufficient first aid trained prison and healthcare staff (especially overnight and during weekends) who have been trained to use a defibrillator, and reviewing the equipment, facilities and personnel needs of the prison for emergency response.	Health services	1.1	all
	Self harm	Review procedures for medical attention to prisoners who have self harmed by cutting, especially use of pre-prepared 'cut-up' packs. Relates to recommendation on first aid-trained unified staff.	Health services, corporate	1.26	Prison & healthcare
	Self harm	Ensure that ALL instances of self-harm are reported, and followed up by healthcare, with an ACCT file opened	Corporate	1.26	Prison & healthcare
	Self harm	Clarify process for constant watch for women at risk of self harm.	Disease headings	1.26	Prison & Healthcare
	Awareness & commun-ication	Improve information on health care services throughout the prison. For example, issues have been highlighted with cancellation and low patient awareness of the 'well woman' clinic.	Corporate	1.35, 1.24	Healthcare, HPAG
		All test results should be communicated promptly to women.	Corporate	1.14	Healthcare
PROCESS	**Pharmacy**	All medication 'near misses' must be reported in line with the NHS procedures, and audited to improve practice.	Corporate	1.3	Prison and NHS Surrey
		Medicine wastage has been highlighted for women coming in via reception or ROTL. We recommend:	Corporate	1.3	Healthcare

		An audit to identify the extent of medication that is destroyed between prison transfers and ROTL, to try to minimise medication wastage; Better communication between healthcare and prisoners to explain why medication is removed.			
		Medication changes must be communicated clearly and promptly to prisoners.	Corporate	1.3	Healthcare
		On the induction wing (A wing), a unified staff officer should be present during dispensing of medication to improve security for healthcare staff.	Corporate	1.3	Healthcare & prison
		Review high level of antipsychotic prescribing of Mirtazepine, and antihistamine prescribing (Loratadine, cetirizine) to see whether the sedative side effects underlie high demand.	Disease headings	1.3	Healthcare
	Smoking	The prison 'no smoking policy' for staff must be more strictly enforced, eg in the education areas.	Corporate	1.35	Prison
	Optician	Review the number of instances of prisoners losing/ breaking their glasses, to reduce wastage.	Corporate	N/A	Healthcare
	External appointments, surgery etc	Ensure that prisoners are properly prepared for external appointments which require medical preparation in advance – such as colonoscopy etc. whilst balancing security needs.	Corporate	1.17	Healthcare, Prison
		Prison and healthcare to work with external hospitals to ensure that external appointments are timed in line with the regime to avoid cancellations.	Corporate	1.17	Healthcare and prison
		Improve escort arrangements for hospital appointments so that prisoners do not miss appointments. Consider whether "cuffing" is required at all times eg during invasive tests, to preserve dignity for prisoners.	Corporate	1.17	Prison, healthcare
	Complex needs	Women with complex health needs or long term conditions should have a care plan informed by healthcare and Personal Officer, which follows the hospital discharge plan where relevant.	Corporate	1.4	Prison & healthcare
		Healthcare to better support the DLO in care planning for prisoners with a disability.	Corporate	1.23b	healthcare
DISEASE HEADINGS	**Physical health**	Use the HPAG to promote smoking cessation and tackle drug use, especially to mitigate chronic respiratory illness such as asthma and COPD.	Disease headings	1.35	HPAG
		Use of SystmOne to identify chronic disease such as hypertension and diabetes (in place and ongoing), ensure care pathways for chronic disease meet national standards, and refer all patients with chronic diseases for appropriate	Disease headings	1.4	Healthcare, NHS Surrey

		investigation (eg for epilepsy) audit care of patients with epilepsy against NICE guidance			healthcare
		NHS Surrey to link Cardiac Network for cardiac pathways	Disease headings	1.4, 1.38	NHS Surrey, healthcare
		Effective programmes to enable weight loss, through healthier food in the canteen and use of the gym – to control related diseases such as Type 2 Diabetes, and prevent 'downstream' illness such as cancer and heart disease.	Disease headings	1.35	HPAG, healthcare, prison
	Infectious diseases	Improve Hepatitis B vaccine coverage to green	Disease headings	1.33	Healthcare
		Ensure that women are educated and advised on testing for BBVs (Hepatitis B and C, HIV) at opportunistic times along their patient journey, not just at reception.	Disease headings	1.33, 1.34	Healthcare
		Ensure that sexual health services address the high levels of risky behaviour and need, including women living with HIV. Ensure that specialist GUM provision is provided, together with improved levels of Chlamydia testing.	Disease headings	1.36	Healthcare
		TB questions to be included within the SystmOne template.	Disease headings	1.37	NHS Surrey & Healthcare
		Ensure that women are appropriately offered vaccination in line with the prison HPA recommendations.	Disease headings	1.32	Healthcare
	Mental health	Improve case finding for depression and other psychiatric illness, and implementation of IAPT	Disease headings	1.25	Healthcare
	Self harm	Increase healthcare and prison work on reducing self harm, with better identification and follow up of women who self harm	Disease headings, corporate	1.26	Prison and healthcare
	Learning disability	When DH guidance released, start screening prisoners for learning disability, and set in place health action plans and annual health checks	Disease headings	1.31	Healthcare
	Alcohol	Address unmet needs around alcohol service provision.	Disease headings	1.20	Healthcare, NHS Surrey
DISEASE HEADINGS	**Women's health**	Ensure that women invited for cervical smears are in appropriate age group or there is a medical indication for smear. Provide easy-read information on cervical smears with invitations.	Disease headings & Corporate	1.24	Healthcare

	Screening	Ensure that women at Downview are offered screening in line with national requirements as there is no current programme for bowel screening or vascular screening.	Disease headings	N/A	Healthcare
	Dentistry	Reduce waiting times for dentistry in line with PHPQI, and reduce DNA to appointments Provide free or cheap toothbrushes / toothpaste for prisoners, and ensure oral health promotion taking place	Disease headings Health services	1.18	Healthcare, NHS Surrey
	Health promotion	Efforts to identify and offer smoking cessation to smokers should be increased. Prison does not report smoking cessation data to NHS Surrey Smoking Cessation Service at the Jarvis Centre, so work should be done to link up PCT data collection with that in prison.	Disease headings Health services	1.35	Healthcare NHS Surrey
		Needs of older women to be included in HPAG	Disease headings	1.23b, 1.35	HPAG
		Review the quality and nutritional content of the prisoner diet	Disease headings	1.35	HPAG & Prison

INTRODUCTION

Background

Prison healthcare was transferred from the Prison Service to the NHS in 2006. A prison health needs assessment (HNA) and prison delivery plan was completed for HMPs Highdown, Downview and the Josephine Butler Unit (JBU) in 2006. This HNA forms part of a suite of HNAs across all Surrey prisons, in line with the requirements of the prison health performance quality indicators.[2] The PHPQIs which scored 'red' for 2009/10 (together with full listing of indicators) are found at Annex 1.

The needs assessment was carried out at unique point, as a new patient management system in prisons (SystmOne) was in the process of being implemented. This provided early data, and will change the way that needs assessments are carried out in future.

Healthcare at Downview is provided by Surrey Community Health, while mental health in-reach is provided by Surrey & Borders NHS Trust.

Health needs assessment

Health needs assessments are carried out so that commissioners can make plans for healthcare, based on a sound understanding of current service provision and patient need. This HNA has been carried out using the model of the Birmingham Toolkit for health care needs assessment in prisons (Annex2).[3] The steering group membership and acknowledgements are found at Annex 3.

Structure of this paper

This paper describes the prison, the methods for the HNA, and the results (service descriptions, comparisons with other prisons, corporate results, and epidemiological descriptions). A gap analysis follows. Recommendations are summarised at the end of each main section, and collated in the executive summary, with suggested ownership for action.

PRISON DESCRIPTION

HMP Downview is a closed women's training prison at Sutton in Surrey, with an operational capacity of 358 women. Downview first opened in 1989, becoming an adult female establishment in 2001. It is a prison for sentenced women (including women with indeterminate public protection orders).[4] All women work, either within the prison or outside.[5]

Description of residential units[6]

A wing	**Induction unit. Capacity: 44, single cell occupancy with in-cell sanitation and electrics**
B wing	General. Capacity: 47, single cell occupancy with in-cell sanitation and electrics
C wing	General - 210 single and one double
D wing	Ready-to-use building used for enhanced level prisoners as a resettlement unit. Capacity: 40, single cell occupancy with in-cell sanitation, shower facility and electrics

[2] Prison health performance and quality indicators 2010 – Indicator 1.15 – An HNA should be carried out yearly for each prison.
[3] Marshall, Simpson & Stevens (2000). Toolkit for health care needs assessment in prisons. Department of Public Health and Epidemiology, University of Birmingham.
[4] http://www.hmprisonservice.gov.uk/prisoninformation/locateaprison/prison.asp?id=3 (last accessed 4.3.10)
[5] Women can work inside the prison – e.g. in the kitchen, gardens, for DHL (a delivery company with on site workshop), recycling, cleaning, the library or the media centre. Women can also work outside the prison, for example at ASDA or in local restaurants. At one point in February 2010 there were 40 (out of approximately 340 women) going out to work.
[6] http://www.justice.gov.uk/inspectorates/hmi-prisons/docs/downview_(2008)-rps.pdf (last accessed 4.3.10)

Demographic profile and turnover (churn)

The prison population fluctuated (as expected) throughout the needs assessment, this is reflected in the whole prison population denominators. Demographic profile (including the five aspects of equality and diversity) are described below. Throughout the HNA, if patient numbers are so small that confidentiality may be compromised, this is indicated with the symbol "*", to denote suppression of exact numbers.

Age

The Downview prison population is young, with the majority of women aged 25 to 34 years, and a mean age of 34 years (Figure 1 and Table 1).

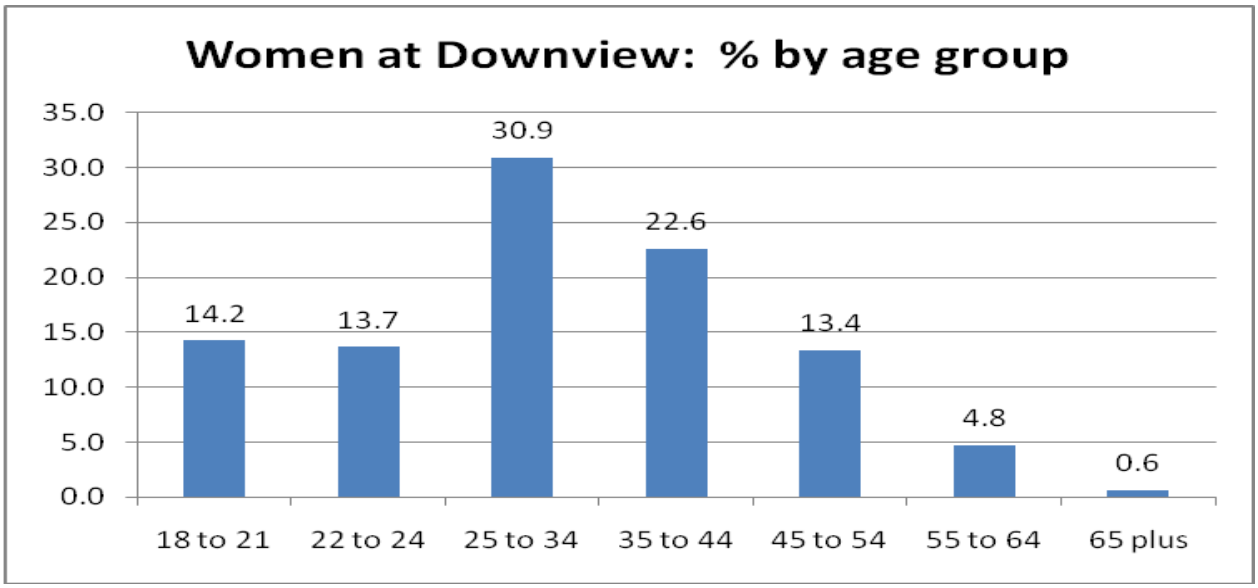


Figure 1: Ages of women at Downview – Percentage in each group. Source: C NOMIS 15 March 2010.

Age range (years)	Number of women in age range	% Women in each age group	*Women (expected) in each age group if full CNA of n=358*
18 to 21	48	14.2%	*51*
22 to 24	46	13.7%	*49*
25 to 34	104	30.9%	*111*
35 to 44	76	22.6%	*81*
45 to 54	45	13.4%	*48*
55 to 64	16	4.8%	*17*
64 plus	*	0.6%	*
	Total n=337		*Full CNA n=358*

Table 1: Ages of women at Downview – Number and Percentage. Source: C NOMIS 15 March 2010.

Strands of equality and diversity

Sexual orientation	**In the prison population on 9 April 2010, 23/348 (6.6%) women described themselves as lesbian, bisexual or transgender.**
Disability	On 9 April 2010, 15/348 (4.3%) women had personal emergency evacuation plans (PEEP). Although these are plans for disabled persons (so that they can be safely evacuated in an emergency), this does not include all women with a disability.
Ethnicity	Detailed data were provided by the Diversity Manager. The highest proportion of women were White British (44.3%), with the next largest group Black or Black British (36.1%). Further detail at Annex 4.
Foreign nationals	80 of 358 women (22) were foreign nationals in February 2010. This is slightly higher than the national proportion of 19% foreign nationals in the female estate[7]. The foreign national women comprise a variety of nationalities with 9% (no raw data) of the women from either the Caribbean or Sub-Saharan Africa. Further detail at Annex 4.
Religion	The greatest proportion of women describe themselves as having no religion (34%). Further detail at Annex 4.

Churn

Downview has a reasonably low turnover, with approximately 30 new women entering per month. This equates to a 'churn' of two (x2) per year.

Prison sentence and length

Data were not available from the prison. However, the HMIP inspection of 2008 showed that approximately 18% of women had sentences of less than one year in length, with the remaining 82% having sentences longer than that, ranging from one year to indeterminate public protection orders.

'Feeder' and transfer prisons

No data were available on the prisons which either sent prisoners to Downview or received women fro Downview.

Children

The reception notes audit of 67 women in March 2010 showed that 38/67 (56.7%) of women had children. Applied crudely to the whole prison, this might indicate that approximately 203 women might have children.

Brief description of healthcare

There is a healthcare unit on site within a prefabricated block, with no inpatient beds. There are additional clinical rooms on the wings, described in more detail in Annex 5.

Prison inspections

The last inspection by Her Majesty's Chief Inspector of Prisons (HMIP) in 2008 found that 'health services were in general good, though both primary mental health and counselling services needed development.' The most recent Ministry of Justice (MoJ) prison performance ratings for Downview gave a score of 3 which denotes 'good performance'.[8]

[7] 19 per cent of female prisoners were foreign nationals in 2009. Realising rights: increasing ethnic minority women's access to justice. Smee & Moosa (Jan 2010). Fawcett Foundation.

[8] The scoring for MoJ is as follows: 1 – serious concerns, 2 – requiring development, 3 – good performance, 4 – exceptional performance. Quarter 4, 2008/9

METHODS

Demographic information

Demographic information was provided by the prison – in the form of either raw or analysed data.

Health services description and activity

Descriptions of key structures and processes were obtained via requests for information and informal discussions with prison and healthcare officials.

Comparative

The comparators were identified by checking female prison descriptions and consulting with an official at the Department of Health (DH). The comparators suggested were HMP Foston Hall, HMP Send and HMP Drake Hall, and these prisons were agreed at the first steering group meeting. Key service details were extracted from HMIP inspection reports, and from existing HNAs obtained from other PCTs.

Corporate

The corporate health needs assessment was carried out in May 2010. A detailed description of the corporate needs assessment is found at Annex 6. A brief summary is found below. The questionnaires were entered into an Exel spreadsheet and 20% were double checked for quality control. The data were analysed using SPSS. Data from surveys and focus groups are set out thematically with recommendations and suggested ownership.

Group	Corporate methods	Response rates for each method	Overall response rate per group
Women (prisoners)	Survey questionnaires	In total 390 questionnaires were distributed through the prison, with 101 received for analysis to give a response rate of 28% (101/358).	30% (108/358)
	Focus groups (two)	Seven (7) prisoners participated in two separate focus groups.	
Healthcare staff - internal	Survey questionnaires	20 questionnaires were disseminated to the 9 internal healthcare staff, with a response rate of 44% (4/9).	78% (7/9)
	Focus group (one)	78% (7/9) of the internal healthcare staff participated in the focus group.	
Healthcare staff - external	Survey questionnaires	23% (3/13) external healthcare providers completed and returned a questionnaire.	23% (3/13)
Prison staff	Survey questionnaires		4/10 (40%)

Disease headings with gap analysis

Epidemiological

Epidemiological data were derived from the following sources:

Epidemiological source	Person carrying out audit
A prison medical notes audit of approximately 1 in 5 sets of notes (n=67) from A, B, C, D wings	Specialist Registrar (March 2010) – of reception clerkings

Preliminary search on SystmOne for chronic diseases	Specialist Registrar & PCT trainer (26 April 2010) – search codes listed below[9]
C wing chronic disease register	Senior Prison Sister on C wing (May 2010)
Pharmacy snapshot audit of top 10 drugs prescribed	Clinical Pharmacist (March and April 2010)
Pharmacy search for number of persons with chronic diseases (physical and mental) using search for common drugs	Clinical Pharmacist (May 2010)
IDTS brief review of current caseload and results of blood spot testing	IDTS Clinical Lead Nurse (April and May 2010)

For the epidemiological analysis, expected prevalences for women in prison were obtained by applying either Birmingham Toolkit or national data to the Downview numbers in each age group (with ***age-specific prevalence*** applied to the number of women in each age group at Downview where available).

Gap analysis

This was achieved by triangulating service descriptions and activity data, comparative results, corporate findings, and epidemiological data - to build a holistic picture of gaps in health care and health promotion, and recommendations for action.

RESULTS - HEALTH SERVICE DESCRIPTION AND ACTIVITY

Structure

Healthcare staff

The healthcare team comprises the following staff (there are two Band 5 vacancies currently):

Band 8	**1 WTE**
Band 7	1 WTE
Band 6	3.7 WTE
Band 5	6 WTE
Healthcare assistant (HCA)	1 WTE
Band 3 (Administrative)	1 WTE

Healthcare facilities

The healthcare unit is a prefabricated block near A wing. It contains a waiting room (with chairs, posters and information boards), four office rooms, and a clinical room with an examination couch.

Healthcare is **wing-based**, with clinical areas in all wings except D (the resettlement unit, which uses B healthcare facilities). C wing has a clinical and nurses' room - neither of which has a sink with mixer taps. A wing has clinic rooms with small disposable sinks, which have to be manually filled and emptied. After the clinical appropriateness of the disposable sinks was queried by NHS Surrey's Infection Control Nurse, Surrey Community Health gave assurance that the sinks were fit for purpose. Detailed wing-based healthcare descriptions are found at Annex 5.

Recommendation: provide mixer taps to healthcare areas in C wing.

[9] Asthma 'H33', diabetes 'C10', epilepsy 'F25', hypertension 'XEO Ub'

Opening times for healthcare

- Mon-Fridays 7.30am-6.30pm
- Weekends and bank holidays 8.30am to 5.30pm

Women can be seen by a nurse seven days a week between the hours listed above. Out of hours, they are triaged by a prison officer and the out of hours healthcare doctor service (Harmoni) contacted if needed.

Care and Support Unit (CSU) – Segregation Unit

The CSU is adjacent to B wing and there were 7 women there on one visit to the prison (maximum capacity of 9 women). Women in the CSU are reviewed daily by a nurse, and on Mondays, Wednesdays and Fridays by the GP.

Process

New arrivals

All new arrivals to Downview come from other prisons (having spent at least four weeks there). New arrivals are seen at induction by a nurse, who carries out the reception screen and decides whether the prisoner needs to be seen by a doctor (as an emergency, or in the next available GP clinic slot), mental health services, or integrated drug treatment system (IDTS). Women are *not* re-assessed in the week immediately following reception, as this is a training prison.

Accessing healthcare

Applications are made by prisoners on A,B,C and D wings and these are triaged by a nurse daily (placed in a locked box only seen by nurses). There are additional 'sick sessions' so that prisoners can see a nurse between 8.30 to 9am each day.

Emergencies

Under the Health and Safety At Work Act 1974[10], prisons must ensure that there are sufficient numbers of first aid trained staff on duty at any one time – which would include emergency first aid and emergency response and resuscitation – this covers both prison and healthcare staff.

From the table below, we see that only a small proportion of unified prison staff are first aid trained. This is important because healthcare are not a 24-hour service, so unified staff deal with medical problems out of hours. In addition, personal communication from Healthcare revealed that the *Heart Start* training (similar to Basic Life Support) has been withdrawn, and that there is an insufficient number of first aid trained staff at the prison.

Type of unified staff	Number of staff	First aid trained	*'Heart Start'(now withdrawn)*
Developing Prison Service Manager (DPSM)[11]	5	2/5	*0*
Senior Officer	14	1/14	*0*
Officer	73	8/73	*21/73*
Operational Support	30	0/30	*6/30*

[10] http://www.hmprisonservice.gov.uk/assets/documents/1000323221_health_and_safety_nov_07.pdf
[11] Previously known as Principal Officers

Grade (OSG)			
Prison Auxiliary (PA)[12]	1	0/1	*0*

There is a resuscitation bag and one defibrillator (automated external defibrillator) located on each prison wing (except for D wing - resettlement). Personal communication has also revealed that AEDs on each floor of each wing would be preferable than one AED only per wing.

Recommendation: prison to ensure safe emergency response in hours and out of hours, by: ensuring sufficient first aid trained prison and healthcare staff (especially overnight and during weekends) who have been trained to use a defibrillator, and reviewing the equipment, facilities and personnel needs of the prison for emergency response.

Voluntary groups

Although the full list of voluntary organisations cannot be described here:

- The Southside partnership offers support for women of BME origin, both in prison and after release (including persons of gypsy and traveller origin).[13]
- Positively women – for women living with HIV.

Gym

Women are able to access the gym, and there is evidence of joint working between gym and healthcare on the 'biggest loser' programme. There is a BACR trained staff member in the gym, although there is not a nurse who could provide cardiac rehabilitation after myocardial infarction (heart attack).

Recommendation: ensure that resources exist for a nurse to deliver nurse-led cardiac rehabilitation after MI.

Disability

The diversity lead is contacted about all disabled prisoners, and aids and adjustments provided where necessary.

Patient Advice and Liaison (PALS)

Downview's Patient Advice and Liaison Service (PALS) was established in 2008. The NHS Surrey Public Engagement Manager holds a PALS surgery once a month, although the number of women seen is currently low (about 6 women per month).

This will soon change to a system using a prisoner orderly (working on a day-to-day basis to respond to their fellow prisoners' concerns, and paid by the prison), who will be supervised by NHS Surrey's Public Engagement Manager.

Complaints

Prisoners make complaints about healthcare by submitting forms to healthcare. Complaints are collated every two months for the prison health partnership board and presented at that meeting.

Prisoner release/transfer

If prisoners are transferred to another prison, they do so with the complete original set of paper medical notes, and with a discharge plan to include both health and social care needs. Women released to the community have assessment of their health needs prior to discharge.

[12] Previously known as Operational Support Grade (OSG)
[13] Beyond Prison – Southside Partnership. Annual Report April 2009-March 2010.

Self harm and suicide

If a prisoner commits an act of deliberate self harm, an Assessment, Care in Custody, and Teamwork (ACCT) file is opened[14]. Prisoners on an ACCT file are placed on a self harm watch which is risk-assessed as to frequency. Mental health in-reach team will then review the patient at regular intervals, and prison healthcare will monitor the patient depending on the needs. This is discussed further in the mental health section.

Self harm and 'cutting'

There has been discussion around the use of pre-prepared dressing packs for women who have self harmed by cutting. These pre-prepared packs for officers were introduced in response to rapid depletion of the dressing packs in first aid kits. This practice has been highlighted as a problematic area – as standard procedure should be for dressings to be provided from first aid kits. Use of first aid kits should only be done by first aid trained officers, and the section above has highlighted a gap in first aid trained officers.

Recommendation: review procedures for medical attention to prisoners who have self harmed by cutting, especially use of pre-prepared 'cut-up' packs. Relates to recommendation above on first aid-trained unified staff.

Listeners

The Safer Custody Team coordinates the function of the Listeners at the prison. The Listeners are prisoners trained to support their peers, and are supported by the Samaritans. Listeners undergo training with the Samaritans comprising 5 to 6 sessions over a 6 week period. The Listeners' Service is available 24 hours per day on C and D wings. The service is promoted at induction to raise awareness amongst incoming prisoners. There is a prison officer who provides support to the Listeners, and a Samaritans worker visits weekly to provide support also. The Samaritan support worker is in turn invited to attend Safer Custody meetings at the prison.

Internal service provision

Stop smoking

This service is delivered once a week – and is delivered by two senior nurses. Activity data are summarised below, but these data are not reported into NHS Surrey Stop Smoking services, which would be an excellent way to support the prison.

Smoking Cessation	Dec 2009	Jan 2010	Feb 2010	
1st attendances		0	0	4
Follow Ups			48	12
Total		0	48	16

Infectious disease-related clinics including Hepatitis B vaccination

Hepatitis B vaccination

This takes place daily on A wing on Monday to Friday, to ensure that a GP is on site. All of the nurses have completed their anaphylaxis training at Downview. For Q4 2009/10 Prison Health Performance Quality Indicators (PHPQI), Downview was rated amber for Hepatitis B vaccination for achieving a coverage of 60% of patients[15].

[14] http://www.hmprisonservice.gov.uk/adviceandsupport/prison_life/selfharm/

[15] HPA PIP team data – coverage is women vaccinated within 31 days of reception plus number already vaccinated / divided by the number of receptions

Hepatitis C

The Hepatitis C Specialist Nurse from Epsom Hospital currently cares for a small number of patients some of whom are on antiviral treatment. Liver ultrasounds for women on treatment are carried out by the visiting Radiologist. The Hepatitis C service has assured Public Health that there is capacity for any women identified as Hepatitis C positive to be cared for by the Epsom Hospital service.

Seasonal flu vaccination

29 persons were vaccinated for seasonal flu in December 2009. This is discussed further in the immunisations section.

Routine general nursing sessions

Nurse triage is a daily open door session for nurses to assess queries. 'Special sick' is a daily clinic for half an hour starting at 8am on each wing – delivered by wing nurse for urgent queries from patients**.** Phlebotomy is offered every other day by nurses The patient numbers are presented below.

	Dec 2009	Jan 2010	Feb 2010
Nurse Triage (includes Dental triage)			
Total	129	160	182
Special Sick			
Total	25	48	49
Phlebotomy clinic			
Total	22	47	32

Women's health

Pregnancy

Antenatal care (where needed) is provided at St Helier Hospital. After women give birth they are then transferred to a prison with a mother and baby unit, unless this is not appropriate for MAPPA/child protection reasons. Last year, a small number of women required either antenatal care or underwent termination of pregnancy (numbers suppressed).

Women's health clinic

There is a weekly nurse-led clinic for women's health, which includes family planning advice and breast care advice. Activity data are shown below.

Womens Health (includes Family Planning & Breast care)(nurse led)	Dec 2009	Jan 2010	Feb 2010
1st attendances	24	7	15
Follow Ups		10	
Total	24	17	15

Sexual health

Sexual health services are delivered by a nurse at the prison. There is no Genito-urinary medicine (GUM) service, and no doctor-led input. Patients living with HIV are seen outside the prison in external appointments (see below). This issue is discussed under disease headings.

Data for June 2010 showed the following activity:

- 10 women had swabs (including Chlamydia tests)
- A small number had pre-counselling for HIV

Cervical smears

These are carried out by nurses - every other day if needed. A high volume service is evidenced by the numbers below.

Cervical Cytology	Dec 2009	Jan 2010	Feb 2010
Total	39	53	35

Colposcopy

Colposcopy is currently delivered in-house by a GP who provides sessions every other week at HMP Downview, and also provides sessions at a local hospital and acute trust. A recent QA report for the colposcopy service showed that in a seven month period in 2009, 4 women were seen.

The latest QA report[16] made several recommendations on safety, such as the provision of forceps for use in case of bleeding, and ensuring that the clinic was staffed by two nurses. These recommendations have been implemented and NHS Surrey has received assurance that the service is safe. However, the low volume through the service does raise concerns about cost effectiveness - further description is outside the scope of the needs assessment, although a cost minimisation analysis has been completed by NHS Surrey.

Recommendation: NHS Surrey to review cost minimisation analysis with Screening Leads and prison to decide on future service provision.

Breast screening

Women attend the Robin Hood Centre in Sutton for breast screening appointments.

Chronic disease (nurse-led) clinics

The Pharmacy technician is carrying out an asthma clinic weekly`. Activity data for nurse-led chronic disease clinics are found below.

Asthma	Dec 2009	Jan 2010	Feb 2010
1st attendances	2	7	3
Follow Ups	15	18	26
Total	17	25	29
Coronary heart disease (CHD)			
1st attendances	2	4	7
Follow Ups			
Total	2	4	7
Diabetes / BM monitoring			
1st attendances	0	1	1
Follow Ups	6	4	6
Total	6	5	7

[16] Cervical screening QA visit Report 2009. HMP Downview colposcopy clinic. Visit 14 December 2009, Report 29 January 2010.

Pharmacy

Pharmacy services are provided five days per week by a Pharmacist (who covers both Highdown and Downview), and a Pharmacy technician.

The Pharmacist is taking an independent prescribing course so there are plans for a minor ailment / dermatology clinic. The Pharmacist provides advice on storage and administration of medication, and provides governance on controlled drugs to the prison. Pharmacy conducts annual quality control assurance, and provides staff training.

Medication is prepared and delivered initially to Highdown and then transported to Downview where it is taken to main healthcare, checked and then separated for each wing. Drug charts are held on each wing, but go to healthcare to be checked by the Pharmacist.

The Pharmacist manages the stocks for the prison wings - stock checks are made once a week on A wing, and once a month in all other areas. Pharmacy also reviews all the drug charts to assess appropriateness of prescribing. Provision of in-possession medication is risk-assessed and the level varies.

Medication is dispensed three times per day and not at night time.

Patient ready packs and homely remedies

These packs are ready made for a course of treatment and are ready for dispensing by a nurse when prescribed by the GP. Examples are antibiotics, and asthma inhalers.

There is a stock of 'homely remedies' – which can be dispensed by nurses. Examples of such items are Paracetamol, and Dioralyte sachets. The full list of items is found at Annex 7.

GP services

A new GP provider has been in place since April 2010 – Cheam Family Practice. The GP sees women in A wing – with a rota for which wing patients seen (C wing has the highest patient numbers):

Mondays	**B wing**
Tuesdays	C wing
Wednesdays	A wing
Thursdays	C wing
Fridays	Emergency patients

Dentistry

There are two dentistry days per week at Downview - on Mondays and Thursdays - delivered by two dentists and two dental nurses, as well as a monthly in-reach oral surgery clinic. Although there are digital oral X-Ray facilities on site, specialised orthopantomogram (OPG) X-rays are carried out at Epsom Hospital.

Downview has an oral health promotion strategy, with the smoking cessation team also working to promote oral health. Oral health education is given to all dental patients as part of their dental treatment plan. It is unclear whether oral health is still provided at Downview.

Patients with dental problems are triaged by the wing nurses and then assessed using an algorithm. For Q4 2009/10, Downview scored amber on the PHPQI for dentistry as access was not within the target waiting times for urgent cases (discussed in later sections).

Recommendation: ensure oral health promotion provided at Downview.

Dental activity data

The dentists' own data show the number of patients who did not attend (DNA).

Dental activity	January 2010	February 2010
Number of dental sessions delivered that month	14	10
Routine appointments	60 (14 new, 46 under treatment)	42 (8 new, 34 under treatment)
Emergency (seen on day of referral)	4	1
Cancelled	*11*	*3*
IMR not available so not seen	*3*	*0*
Did not attend	*9 (9/87=10%)*	*7 (7/53=13%)*
Total patients seen	64	43
Total appointments	87	53

Combining patients who did not attend (DNA) with those with a missing IMR, we see that 13% to 14% of appointments in January / February 2010 were missed either because there was no medical record or the patient did not attend: this is discussed further in another section.

Integrated drug treatment system (IDTS) and alcohol

IDTS

The staffing for the IDTS team is as follows:

Manager (Band 7)	1 WTE
Nurse (Band 6)	1 WTE
Dual diagnosis Nurse (Band 6)	1 WTE
GP with special interest	0.1 WTE
Administrative support	0.5 WTE

Women with a past or current drug misuse or on opioid maintenance are referred to the IDTS team after being identified at reception. Downview accepts women who are stable, either Methadone or Buprenorphine (Subutex). For patients who have misused benzodiazepines, there is also an active client list. Withdrawal can be undertaken for benzodiazepines or stimulants. History of stimulants is elicited using a clinical assessment tool.

All IDTS clients are also seen by the Care Assessment Referral Advice and Throughcare (CARATs) team for psychosocial support.

Methadone is dispensed once each day at 11am from A wing, using a dispensing pump (to accurately measures the methadone), sugar-free methadone, and iris recognition. Two IDTS officers together with the CARATs officer supervise the dispensing of methadone. All controlled drugs are always dispensed by a qualified nurse and one other suitable witness, and administered under supervision.

A substance misuse doctor (GP with special interest) visits once a week. The substance misuse nurse cover is for seven days per week.

Harm minimisation

Bleach tablets in dispensers are available throughout the prison, and women are allowed up to up to four tablets in possession at a time – for cleaning personal possessions or injecting equipment, to reduce the spread of blood borne viruses. Information on cleaning injecting equipment ('works') is given to all prisoners at induction.

Drug testing

Mandatory drug testing occurs for the whole prison population using names are drawn at random. In addition, patients under the care of CARATs or IDTS volunteer for drug testing, although a positive result does not carry a penalty and is done to encourage positive behaviour and earn certificates which count towards the reducing reoffending pathway on drugs. The IDTS team joins the prison drug strategy meetings every month to report on their caseload.

Drug reviews

In line with new DH Gateway guidance on three-monthly reviews to encourage reduction in methadone with a view to becoming drug free, Downview is fully compliant – the IDTS team carries out three monthly reviews on all clients on methadone or other opiate replacement therapy.[17]

Dual diagnosis

The nurse for dual diagnosis manages cases and joins the mental health team for multidisciplinary weekly review of the dual diagnosis patients.

Alcohol

The prison scored amber on the recent 2009/10 PHPQI for alcohol. Although AUDIT tools are used at reception to identify prisoners with an alcohol problem, a full range of services is not yet available, although literature and advice are offered by the IDTS team.

The IDTS team is currently identifying an appropriate AUDIT tool to use for SystmOne, with which to screen new entrants to the prison.

Mental health

The staffing structure for mental health at for Downview is as follows – which gives a total of 3.25 WTE:

Mental health expertise	WTE
Lead for Psychiatry	0.2 WTE – delivers a nurse prescribing clinic once every fortnight
Consultant Psychiatrist	0.2 WTE (3 sessions per week ie 1.5 days of which 0.5

[17] Gateway Ref 13944 DH Updated Guidance for opioid maintenance prescribing

	day at JBU)
RMN	1 WTE
RMN with primary MH care focus	0.5 WTE
Counsellor (unfunded)	0.1 WTE
STR worker (Psychologist)	1 WTE
[STR post (Prisoner) post currently vacant]	1 WTE – prisoner post currently vacant
Clinical Psychologist	0.05 WTE (half day every fortnight for functional assessment)
Psychotherapist	0.2 WTE
Consultant Psychiatrist, LD expertise, eating disorder expertise	As needed

Mental health referrals and additional services

The mental health team holds weekly referral meetings to discuss and triage referrals.

The GPs are wing based and provide support for routine psychiatric prescribing only. All other mental health – including primary mental health interventions - is provided by the mental health team.

There is a 'drop in' clinic once a month which rotates through different wings and is booked by healthcare. Prison officers are also able to refer women to this service. Additional services are:

- Movement psychotherapy for 1.5 days per week
- Capoeira class once a week
- Mental health corner in the library

Mental health waiting times

Urgent cases are seen within one day. Routine waits for Psychiatry appointments to see either the RMN of Psychiatrist are currently 7-10 days apart from the wait for a Counsellor or Psychotherapist which is longer.

Mental health - Out of hours

Out of hours, the GP service can be called, and the Lead for Psychiatry is available on a pager and mobile for emergencies or advice.

Mental health Specialist services

Patients with dual diagnosis (mental health as well as substance misuse problems) are seen by both relevant teams. The new learning disability tool pilot is due to start in another Surrey prison but not yet at Downview. Specialist services for eating disorders are available if needed.

CPA

The new Care Program Approach (CPA) requires patients to either have a statement of care (standard or enhanced), or a CPA – which entails coordinated care from a multi-disciplinary team for those patients with serious enduring mental illness. The mental health team has an offender management lead who participates in MAPPA – multi agency public protection arrangements.

Mental health involvement in care of patients at risk of self harm and suicide

The mental health team is heavily involved in ACCT assessment when needed, and is part of the monthly safer custody meetings. Training for prison officers runs every 4-5 months.

There was a fund for Highdown and Downview to run in-depth training for prison officers in dealing with prisoners who self-harm, although this has not been consistently available. PSO 2700 recommends providing post incident support for prison officers[18].

Recommendation: providing post incident support for prison officers who have cared for women who self harm.

Mental health transfers

Transfers to mental health beds – typically 2-3 women require a mental health bed per year at Downview and the wait is typically 3 months for a bed. The Q4 2009/10 data for PHPQI showed that waits were within the target period.

External provision

External specialists – in-reach

The following providers come in to the prison, with a snapshot of activity (appointments) for the time period December 2009 up to and including February 2010 (three month snapshot):

Type of clinic	Frequency	Activity data – appointments from Dec 2009, Jan 2010, Feb 2010
Oral surgery	Once a month	•
Physiotherapy	Weekly	14, 21, 22 appointments respectively for each month above
Chiropody	Every 2 weeks	11, 18, 27 appointments respectively for each month above
Diabetic nurse	Once a month	•
Consultant Radiologist - ultrasound	Once a month, in-reach from Royal Surrey County Hospital	0,6,0 appointments respectively for each month above
Hepatitis C management (chronic). There is a care pathway for Hepatitis C at the prison, developed by the Specialist Nurse and Hepatologist from Epsom Hospital. Liver ultrasound scanning for Hepatitis C is carried out by the visiting Radiologist (see above).	Every two weeks - Sister from Epsom General Hospital	6, 9, 8 appointments respectively for each month above
Optician	weekly	•

[18] PSO 2700: 3.5 post incident support

External specialists – external outpatient appointments

The following list of outpatient appointments from January-March 2010 shows the following picture:

Specialist appointment (external)	Number of external appointments (Jan-Mar 2010)
Dermatology	11
Dental (maxillofacial and specialist dental)	20
Gynaecology	5
Ophthalmology or eye unit	8
X-ray	18
Mammogram or follow up from mammogram	6
MRI , CT scanning, cardiac echo, ultrasound	7
Diabetes Unit	*
HIV	*(small number suppressed)
General surgery	1
Day case	7
ENT	4
General medicine	11
Cardiology	1
Urology	1
Renal	1
Termination of pregnancy (TOP)	*(small number suppressed)

A few points could be raised from these raw data - a high number of external dental appointments, high number of dermatology appointments and a small number of TOPs. Given that this is a training establishment with ability for release on temporary license (ROTL), greater focus on family planning may avoid need for TOPs (discussed in later section).

Recommendations from health service description and activity

Recommendation	Owner
Install mixer taps in healthcare areas on C wing	Prison, healthcare
Ensure safe emergency response in hours and out of hours, by: ensuring sufficient first aid trained prison and healthcare staff (especially overnight and during weekends) who have been trained to use a defibrillator, and reviewing the equipment, facilities and personnel needs of the prison for emergency response.	Prison and Healthcare
Ensure that resources exist for a nurse to deliver nurse-led cardiac rehabilitation after a heart attack.	NHS Surrey and Healthcare

Review procedures for medical attention to prisoners who have self harmed by cutting, especially use of pre-prepared 'cut-up' packs. Relates to recommendation above on first aid-trained unified staff.	Prison and Healthcare
NHS Surrey to review cost minimisation analysis with Screening Leads and prison to decide on future service provision.	NHS Surrey
Provide post incident support for prison officers who have cared for women who self harm.	Prison
Ensure oral health promotion service at the prison	NHS Surrey and healthcare

RESULTS – COMPARATIVE

The results of the comparative analysis are found below. The main findings (although this is difficult as prisons may not report on WTE in a similar way) are that general healthcare and mental health provision is slightly higher in other establishments.

Service provision for comparison	Downview, Surrey	Foston Hall, Derbyshire[19]	Drake Hall, Staffordshire[20]	Send, Surrey[21]
CNA	358	283	315	281
Type of prison	Training	Training (n=203) Remand (n=80)	Training (closed resettlement) specialist provision for foreign nationals	Training (closed)
Foreign nationals	Approximately 22% (80/358)	7%[22]	Approximately 30% (97/315)	13%
Staffing levels	13.7 WTE staff (two Band 5 vacancies)	21 WTE staff	No information available	17 WTE
Inpatient care	no	no	no	no
GP	Clinic on every week day	Half day session every week day	Weekday service	3 days per week

[19] Dewis R – HNA Foston Hall - Derbyshire County PCT (2007) and HMP Foston Hall - HMIP (1-3 May 2007)
[20] HNA HMP Drake Hall (December 2009). South Staffs Prison Health Partnership
[21] HNA Send NHS Surrey
[22] HMIP (2009) Report on an announced inspection of HMP Foston Hall

Mental health	3.25 WTE: 0.2 WTE Lead Service Manager 0.2 WTE Psychiatrist 1 WTE RMN 0.5 WTE RMN primary MH care focus 0.1 WTE counsellor (unfunded) 1 WTE STR worker (Psychologist) 0.05 WTE Clinical Psychologist (half day every fortnight) 0.2 WTE Psychotherapist	3.5 WTE comprising: 0.5 WTE Manager, 1 Senior OT, 2 WTE Community Psychiatric nurses[23]	1 in reach and 1 RMN from prison health care. 1 Counsellor who sees approx 55 persons per month - but no information on WTE equivalence	3.5 WTE: 0.2 WTE Lead Service Manager 0.1 WTE Psychiatrist, 0.1 WTE SpR 1 WTE RMN 0.4 WTE RMN Primary care focus 1.4 WTE STR 1 day per month clinical psychologist 0.4 WTE mental health social worker
IDTS	3.6 WTE	6.5 WTE comprising: 1 WTE Lead, 2 staff nurses, 1 Health Care Assistant, 1 Dual diagnosis worker, 0.5 Pharmacy technician, 1 administrative post[24]	IDTS provided, but no further quantification (South Staffs HNA Dec 2009)	Formal IDTS not yet in place so cannot compare
Dental	2 sessions per week	2 sessions per week[25]	Dentist and dental nurse – 1.25 sessions per week (South Staffs HNA 2009)	Weekly clinic
Examples of good practice	In-reach Radiologist who provides ultrasounds, in-reach Hepatitis C treatment, continuity of care for women living with HIV, IDTS and dual diagnosis management	Prison using the 'walking the way to prison health' model to encourage physical activity Prisoners who have witnessed serious self harm are seen by wing staff and Listeners.	Two health trainers in post who are cover a whole day each week. Referrals to and from the health trainer service from the gym and the smoking cessation service	Prison orderly working with PALS manager to provide an internal link between prisoners and PALS Manager

[23] Dewis R – HNA Foston Hall - Derbyshire County PCT (2007)
[24] Dewis R – HNA Foston Hall - Derbyshire County PCT (2007)
[25] Dewis R – HNA Foston Hall - Derbyshire County PCT (2007)

RESULTS – CORPORATE

Corporate findings - women

- Overall, prisoners' views of healthcare were sub-optimal, with an average rating of both healthcare and access to healthcare at 4, out of a maximum score of 10. All the main findings are summarised below, and women's suggestions for 'one change' to improve healthcare are found at Annex 8.

Topic	Result	Q[26]	FG[27]
Healthcare usage	• 94% (95/101) of prisoners had seen a doctor in HMP Downview	●	
	• 98% (99/101) of prisoners had seen a nurse at HMP Downview	●	
	• 27% (27/101) of prisoners had seen an optician at HMP Downview	●	
	• 44% (44/101) of prisoners had seen a dentist in HMP Downview	●	●
Prisoner impression	• The average rating of healthcare in HMP Downview was 4/10 • While 32% (32/101) of prisoners were happy with the treatment that they had received from healthcare, and 16% (16/101) believed that the healthcare staff worked well: • 54% (54/101) of prisoners were not happy with the treatment that they had received for their health problems, and 20% (20/101) of prisoners felt that 'nothing' in healthcare worked well	●	
Ease of access	• The average rating for ease of access to healthcare was 4/10	●	
	• In addition, prisoners felt that the waiting times to see the doctor, optician and dentist were too long		●
Healthcare outside HMP Downview: comparisons	**OTHER PRISONS** • 10% (10/101) of prisoners felt that healthcare was better in HMP Downview than other prisons, while • 24% (24/101) of prisoners felt that healthcare was of the same standard that they had received in other prisons	●	
	COMMUNITY HEALTH SERVICES • While only 2% (2/101) prisoners felt the healthcare at DV was better than healthcare services in the community, • 12% (12/101) prisoners felt that the healthcare at HMP Downview was the same as the healthcare services in the community	●	
Out of hours healthcare provision	• Although only 1% (1/101) of prisoners agreed that if they had a health problem when healthcare was closed they could get the help they needed, only 8% (8/101) felt that there was a need for a 24-hour healthcare service	●	
Medication	• Complaints of being given the wrong medication ('near miss')		●
	• Instances of repeat medication not arriving on time and as a result, prisoners missing doses of their medication	●	●
	• Lack of communication around why medication prescribed in hospital discontinued when returning to Downview	●	●
	• Some concern that medication is changed without consultation with patient		●
Optician	• Inmates felt that they were not happy with the frames available. Prisoners requiring a prescription change were unable to have their new lens put into their old frames	●	●
External healthcare appointment	• Complaints of missing external hospital appointments as a result of the prison regime. If miss external appointments then they have to go back on the waiting list - in effect doubling waiting time		●
	• Difficulty preparing for external appointments which require preparation, such as surgery		●
	• Understand the need for prison security, but instances of being cuffed to officers during invasive procedures		●
	• Appears to be limited communication between healthcare staff and hospital, on return to the prison		●
	• When women have tests they don't receive the results promptly		●

[26] Questionnaire survey
[27] Focus group

	Out of the ten prisoners aged over 50 years of age: 70% (7/10) reported receiving an invitation for breast screening; and • 5/10 (50%) reported undergoing breast screening whilst at HMP Downview	●	
	Out of the 79 prisoners aged between 25 and 65 yrs of age: • 48% (36/79) had received an invitation for cervical screening • 27% (21/79) had received cervical screening in HMP Downview		
	• No women reported receiving bowel screening in HMP Downview	●	
Management of long term conditions	• Prisoners reported feeling a lack of care planning, review, monitoring or support for complex health needs or long term conditions		●
Drug treatment	• Some prisoners felt that they had to wait a few days after arriving in HMP Downview before being assessed for drug treatment, and felt they experienced withdrawal symptoms		●
Dentist	• Prisoners had experienced long waiting times for dental appointments	●	●
Privacy and confidentiality	• Some women felt that there was a lack of privacy. Perception that other inmates knew of their health complaint and that other inmates claimed that they overheard nurses/ officers talking.		●
Relationship with prison staff	• Prisoners described the relationship between themselves and prison staff- both uniformed and non-uniformed as very good.	●	
	• Prison staff were approachable and good advocates.		●
Diet	• Only 13% (13/101) prisoners felt that the food at HMP Downview was good for them.	●	
	• 28% (28/101) of prisoners felt that the diet at HMP Downview needed to be improved.	●	
	• Half (50/101) of the prisoners agreed that they could buy healthy foods from the canteen	●	
	• Prisoners felt that the quality of the food in HMP Downview was poor, describing it as "stodgy", "poor quality" and "unhealthy"		●
	• Although salads and healthy options were readily available, they were "repetitive and boring". Vegan and special diets were poor and prisoners reported regularly missing meals as a result..		●
Food preparation	• Prisoners felt that the quality of the food was poor. Issues around length of time food stored on the hot-plate after preparation.		●
Food hygiene	• Prisoners concerned that kitchen workers wore their kitchen uniform around the prison and that this was not hygienic.		●
Health promotion	• Prisoners felt that there was no clear structure for the delivery of health promotion messages, and that they often turned to non-uniformed prison staff for support.		●
Smoking	• Complaints of staff - (both prison and healthcare) smoking near residential areas and gardens, with second-hand smoke reaching women's rooms.	●	●
	• Other prisoners smoking in the education block/association room		●
	• Prisoners were happy with the stop smoking service provided in HMP Downview	●	●
Physical exercise	• 59.4% (60) of prisoners agreed that they could exercise on a daily basis	●	
	• 50.5% (51) of prisoners agreed that remedial gym was available in HMP Downview	●	
	• Although the gym is easy to access, low levels of staffing in the rest of the prison often result in gym staff having to work in other areas, and the gym being closed.		●
	• Gym staff – perception of lack of guidance and encouragement for prisoners. • Gym peer support orderlies sometimes perceived as not supportive.		●

Corporate findings – internal healthcare staff, external healthcare staff and prison staff

The most salient results of the feedback from the internal healthcare staff, external healthcare staff and prison staff have been presented in the table below. However, full tables containing all of the feedback are found at Annex 9.

What works well in healthcare?	Internal	External	Prison staff
Triage system	●	●	●
Communication from some healthcare staff	●		●
Communication between healthcare staff	●		
Healthcare team well established	●		●
Leadership of the team	●		

What are the main health concerns of Prisoners in HMP Downview?	Internal	External	Prison staff
Substance misuse	●	●	●
Mental health- depression, low moods	●	●	●
Chronic pain		●	
Poor dental health	●	●	●
Not receiving medication on time		●	●
Missing external hospital appointments due to prison regime	●	●	●

GOOD examples of how the health needs of prisoners in HMP Downview are met	Internal	External	Prison staff
Health care triage is prompt and inmates are seen quickly	●	●	●
Gynaecologist visits and does family planning for women looking at long-term contraception	●		
Reception screening works very well	●		●

	Internal	External	Prison staff
Views on healthcare staff			
Poor relationships between internal healthcare; and the external healthcare and prison staff	●	●	●
Healthcare staff are carrying out lots of administration work that reduces time with patients		●	
Healthcare staff work very hard	●	●	●
Some healthcare staff don't treat prisoners sympathetically			●
Prison staff do not understand that prison healthcare capability is limited, so that prisoners have to stay in hospital for medical reasons	●		
Healthcare staff are not prompt in providing support, or following up queries			●

Views on Prison regime, and food	Internal	External	Prison staff
Good partnership working between internal healthcare staff and officers	●		●
Governors are very supportive of the healthcare team	●		
Senior management are not supportive of healthcare (in terms of room allocation) and do not carry out essential works required to deliver a clinic within the regulations		●	
If short staffed the gym staff are deployed to the wings, so gym is closed	●		●
Diet - Food is very high in fat and lacks nutritional content	●	●	●
Diet - Medical diets inappropriately given to prisoners by canteen staff	●		●

	Internal	External	Prison staff
Mental health			
The “In reach team” work really well- readily offer support, advice and assistance	●	●	●
Self harm is under reported due to prisoners being able to self manage via first aid / dressing packs			●
Healthcare staff don’t routinely follow up self harm			●

Long term conditions	**Internal**	**External**	**Prison staff**
If prisoner is on treatment for HIV, procedures to ensure that they are kept with usual hospital if practicable – this is already in place	●		●
No structured support for prisoners with long term conditions such as diabetes, heart disease cancer		●	●

Other areas	Internal	External	Prison staff
Medication			
Medication is taken from prisoners when they arrive in HMP Downview and re-prescribed by the doctor, as a result some women go without medication for a few days	●		●

The feeder prisons don't always prescribe similarly to the Surrey prisons preferred prescribing list - and the prescribing is patchy as a result, so some women are unable to continue their medication in HMP Downview. The doctor will then prescribe an alternative medication in line with the Surrey preferred prescribing list.	●	●	

Why do you feel the health needs of prisoners in HMP Downview are <u>NOT</u> met?	Internal	External	Prison staff
Healthcare staff do not do any regular preventative work		●	●
The poor cooperation from prison staff and healthcare management makes it hard to deliver good quality services		●	
Acute illnesses are not treated as priority		●	●
There are long waiting times to see a doctor	●	●	●
Prisoners wait too long to see a dentist	●	●	●
Prisoners often <u>miss external appointments</u> that they have waited a long time for due to short staffing at the prison, and security	●	●	●
A & B wing, no officer during medication time and prisoners often cause a disruption resulting in healthcare staff for their safety, shutting the hatch	●		
<u>The clinical areas are 'filthy'</u>		●	

What could be done to improve the health of prisoners in HMP Downview?	Internal	External	Prison staff
Better management of healthcare appointment allocation and delivery of healthcare slips		●	●
Clinical areas and waiting areas to be <u>cleaned regularly</u>		●	
Awareness session for officers on the management of LTC such as diabetes	●	●	●
Give prisoners more information about test results		●	

Better continuity of healthcare- when prisoners enter and leave the prison	●	●
Improved working between healthcare team and Disability Living Officer on a support plan for prisoners with disabilities.		●
Evaluation and monitoring of the use of pre-prepared dressing / first aid packs, with set guidance on their use	●	

Recommendations from all of the corporate work

Area	Recommendation	Prison	Health-care
Awareness of services and commun-ication	Improve information on health care services throughout the prison. For example, issues have been highlighted with cancellation and low patient awareness of the 'well woman' clinic.		●
	All test results should be communicated promptly to women.		●
Healthcare staff	Relationships between healthcare and unified staff should be improved, with continuation of joint handover sessions to discuss difficult issues and foster improved relationships.	●	
Prison staff	All prison staff must ensure that when discussing health issues with prisoners they maintain confidentiality.	●	●
Long terms conditions and Care planning	Women with complex health needs or long term conditions should have a care plan informed by healthcare and Personal Officer, which follows the hospital discharge plan where relevant.	HC and prison	
	Healthcare to better support the DLO in care planning for prisoners with a disability.		
Self-harm	Ensure that ALL instances of self-harm are reported, and followed up by healthcare, and review the current policy of distributing dressings to women who are known to self harm, as this may be masking episodes and promoting self harm.	●	●
IDTS	Ensure that all women requiring IDTS review are referred promptly to assess need.	●	●
Medication	All medication 'near misses' must be reported in line with the NHS procedures, and audited to improve practice.		●
	Medicine wastage has been highlighted for women coming in via reception or ROTL. We recommend: An audit to identify the extent of medication that is destroyed between prison transfers and ROTL, to try to minimise medication wastage; Better communication between healthcare and prisoners to explain why medication is removed.		●
	Medication changes must be communicated clearly and promptly to prisoners.		●
	On the induction wing (A wing), a unified staff officer should be present during dispensing of medication to improve security for healthcare staff.	●	●
Food and food hygiene	Review the quality and nutritional content of the prisoner diet; Review regulation on wearing kitchen uniforms around the prison, and check whether food kept in 'bains-marie' meets food hygiene requirements.	●	●
Environment and cleaning	Ensure that all clinical and waiting areas are cleaned adequately and regularly to meet NPSA and NHS standards.		●
Screening	Ensure that cervical smears are carried out for all women who need them, with adequate information on the screening test.		●
Outside	Ensure that prisoners are properly prepared for external appointments which require medical preparation	●	●

hospital appoint-ments, invest-igations, and elective surgery	in advance – such as colonoscopy etc. whilst balancing security needs. External appointments: • Prison and healthcare to work with external hospitals around appointments so that these are arranged in line with the regime, to reduce cancellations and delays. • Improve escort arrangements for hospital appointments so that prisoners do not miss appointments. • Consider whether "cuffing" is required at all times eg during invasive tests, to preserve dignity for prisoners.	•
Smoking	The prison 'no smoking policy' for staff must be more strictly enforced, eg in the education areas.	•
Optician	Review the number of instances of prisoners losing/ breaking their glasses, to reduce wastage.	•

RESULTS - DISEASE HEADINGS WITH GAP ANALYSIS

Burden of disease including pharmacy audit

It has been documented that female prisoners report much higher levels of longstanding illness (83%) than the general female population (32%)[28]. The following sections outline the expected and observed levels of disease at Downview, comparing national data with local findings.

To provide a brief snapshot of physical and mental health disease burden, the Lead Clinical Pharmacist's monthly top ten prescribing snapshots from April and May 2010 are set out below.

1.	**Paracetamol**	**analgesia**
2.	Ibuprofen	analgesia
3.	Citalopram	Antidepressant (Serotonin specific reuptake inhibitor, SSRI)
4.	Salbutamol	Beta agonist (asthma inhaler)
5.	Emollients e.g. aqueous cream	emollient
6.	Mirtazepine	Antidepressant (noradrenergic and SSRI properties)
7.	(Joint 7th) Loratadine	Antihistamine
	Omeprazole	Proton pump inhibitor
8.	Cetirizine	antihistamine
9.	Fluoxetine	Antidepressant (SSRI)
10.	Contraceptives	

The pharmacy audit at first glance shows a high level of analgesic and bronchodilator prescribing, as well as antidepressant prescribing. The high level of antihistamine (Loratadine, cetirizine) prescribing and antipsychotic prescribing of Mirtazepine might arise from desired sedative side effects known to patients.

Recommendation: review high level of antipsychotic prescribing of Mirtazepine, and antihistamine prescribing (Loratadine, cetirizine) to see whether the sedative side effects underlie high demand.

Physical health

The table below contrasts the expected (from age stratified national data for the female estate) and observed prevalence of physical illness at Downview.

Reception notes audit

The reception notes audit involved review of 67 notes out of an approximate CNA of 358 (19%). Demographic characteristics of the reception notes audit:

- Mean age of the patients whose notes reviewed was 32 years (n=67)
- Oversampling of foreign national patients to ensure capture of the health needs of this group (n=19/67, 28.4%, mean age 31 years).

[28] Plugge et al (2006) The Health of women in prison study findings (Oxford University)

The table below contrasts expected, mostly age-stratified data (indicated below) with observed levels at Downview. Underlined expected prevalences are from non-prison data sources such as the Health Survey for England.

Physical illness	Expected prevalence (Birm Toolkit) female prisoner %	CNA	Age stratified data?	Expected number at DV (using national female prisoner data)	Observ'd DV (IMR reception notes audit) (#, %)	Observ'd DV (Systm1)[29] (#, %)	Observ'd DV (chronic disease register C wing) (%)	Observ'd DV (Pharm data) (#,%)	Observ'd number DV (range) using prison data CNA of 358
Asthma	5-8%	358	yes	**23**	13/67 (19.4%)	110/337 (32.6%)	56/183 (30.6%)	35/338 (10.4%)	**37 to 117**
COPD	0.3-3.6%[30]	358	yes	**2**	0 (0%)	•	2/183 (1.1%)	•	**4**
Diabetes	0.3-4%	358	yes	**4**	0 (0%)	11/337 (3.3%)	4/183 (2.2%)	15/338 (4.4%)	**0 to 16**
Heart disease	0.1-5.9%	358	yes	**2**	5/67 (7.5%)	•	3/183 (1.6%)	13/338 (3.8%)	**6 to 27**
Hyper-tension	1-18%[31, 32]	358	yes	**33-64**	3/67 (4.5%)	23/337 (6.8%)	10/183 (5.5%)	21/338 (6.2%)	**16 to 24**
Epilepsy	3%[33]	358	no	**11**	1/67 (1.5%)	14/337 (4.2%)	8/183 (4.4%)	5/338 (1.5%)	**5 to 16**
Obese and over-weight	29.5%[34]	358	no	**106**	25/53 (47.2%)	•	•	•	**169**
Haemo-globinopathy	1 in 500 Black births sickle cell anemia[35]	358	no	**1**[36]	3/67 (4.5%) – sickle trait	•	•	•	**16**

Asthma

Data on disease prevalence can also be contrasted with prescribing data and drug using data from the audit. Of the 13 out of 67 women who identified themselves as asthmatic (almost 20%), almost half (6/13, 46.2%) used either cannabis or crack, and over three-quarters (10/13, 76.9%) were *tobacco* smokers. This is illustrative of damaging behaviours which will exacerbate a chronic condition.

Of note, only about one-third (4/13, 30.8%) of women who said they were asthmatic were actually using inhalers at reception - an indicator of untreated disease or chaotic lifestyles (or indeed both).

[29] Using the CNA on 26/4/2010 of n=337. Downview and JBU not disaggregated.
[30] National female prevalence data age adjusted, not prison data. www.doncasterhealth.co.uk/phin/pdfs/QOF/COPDModel.pdf
[31] Plugge et al (2006) The Health of women in prison study findings (Oxford University) - hypertension
[32] Health Survey for England 2006: 53
[33] Plugge et al (2006) The Health of women in prison study findings (Oxford University) - % of women taking antiepileptic medication on reception to prison. Proportion self-reporting epilepsy (12.2%) not used as this may include fits related to alcohol or benzodiazepine withdrawal
[34] Plugge et al (2006) The Health of women in prison study findings (Oxford University) : 45
[35] Wikipedia 1 in 500 Black births US data so use with caution
[36] Difficult to apply birth data to Black or Black British population of circa 36% of 358 to give 128 women.

Data obtained as a crude estimate from SystmOne provide a reassuringly higher disease prevalence than either the paper-based wing register or notes audit – an early signal that SystmOne data may help address under-reporting of disease.

Chronic obstructive pulmonary disease (COPD)

The table above shows the expected and observed numbers of women with COPD to be roughly comparable between national (age-stratified) community and prison data. Work on smoking cessation is essential to both mitigate and prevent COPD.

Diabetes (Types 1 and 2)

The highest observed number of diabetics in prison (from Pharmacy data) was actually higher than expected – possibly due to the high number of BME prisoners, and indicative of a population with significant chronic disease needs. These data are especially salient when looking at the obese and overweight data below, as weight loss is an important intervention for Type 2 diabetes.

There were no diabetic appointments (GP) recorded in a three month period from December 2009 to February 2010 – so it is essential that all women with chronic disease have access to primary care and secondary care (only one visit in three month period Jan-March 2010).

Heart disease and hypertension

Observed levels of heart disease were actually *higher* at Downview than expected from national prison data. Again it is difficult to speculate on the reasons – a high proportion of BME prisoners, and high levels of smoking, alcohol consumption and unhealthy lifestyles may all play a part.

Hypertension data reveal a lower observed number at Downview than expected. Given the high alcohol consumption, BME population and stressful living conditions of patients – identifying women with undiagnosed hypertension is important. The highest proportion picked up again came from SystmOne data, which is positive for future reporting – but this was still lower than expected.

Work is underway to link the cardiac network with prisons, for referral and care pathways, by NHS Surrey.

Epilepsy

Data at Downview for epilepsy show the observed range to be comparable to expected prison levels from the Birmingham toolkit, and this time the highest reporting came from the C wing chronic disease register, a possible indicator of good identification of disease.

It is unclear, however whether all epileptics are referred for standard investigations such as CT Head, and referral to a Specialist Nurse etc. This is especially important for a group of people (prisoners) who may drift in and out of prison without ever being adequately investigated for chronic diseases.

Recommendation: audit care of epilepsy against NICE guidance

Obesity, exercise and healthy eating

Comparing expected with observed levels of obesity and overweight in the table above, the expected levels for female prisons are *comparable to Downview*.

Further detailed data from the notes audit, for 53 women whose BMI was either recorded or could be calculated, are found below and shows that almost *half the women sampled* were either *overweight or obese.*

	Number of women per BMI category	Total number of women with BMI measured	% in each category
Healthy weight	24	53	45.3
Underweight	4	53	7.5
Overweight	13	53	24.5
Obese	12	53	22.6

These data show a real need for weight loss programmes. When combined with healthier food (a gap identified in the corporate work), and gym work (with gaps in gym instructor sessions), helping women to lose weight will help downstream illnesses such as diabetes, joint disease, mobility, cancer and heart disease.

Physical health gaps

Overall, several gaps and recommendations emerge:

- Review high level of antipsychotic prescribing of Mirtazepine, and antihistamine prescribing (Loratadine, cetirizine) to see whether the sedative side effects underlie high demand.
- Use the HPAG to promote smoking cessation and tackle drug use, especially to mitigate chronic respiratory illness such as asthma and COPD.
- Recommendation: audit care of epilepsy against NICE guidance
- Use of SystmOne to identify chronic disease such as hypertension and diabetes (in place and ongoing), ensure care pathways for chronic disease meet national standards, and refer all patients with chronic diseases for appropriate investigation (eg for epilepsy) .
- Effective programmes to enable weight loss, through healthier food in the canteen and use of the gym – to control related diseases such as Type 2 Diabetes, and prevent 'downstream' illness such as cancer and heart disease.

Infectious diseases and immunisations

The table below sets out the expected and observed disease prevalence for Hepatitis B, C and HIV, sexually transmitted infections (STI) and TB in the prison.

Infectious Disease	Expected prevalence	Expected number at Downview if CNA of 358	Observed prevalence	Observed number with CNA of 358
Hepatitis B infection	43/358 (12%)	43	0/67 (0%)[37]	0
Fully vaccinated against Hepatitis B	24.8-54.9%[38]	89-197	18/67 (26.9%)	96
Hepatitis C infection	39/358 (11%)[39]	39	9/358 (2.6%)[40]	9
HIV infection	4/358 (1.2%)	4	(withheld to ensure	16

[37] Reception notes audit March 2010 n=67.
[38] Plugge, Douglas & Fitzpatrick (2006). The health of women in prison. Study findings. Department of Public Health, University of Oxford.
[39] Birmingham Toolkit and also Weild AR, Gill ON, Bennett D, Livingstone SJM, Parry JV, Curran L (2000). Prevalence of HIV, hepatitis B, and hepatitis C antibodies in prisoners in England and Wales: a national survey. Communicable Disease and Public Health Vol 3 No 2: 121-6.
[40] IDTS statistics personal communication from IDTS Clinical Lead.

anonymity)[41]

Hepatitis B

The national prison-based Hepatitis B vaccination programme started in 2001, set against a background of 61% of injecting drugs users having been in prison, with only 40% vaccinated[42]. The program has been credited with reducing incidence of acute Hepatitis B in community intravenous drug users in the period from 2005-8.

In the last reporting period (Q4) for PHPQI, Downview achieved a vaccination coverage of 60%, with a rating of amber, an improvement from last year.

The proportion of women with a past history of vaccination is actually lower at Downview than expected, which adds impetus to the need to improve Hepatitis B vaccine coverage still further. We would also expect a higher prevalence of Hepatitis B infection than has been identified.

Hepatitis C

The number of women found to be positive for Hepatitis C is actually lower than expected (9 versus 39 expected). The recent capillary blood test at the April 2010 Information Fair similarly showed what we might assume to be spuriously low results (no positives out of 93 tests).

Hepatitis C is now part of the PHPQI indicators – with documentation of offering Hepatitis C screening to at-risk prisoners sought. Research from the male prison cluster on the Isle of Wight recommended that 'increasing awareness of the condition and the effectiveness of therapy may encourage more inmates to accept testing'[43], so there is a need to counsel and offer tests at opportune moments along the patient journey.

HIV

Of the 67 women whose notes were audited, a small number were HIV positive. Extrapolating this proportion to the whole prison we might expect to have 16 HIV positive women. This number is actually *higher than expected* from national prison data.

One explanation is that the high proportion of women from highly endemic countries may account for this. Similar opportunistic education of women in healthcare and other venues should be actively pursued so that cases are picked up early and referred to specialist services. Corporate work in addition has highlighted gaps with women not able to access specialist services as they are far from their specialist provider near their home.

Sexually transmitted infections and Chlamydia

Although published research showed that the majority of a sample of female prisoners had had two partners at most in the last year, 11.8% had had ten or more partners. Even more worrying is a range of estimates of women in prison who have been paid in the past for sex, from 15% of female prisoners[44] to 26.8%[45]. Given the high risk that this places women at prison represents an excellent opportunity for a comprehensive sexual health screen.

[41] Reception notes audit March 2010 of n=67 notes.
[42] Gilbert RL, Costella A, Piper M, Gill ON (2004). Increasing hepatitis B vaccine coverage in prisons in England and Wales. Communicable disease and public health Vol 7 No 4: 306-11.
[43] Skipper et al (2003) Evaluation of a prison outreach clinic for the diagnosis and prevention of hepatitis C: implications for the national strategy. Gut 52: 1500-1504.
[44] Weild et al (2000) prevalence of HIV, Hepatitis B, and hepatitis C antibodies in prisoners in England and Wales: a national survey. Communicable Disease and Public Health Vol 3 No 2: 121-6.
[45] Plugge et al (2006) The Health of women in prison.

In 2009/10, 44 Chlamydia tests were carried out at Downview (and JBU). The target for 2010/11 will be 150 tests, so there will have to be a significant increase in testing for Chlamydia (and all STIs). The lack of data and lack of specialist sexual health (GUM) provision to the prison points to a gap in provision.

Tuberculosis

Prisoners 'are known to be at increased risk of tuberculosis infection and disease'[46]. However, it is difficult to apply existing estimates of incidence and prevalence (which are not female-specific) to Downview. NICE guidance for TB states that in terms of screening, 'prisoners should be screened for TB by: a health questionnaire on each entry to the prison system'[47]. Currently there are no TB specific questions on the paper based reception screen, which should be addressed.

Immunisations

The vaccine requirements for the prison are set out below, as per PHPQI indicator 1.32 (Vaccination / immunisation policy).

Immunisation	Eligibility criteria	Number of women expected at Downview	Frequency	Added notes
Measles Mumps Rubella (MMR)	'MMR vaccine can be given to individuals of any age. Entry into…prison…provides an opportunity to check an individual's immunisation history'. See HPA guidance for prisons.[48],[49]	•	•	Depends on year of birth. Contraindications found at DH Green Book[50]
Diphtheria Tetanus Polio	See HPA guidance for prisons[51]	•	•	•
Meningitis C	Persons under 25 years[52],[53]	100 women if full CNA	•	•
Hepatitis A	For IVDUs[54]	•	•	•
Hepatitis B	All women, 716 with churn	•	•	•
BCG	Not routinely given to adults	•	•	•
Pneumococcal	Persons over 65 and persons in risk groups	Women aged 65 and over is small	Once only	See Green Book for risk groups (Table 25.1)[55].
Seasonal Flu	Persons aged 65 and over and persons in risk groups	Women aged 65 and over is small	Annually	See Green Book for risk groups (Table 19.2)[56]

[46] Anderson et al (2010) Tuberculosis in UK prisoners: a challenge for control. J Epidemiol Community Health; 64: 373-376.
[47] NICE Clinical Guidance 33 (2006) Tuberculosis. Clinical diagnosis and management of tuberculosis, and measures for its prevention and control.
[48] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_063649.pdf
[49] http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1209023458513
[50] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_063649.pdf
[51] http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1209023458513
[52] , http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1209023458513
[53] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_108821.pdf
[54] http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1209023458513
[55] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_115268.pdf
[56] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_107815.pdf

Human Papilloma Virus (HPV)	Vaccination is not routinely recommended for those aged 18 years or over[57]	•	•	•

The immunisation guidance provided by the HPA for prisons should be used to provide a basis for vaccination.

Infectious diseases and immunisations gaps

- Improve Hepatitis B vaccine coverage to green
- Ensure that women are educated and advised on testing for BBVs (Hepatitis B and C, HIV) at opportunistic times along their patient journey, not just at reception.
- Ensure that sexual health services address the high levels of risky behaviour and need, especially around HIV input. Ensure that specialist GUM provision is provided, with improved levels of Chlamydia testing.
- TB questions to be included within the SystmOne template.
- Ensure that women are appropriately offered vaccination in line with the HPA requirements above.

Mental health, self harm and suicide, learning disability

The observed and expected prevalence of mental illnesses at Downview are set out below.

Mental illness	Overall expected prevalence	CNA	Age stratified national data?	Expected number at DV (national female prison data)	Observed % Downview (reception notes audit n=67)	Observed % treated ie anti-depressant or anti-psychotic (Pharmacy audit)	Observed number Downview (If CNA of 358)
Depression	56.6%[58]	358	no	**203**	20/67(29.9%)	*78/358 (21.8%) note antidepressant AND antipsychotics*	**78 to 107**
Anxiety and panic attacks	42.4%[59]	358	no	**152**	4/67 (6.0%)	•	**21**
DSH – non suicidal self harm	10%[60]	358	no	**36**	14/67 (20.9%)	•	**75**
Suicide attempts	19%[61]	358	no	**68**	13/67 (19.4%)	•	**70**
Personality disorder	50%[62]	358	no	**179**	3/67 (4.5%)	•	**16**
Functional psychosis past	14%[63]	358	no	**50**	•	14/358 (3.9%)[64]	**14**

[57] DH Green Book http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087787.pdf
[58] Plugge et al (2006) The Health of women in prison: 43.
[59] Plugge et al (2006) The Health of women in prison: 43.
[60] Birmingham Toolkit female prisoner female data non age-stratified, for females
[61] HMIP 2006/7. Proportion of women who had attempted suicide during the year before custody. Short study on women offenders. Cabinet Office social exclusion unit, MOJ. 2009.
[62] Birmingham Toolkit non age stratified proportion for female prisoners
[63] Birmingham Toolkit non age stratified proportion for female prisoners
[64] Number of women in prison on an anti-psychotic, so not an exactly equivalent comparison with prevalence

year			

Mental health

From the data above, a lower number of women was observed with depression than expected. Further analysis of prescribing for depression from the notes audit shows that of the 20/67 depressed patients on admission, 6/20 (30%) were on antidepressants. Of these 6 women, 3/6 were on Mirtazepine, which has been highlighted as having desirable sedative properties and the 3/6 remaining patients were on a serotonin-specific re-uptake inhibitor (SSRI).

There also seems to be a lower observed prevalence of anxiety, personality disorder and psychosis than expected – if there is difficulty in identifying mental illness at reception this will need to be addressed.

Given the significant mental health needs of prisoners, and observed disease levels which are lower than expected, active case finding and implementation of Improving Access to Psychological Therapies (IAPT) must all contribute to improved service provision (amber on PHPQI 2009/10).

Recommendation: Improve case finding for depression and other psychiatric illness, and implementation of IAPT

Self harm and suicide

Although the number of women with a *history* of deliberate self harm (DSH) is higher at Downview than expected, the number of women with a history of suicide attempts is comparable to expected levels.

Information from partnership board shows recent issues around self harm and use of constant watches. In addition, issues around women who self harm by cutting have been highlighted in the section on health services. Anecdotal reports of an increase in self harm by ligaturing also highlights the need for vigilance.

Data from Safer Custody for March-May 2010 show the following picture of volume and nature of self-harm at Downview.

Month 2010	Number of self-harm incidents	Number of women	Highest frequency methods of DSH	Admitted to hospital?	ACCT opened for all episodes?
March 2010	77	8	Majority cutting/scratching or ligature	none	Yes (if not open already)
April 2010	53	7	Majority cutting/scratching or ligaturing	2	Yes (if not open already)
May 2010	54	9	Majority cutting/scratching or ligaturing	1 (but 3 'near misses' from ligatures see footnote)[65]	No, as one opened next day

[65] The 'near misses' refer to ligatures which were so tight they required oxygen and were then dealt with by in house healthcare department. Near misses are life threatening events. Decision is then taken by Healthcare as to whether hospital treatment is required.

The data above bring several interesting points to light:

- Crudely interpreted (if all women above are self-harming at the same rate) each woman is doing so at a rate of about 6 to 10 episodes per month.
- Most self harm is by either cutting/scratching or ligaturing.
- There is a low level of hospital admissions due to self-harm.

All women either had an open ACCT file, or one was opened at time of the episode – except for one case, this was flagged by the Safer Custody Officer and a file subsequently opened.

Recommendations:

- Clarify process for women on constant watch
- Increase healthcare and prison work on reducing self harm
- Ensure that ACCT file opened after all self harm episodes

Learning disability

Data from reception screening for disability identified 7 out of 348 women with a learning disability. The PHPQI asks that prisons identify patients with learning disability and produce a health action plan and annual health check. None of these are yet in place at Downview, and the PHPQI indicator was red for 2009/10.

Mental health, self harm and suicide, learning disability gaps

Recommendations:

- Improve case finding for depression and other psychiatric illness, and implementation of IAPT
- Clarify process for constant watch for women at risk of self harm.
- Increase healthcare and prison work on reducing self harm
- Ensure that ACCT file opened after all self harm episodes
- When DH guidance released, start screening prisoners for learning disability, and set in place health action plans and annual health checks

Substance misuse, IDTS, and alcohol

Substance misuse, IDTS, and alcohol

The last IDTS needs assessment was carried out for 2008/9. The needs assessment used data from June to August 2008. In that three month period, of the 104 new receptions to prison, 68/104 (65%) were drug users.

More current data from the IDTS team shows the following level of assessed need for drug services in the whole prison population (ie prevalence not new receptions):

Client groups	Number	Proportion at Downview (April 30 2010)
IDTS clients	n=43, comprising: Methadone n=35 (of which 10/35 reducing) Buprenorphine n=8 (of which 1/8 reducing)	43/342 (12.6%)
CARATs only	n=126 (not on scripts ie additional to 43 above) 87 'engaged'-undergoing courses and active work 39 'suspended' (i.e. known to have misused drugs but either not wishing to undergo courses, or completed courses)	126/342 (36.8%)
Total with history of drug misuse	169/342	169/342 (49.4%)

The data below show that observed levels of drug and alcohol misuse at Downview are consistently lower than expected, apart from cannabis use. This interpretation is difficult as it is based mainly on the notes audit – which looked only at reception screens, and may not be representative of the whole prison population.

Drug misuse	Expected prevalence (BirmTool-kit unless stated otherwise) female prisoner sentenced	CNA	Age stratified data?	Expected number at DV (using national female prisoner data)	Observed number, % DV (reception notes audit)	Observed number IDTS team and CARATs	Observed number DV (range) if CNA of 358
Drug user before prison	75.3%[66]	358	no	**270**	24/67 (35.8%)	169/342 (49.4%)	**128-177**
Opiates	23%	358	no	**82**	10/67 (14.9%)	•	**53**
Stimulants only	12%	358	no	**43**	4/67 (6.0%)	•	**22**
Cannabis only	5%	358	no	**18**	5/67 (7.5%)	•	**27**
Alcohol	42%[67]	358	no	**150**	16/67 (23.9%)[68]	•	**86**

Substance misuse, IDTS, and alcohol gaps

Although observed levels of drug and alcohol misuse are consistently lower than expected, the IDTS service on the whole works efficiently to address drug use. However, corporate work has highlighted an instance of concern about a *late review of drug misuse, with subsequent*

[66] Plugge et al (2006) The Health of women in prison: 29. Ever used drugs in 6 months before coming into prison.
[67] Plugge et al (2006) The Health of women in prison: 28. 42% of the sample of 500 women drank alcohol in excess of Government guidelines prior to imprisonment.
[68] Caveat that range of alcohol consumption documented, from patients with evidence of alcohol dependence, spirit consumption, and social drinking.

withdrawal symptoms. The needs are significant and this area will have to continue to be robustly funded to meet the huge needs of the population.

Recommendation - Unmet needs around alcohol provision will have to be addressed.

Women's health including pregnancy, cervical smears and breast screening

The National Service Framework (NSF) for 'women offenders' sets out the needs for females in prison. The key aspects for health are as follows: 'completing high quality needs assessments', addressing health inequalities for example in mental health, drugs and alcohol, and ensuring that women who have been involved in sex work can access specialist services[69].

Pregnancy and antenatal and TOP

There were no pregnant women documented in the reception notes audit – this is to be expected given that Downview is a training establishment. The small number of TOPs highlighted in the health service section initially raised concerns that family planning was not robust enough to take account of women who are eligible for ROTL. Placed in context, after discussion with the Head of Healthcare, the small number of TOPs (suppressed) was out of 160 women who were out on ROTL, a very small proportion.

Cervical smears and colposcopy

The expected numbers eligible for cervical screening are found in the screening section below. Detailed data from the notes audit shows that the proportion of women who had already had a smear within the correct time period was almost one quarter (16/67, 23.9%). Almost 40% of women had either a smear overdue, smear not recorded at reception, or had never had a smear in the past, which highlights a real need.

	Number of women	Total women sampled in notes audit	% of notes audit
Cervical smear overdue, not recorded at reception, or never had smear in past	26	67	38.8
Had smear <25 - unclear history	8	67	11.9
No smear but < 25 - not needed	17	67	25.4
Within correct time since last cervical smear	16	67	23.9

A number of women under 25 had had smears – although this is at first glance outside the correct age range, it is not possible to ascertain whether this was the result of a history of cervical dysplasia.

Breast screening

Expected numbers eligible found in the screening section below.

Women's health gaps

- Ensure that women invited for cervical smears are in appropriate age group or there is a medical indication for smear. Provide easy-read information on cervical smears with invitations, to reflect comments in corporate work.

[69] National Service Framework - Improving services to women offenders (2008) MOJ, NOMS.

Screening

Type of screening	Ages eligible	Frequency	Number at Downview eligible at baseline	Notes
Breast	47-73 years (from 2010)	Every 3 years	Approximately 67 women	Need to elicit via SystmOne, add churn
Cervical	25 to 64 years[70]	25: first invitation 25-49: 3 yearly 50-64: 5 yearly 65+: only if none since age 50 or recent abnormal test	Approximately 259 women aged 25 to over 64 at Downview eligible on basis of age if we assume full CNA:	Churn would give approx 500 smears per year. Activity data circa 44 smears per month, so 528 per year.
Bowel	60-69 years	2 yearly	7 women	Need to also factor x2 for churn, n=14
Diabetic retinopathy	Aged over 11 years old with diabetes	1 yearly	12 women	Assume prevalence of 3.3%, CNA of 358 Need to also factor x2 for churn, so n=24
Vascular	40-74 years	5 yearly	Not implemented in Surrey so not applicable	•

Data above show that the volume of cervical screening is in line with expected levels for the ages at Downview.

Other Screening gaps

Recommendation: The prison healthcare must ensure that women at Downview are offered screening in line with above requirements as there is no current programme for bowel screening or vascular screening.

Oral health

Need for dentistry in prisons is great – estimated to be four times higher in the prison population than in the general population of the same background[71]. National research showed that only half of women in prison had seen a dentist in the last two years as per national recommendations[72]. A Surrey prison dental needs assessment is planned as part of a SE Coast approach in the future.

Even though the canteen list shows that toothpaste and toothbrushes are relatively expensive, an interim report for Surrey in 2009 recommended that toothpaste and tooth brushes should be free for prisoners, and that the toothpaste they buy should be high fluoride. In addition, the toothpaste for patients with high fluoride needs (eg IDTS patients) should be high fluoride[73].

[70] http://www.cancerscreening.nhs.uk/cervical/#eligible
[71] Strategy for modernising dental services for prisoners in England DH & HMPS 2003
[72] Plugge et al (2006) The Health of women in prison: 42.
[73] Dentistry in Surrey prisons- an interim report on needs, demands and performance (Aug 2009). NHS Surrey Dental Public Health Consultant.

Waiting times highlighted in the high DNAs for appointments in the health services section, and the corporate work and by amber status in the PHPQI this year 2009/10.

Oral health gaps

- Reduce waiting times for dentistry in line with PHPQI, and reduce DNA to appointments
- Provide free or cheap toothbrushes / toothpaste for prisoners, and ensure health promotion work for dentistry is available.

Smoking

	Expected female prisoners %	CNA	Expected number at DV (using national female prisoner data)	Observed DV (IMR reception notes audit)	Observed DV (if CNA n=358)
Smoking	85%	358	**304**	40/67 (59.7%)	**214**

We see from the data above that there is a lower observed level of smokers at Downview than expected from national prison data.

Smoking gaps

- Efforts to identify and offer smoking cessation to smokers should be increased.
- Combined with health service data which shows that the prison does not report data to NHS Surrey, work should be done to link up PCT data collection with that in prison.
- Efforts should also be made, highlighted by the corporate work, to reduce prison staff smoking in areas shared with prisoners.

Foreign national women

The foreign national female prison population is very important, as such women may by isolated by virtue of a language barrier. HMIP notes that '16% of self-inflicted deaths in 2008 were of foreign national prisoners, although in that year foreign national prisoners represented 14% of the population in prison'.[74] Such women may also come from countries with higher disease burden of BBVs, or poorer health services.

Using a small sub-analysis of the 19 out of 67 foreign national women whose notes were audited, we see that their mean age was 31 years.

In terms of disease burden, these women of foreign national origin had the following profile compared with all women in the notes audit.

[74] HM Chief Inspector of Prisons for England and Wales (2009) Annual Report 2007-08, London: HMIP

Disease	Prevalence in foreign nationals n=19	Prevalence in non-FN women from notes audit n=48	Significant difference between FN and non-FN? Z test
Asthma	2/19 (10.5%)	11/48 (22.9%)	No (Z=-1.1588, p=0.1230)
CHD/Hypertension	1/19 (5.3%)	7/48 (14.6%)	No (Z=-1.0604, p=0.1446)
Depression	***1/19 (5.3%)***	***19/48 (39.6%)***	***Yes (Z = -2.77, p=0.00280)***
Drug user	***3/19 (15.8%)***	***21/48 (43.8%)***	***Yes (Z=-3.24, p=0.00060)***
Haemoglobinopathy	1/19 (5.3%)	2/48 (4.2%)	No (Z= 0.196, p=0.42)
Cervical smear overdue, not recorded at reception, or never had smear in past	7/19 (36.8%)	19/48 (39.6%)	No

We see from the above data that foreign national women had significantly lower levels of depression than non foreign nationals. It is difficult to judge whether this is truly a lower prevalence as there may be cultural issues or stigma associated with depression that lead to under reporting. Foreign national women were also significantly less likely to be drug users.

Over 50s women

The NSF for older people highlighted eight (8) key standards[75] as follows which have been related to prison performance:

- rooting out age discrimination – there is a Diversity Manager for all strands of diversity
- person centred care (see above)
- intermediate care and general hospital care (not applicable)
- stroke – pathways
- falls – aids/adaptations are sourced after women undergo the older person's assessment
- mental health – see above
- promotion of health and active life in older age – health promotion action group

As only four women (4/67) in the reception notes audit were aged over 50, and the corporate focus group for over 50s did not go ahead as planned, it is difficult to draw conclusions about the health needs of women over 50 – although they must be *included in the HPAG work*.

[75] NSF for older people (2000). DH. Executive summary.

Recommendations summary from disease headings and gap analysis

Disease area	Recommendation	Owner
Pharmacy	Review high level of antipsychotic prescribing of Mirtazepine, and antihistamine prescribing (Loratadine, cetirizine) to see whether the sedative side effects underlie high demand.	Pharmacy
Physical health	Use the HPAG to promote smoking cessation and tackle drug use, especially to mitigate chronic respiratory illness such as asthma and COPD.	Healthcare (HC)
	Use of SystmOne to identify chronic disease such as hypertension and diabetes (in place and ongoing), ensure care pathways for chronic disease meet national standards, and refer all patients with chronic diseases for appropriate investigation (eg for epilepsy) .	NHS Surrey, prison, Healthcare
	audit care of patients with epilepsy against NICE guidance	NHS Surrey, Healthcare
	NHS Surrey to link Cardiac Network for cardiac pathways	
	Effective programmes to enable weight loss, through healthier food in the canteen and use of the gym – to control related diseases such as Type 2 Diabetes, and prevent 'downstream' illness such as cancer and heart disease.	healthcare, prison
Infectious diseases	Improve Hepatitis B vaccine coverage to green	Healthcare (HC)
	Ensure that women are educated and advised on testing for BBVs (Hepatitis B and C, HIV) at opportunistic times along their patient journey, not just at reception.	HC
	Ensure that sexual health services address the high levels of risky behaviour and need, especially around HIV input. Ensure that specialist GUM provision is provided, with improved levels of Chlamydia testing.	HC (SCH)
	TB questions to be included within the SystmOne template.	NHS Surrey, HC
	Ensure that women are appropriately offered vaccination in line with the HPA requirements above.	HC
Mental health	Improve case finding for depression and other psychiatric illness, and implementation of IAPT	Healthcare
	Clarify process for constant watch for women at risk of self harm.	Prison, healthcare
	When DH guidance released, start screening prisoners for learning disability, and set in place health action plans and annual health checks	NHS Surrey, Healthcare
IDTS and alcohol	Address unmet needs around alcohol service provision.	NHS Surrey and then Healthcare
Women's health	Ensure that women invited for cervical smears are in appropriate age group or there is a medical indication for smear. Provide easy-read information on cervical smears with invitations, to reflect comments in corporate work.	Health care
Screening	Ensure that women at Downview are offered screening in line with national requirements as there is no current programme for bowel screening or vascular screening.	Healthcare
Dentistry	Reduce waiting times for dentistry in line with PHPQI, and reduce DNA to appointments	Healthcare & prison
	Provide free or cheap toothbrushes / toothpaste for prisoners, and ensure dental health	

	promotion taking place	
Smoking	Efforts to identify and offer smoking cessation to smokers should be increased. Combined with health service data which shows that the prison does not report data to NHS Surrey, work should be done to link up PCT data collection with that in prison. Efforts should also be made, highlighted by the corporate work, to reduce prison staff smoking in areas shared with prisoners.	Healthcare & prison & NHS Surrey
Older women	To be included in the HPAG work	HPAG

REFLECTION ON HNA

In terms of the corporate work, a focus group for foreign national women and over 50 year-olds had been planned but was cancelled due to logistical difficulties. This would have allowed a rounded picture of such women to be obtained, especially for foreign national women who represent a substantial proportion of the prison population.

The epidemiological work has been age stratified to match Downview's structure as far as possible, so that expected prevalences are as accurate as possible.

The use of a time consuming reception notes audit may not be representative of the prison population, at just under 20% of notes sampled. This methodology, however (for HNAs) should become obsolete as SystmOne is now running at Downview and all of the other Surrey prisons.

ANNEXES

Annex 1 – PHPQIs 2009/10

Red scores on PHPQI 2009/10

- Financial governance (1.10)
- HNA (1.15)
- Comprehensive range of services (1.16)
- Services for adult women (1.24)
- Learning disability (1.31)
- Vaccination policy (1.32)
- HPAG (1.35)

All scores PHPQI 2009/10

	PRISON NAME (select from dropdown box in cell C1)	Downview
	Input your new or changed Prison name in Cell C6 only if Prison name is NOT on drop down list in Cell C1	
	Prison Category	C Training female
	Prison healthcare manager Name	Mandy Darville
	Telephone no.	0208 196 6422
	Email addr	Mandy.Darville@hmps.gsi.gov.uk
	PCT contact Name	Nicky Croft
	Telephone no.	01372 201673
	Email addr	Nicky.Croft@surreypct.nhs.uk
	Validated at Regional Review Meeting	Yes
	Date of Regional Review (DD/MM/YYYY)	10/05/2010
Ind.No		
1.1	Patient safety	Green
1.2	Healthcare environment	Green
1.3	Medicines management	Amber
1.4	Chronic disease and long term conditions care	Green
1.5	Continuity of case management	Green
1.6	Discharge planning	Green
1.7	Clinical governance	Green
1.8	Corporate governance	Green
1.9	Information governance	Green
1.10	Financial governance	Red
	Accepted Finance Plans based on PHDP and Prison Healthcare Budget	No
	Spend against budget is transparent and maintained within acceptable limits	Yes
	Prison and PCT processes are in place to review expenditure against plan	Yes
1.11	Workforce plan	Green
1.12	Personal development plans	Green
1.13	Equality and Human Rights	Amber

1.14	Service user involvement	Amber
1.15	Health needs assessmewnt	Red
1.16	Comprehensive range of services	Red
1.17	Access and waiting times	Green
1.18	Prison dentistry	Amber
1.19	Substance Misuse Activities - IDTS	Green
1.20	Alcohol Screening, Intervention and Support	Amber
1.21	General health assessment	N/A
1.22	Secondary Health screen - Prison Transfers	Green
1.23a	Services for Children and Younger people (under 18s only)	N/A
1.23b	Services for Older Adults (not YOI Estate)	Amber
1.24	Services for Adult Women	Red
1.25	Primary care mental health	Amber
1.26	Suicide prevention	Amber
1.27	Care Programme Approach Audit	Green
1.28	Access to specialist mental health services	Green
1.29	Section 117	Green
1.30	Mental Health transfers	Green
1.31	Learning Disability	Red
1.32	Vaccination/immunisation policy	Red
1.33	Hepatitis B Vaccination of Prisoners	Amber
1.34	Hepatitis C	Amber
1.35	Health Promotion Action Groups	Red
1.36	Sexual Health	Amber
	Means of accessing condoms	Yes
	Access social/life skills modules on SRE education or similar	No
	Access to GUM clinic in prison	Yes
	Access to chlamydia screening programme	Yes
	Access to barrier protection and lubricants	Yes
1.37	Communicable disease control	Green
1.38	Exercise	Green

TOTAL GREEN	19
TOTAL AMBER	11
TOTAL RED	7
Total Indicator Replies (Should be 38 in total)	37

Annex 2 Birmingham Toolkit

This model comprises a:

- Corporate approach – collating and analysing stakeholder views from both prison staff and prisoners
- Comparative approach – comparing health services with those at similar prisons
- Epidemiological approach – estimating disease burden using health data
- Service descriptions – building a picture of current provision

Annex 3 - Steering group membership and acknowledgements

Steering group membership

- Prison: Governors Emily Martin, Governor Julie Blacklock, Julie Evans (Head of Activities)
- SCH: Mandy Darville, Daniel Chikanda, Becky Wall, Susan Davis
- IDTS: Julia Berryman, Darren Thomas
- Dental: Dr Susanna Mayne and Dr Jane Powell
- Mental Health: Mark Girvan
- Pharmacy: Nicky Evans, Khurshid Choudhury
- NHS Surrey: Jo-Anne Bradford, Nicky Croft, Rajinder Nanu Chumber, Christine Raven
- SCH: Linda Murray

Acknowledgements

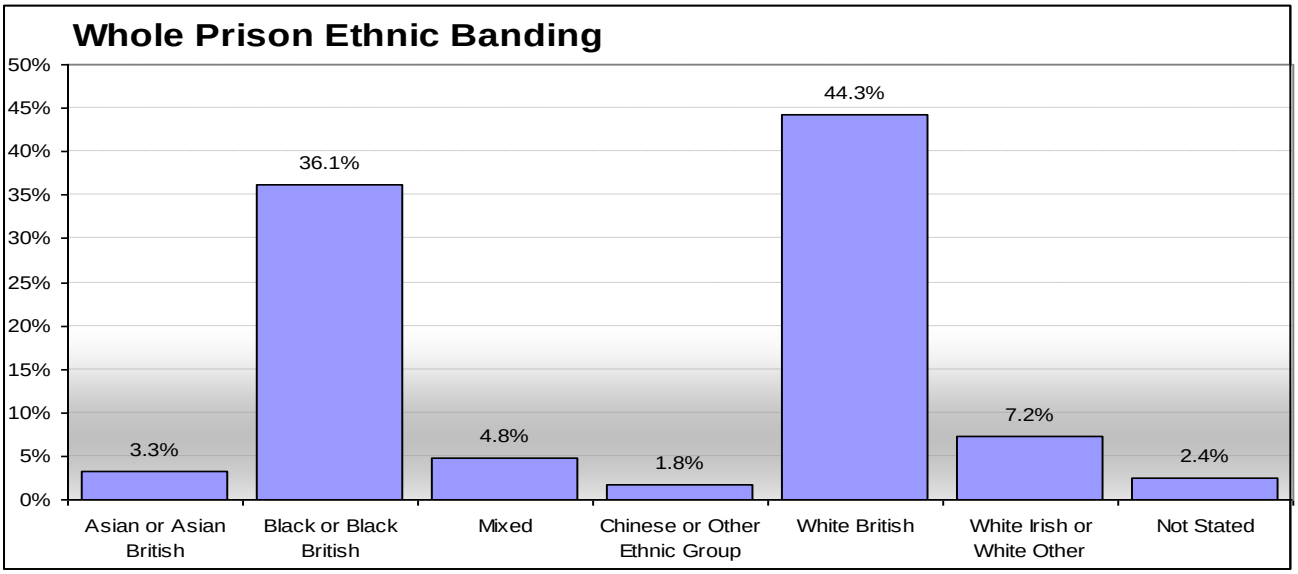
With thanks to the prison and healthcare teams, for allowing and facilitating the HNA.

Special thanks are given to the following individuals:

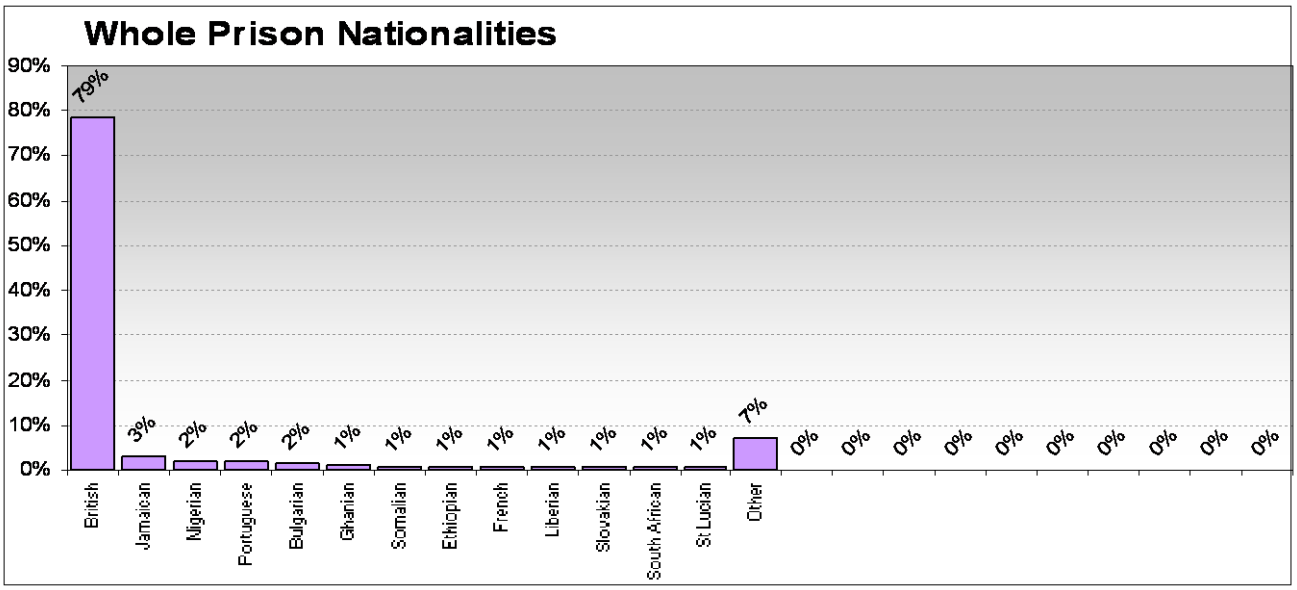
- HMP YOI Downview Senior Management: Governor Emily Martin and Governor Julie Blacklock, Governor Sally Hill, Head of Activities Julie Evans, DLO Jackie Gourley, and SO Sam Freeman (Safer Custody)
- HMP Downview Healthcare Team: Mandy Darville (Cluster Manager), Daniel Chikanda (Deputy Head of Healthcare), Sister Becky Wall, and Paul Darville (Administrator)
- IDTS: Darren Thomas Clinical Nurse Lead
- Dentistry: Susanna Mayne
- Mental Health In-Reach: Mark Girvan
- Pharmacy: Khurshid Choudhury
- NHS Surrey: Christine Raven (support with focus groups)
- NHS Surrey: Public Health Development Worker Miss Rajinder Nanu Chumber (Corporate work)
- The women at HMP Downview for sharing their views and time

Annex 4 - Demographic data

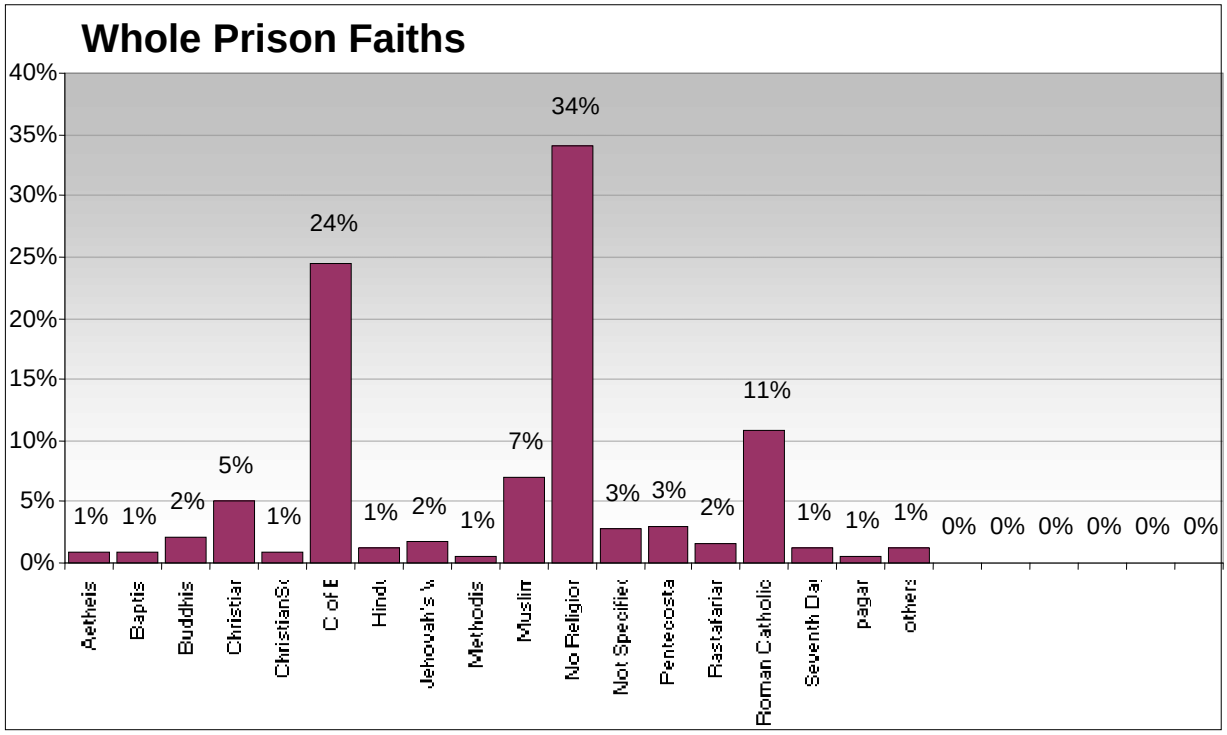
Ethnicity



Foreign nationals



Religion



Religion of women at Downview Source: DLO March 2010

Annex 5 - Detailed healthcare descriptions

A wing

This wing contains the reception area for new arrivals, and contains one clinical room and a dispensary. A wing has a gated door leading into a narrow hallway. A hatch to the dispensary is found on the right hand side, with a machine for iris recognition for Methadone dispensing.

One further clinic room (with a small 'disposable' metal sink with manual filling and draining of water) is found through another locked gate, as well as a nurses' office with locked patient files, a file store room, and a computer room for data entry. Turning right from the hatch, there is a waiting room for the dispensary, and a clinical room (with X-ray facility - used by the dentist, optician, physiotherapist and chiropodist) and a staff kitchen. There is one vaccine fridge in A wing.

A wing also holds the reception area where women are first assessed on arrival, a well lit and noisy room with a central reception desk, and glass-windowed rooms off this main reception area in which women are seen in privacy.

A wing has 2 nurses on duty each day.

A wing has a servery for food and sofas on which women can eat their food – or they can eat in their cells.

B Wing

B wing contains the segregation unit which accommodates up to 7 women, and is found down a hallway to the right on entry to the wing. There is a further large communal area with dining tables, on which women can eat their meals. B wing holds prisoners over 50 years of age, and kitchen staff. There is no examination couch for patients in the B wing healthcare office – a stable-door hatch is used to dispense medications out of the nurses' office, there is a locked medication cupboard, a desk, and a locked filing cabinet for notes.

C wing

There is a large clinical room containing a large sink (no mixer taps) and extensive counter tops. Two stable doors are used from which to dispense medications.

A further nurses' office contains large filing cabinets for notes (locked), a sink (without mixer taps), shelving, and a computer. There is no examination couch in C wing.

Defibrillators are located in the healthcare wing of each block (except for D wing the resettlement unit).

D wing

This is the resettlement wing, and was not visited. There are no healthcare rooms in D wing. Any women residing in D with healthcare problems present to B wing healthcare for consultation.

Annex 6 - Corporate needs assessment

Prisoners

The corporate health needs assessment was carried out in May 2010 by the NHS Surrey Public Health Development Worker for Prisons and Learning Disability.

'Time TV' (the HMP Downview internal television channel) was used to inform women of the health needs assessment, and encourage them to complete questionnaires and participate in focus groups.

Prison officers and a member of the public health team distributed the questionnaires to all prisoners via a cell drop. In total, approximately 340 questionnaires were distributed through the cell drop and an extra 50 were put out at the prison Health Fair on 28 April 2010. A sealed box was put in every wing, and these boxes were collected by a member of the public health team one week after the questionnaires were distributed. Based on the number of questionnaires that were disseminated, the response rate was 28% (101/358) for the surveys.

At the prison Health Fair described above, the Public Health Development Worker (PHDW) for Prisons and Learning Disability directly engaged with prisoners to encourage participation in the needs assessment. To preserve confidentiality, prisoners were asked to complete the questionnaires and register to attend a focus group, rather than share their views openly at the Health Fair.

The two focus groups were organised by NHS Surrey's Public Engagement Manager and facilitated by the PHDW and the Public Engagement Manager. Although 18 prisoners signed up for the focus groups, on the day actual of the focus group only seven (7) prisoners attended. The low attendance may have been the result of logistic problems with movement slips.

Summary of prisoner participation

- In total 390 questionnaires were distributed through the prison. The response rate for the questionnaire was approximately 28% (101/358).
- Eighteen prisoners signed up to attend a focus group, although only 7 eventually participated in the focus groups.

Healthcare staff - Internal

Healthcare staff at HMP Downview were encouraged to participate in the corporate health needs assessment by the PHDW meeting with them first to explain the rationale for the needs assessment. The healthcare manager and deputy healthcare manager also met with the PHDW individually to set the scene for the HNA.

An envelope contacting a questionnaire, covering letter and a prepaid envelope was disseminated to all healthcare staff, by the healthcare administrator.

A focus group was organised for the 7th May 2010 by the healthcare managers. All healthcare staff were encouraged and supported to attend. The focus group was delivered in the healthcare block during a

lunch break and no healthcare managers were present. The focus group template used in all the other Surrey prison health needs assessments was employed.

Summary of internal healthcare staff participation

- Twenty healthcare questionnaires were disseminated to internal healthcare staff. The return rate was 20% (4/20).
- 78% (7/9) of the internal healthcare staff present on the day participated in the focus group.

Healthcare Staff - External

Thirteen visiting practitioners and the GP provider service were given the opportunity to share their views through a questionnaire. The questionnaire used in all the other Surrey prison health needs assessment carried out in 2009/10 was employed.

An email with covering information about the corporate health needs assessment and the questionnaire was sent individually to each visiting practitioner. As the initial response was low, a month later the email was resent and external practitioners were encouraged to give their views.

Summary of external health staff participation

- 23% (3/13) external healthcare providers completed and returned a questionnaire, two by email and 1 by post.

Prison Staff

At the time of the health needs assessment, HMP Downview was experiencing a staff shortage and it was decided at the steering group to elicit the views of prison staff solely through questionnaires.

In total, 70 questionnaires were disseminated to prison staff. This was done through the Human Resources team and some questionnaires were put in the wing office. To encourage prison staff to return the completed questionnaire a box with a large poster above it was put on the front gate.

Three prison staff (one uniformed, two non-uniformed) kindly participated in an hour-long interview and a further three uniformed prison staff gave very some brief feedback. The focus group schedule that was used in all the other Surrey prison health needs assessment carried out in 2009/10 was converted into an interview format.

Summary of prison staff participation

- 11% (8/70) competed questionnaires
- 3 prison staff participated in an interview
- 3 prison officers gave brief feedback

Annex 7 - Pharmacy

Patient ready packs

IPRATROPIUM 250MCG NEBULES	**CO-AMOXICLAV 625MG X 21**	**PENICILLIN VK 250MG TABLETS X 28**
SALBUTAMOL 2.5MG NEBULES	DICLOFENAC 50MG TABLETS X 21	**QUELLADA**
SALBUTAMOL 5MG NEBULES	ERYTHROMYCINE 250MG X 28	**SALBUTAMOL INHALER**
AMOXYCILLIN 3G SACHETS X 2	FLUCLOXACILLIN 250MG CAPSULES X 28	**SODIUM CROMOGLYCATE EYE DROPS**
AMOXYCILLIN 250MG CAPSULES X 21	FLUCLOXACILLIN 500MG CAPSULES X 28	**TRIMETHOPRIM 200MG TABLETS X 6**
AMOXYCILLIN 500MG CAPSULES X 21	FLUCONAZOLE 150MG X 1	**TRIMETHOPRIM 200MG X 14**
BECLOMETHASONE NASAL SPRAY	GTN SPRAY	**VOLUMATIC SPACER**

BECLOMETHASONE 100 INH (CLENIL)	IBUPROFEN 400MG X 21	
CEFALEXIN 250MG CAPSULES X 28	LEVONELLE 1500MG TABS (+ C WING N/S)	
CHLORAMPHENICOL EYE OINTMENT	LYCLEAR CRÈME RINSE	
CHLORHEXADINE MOUTHWASH	MEFENAMIC ACID TABLETS 500MG X 9	
CLORTRIMAZOLE COMBI PACK	METRONIDAZOLE 1G STAT (5X400MG)	
CLORTRIMAZOLE 200MG PESSARIES X 3	METRONIDAZOLE 200MG TABLETS X 21	
CO-AMOXICLAV 375MG X 21	METRONIDAZOLE 400MG TABLETS X 21	
	NYTOL HERBAL TABLETS X 14	

Homely remedies

ACICLOVIR CREAM 2G	**LOPERAMIDE 2MG X X16**
ANUSOL 23G	**PARACETAMOL 500MG X16**
BONJELA	**POTTERS PASTILLES**
CLOTRIMAZOLE CREAM	**SENNA 7.5MG X6**
CYMALON SACHET	**SODIUM BICARBONATE EAR DROPS**
DIORALYTE SACHETS X6	**TRANSVASIN HEAT RUB**
EURAX CREAM	**YELLOW SOFT PARAFFIN 15G**
GAVISCON COOL X16	**MYCIL**
IBUPROFEN 200MG X12	

Annex 8 - Corporate results 'one change' - prisoners

'One change'			
		Q	FG
Diet	• 28% (28) inmates felt that the diet at HMP Downview needed to be changed	●	
Health care staff	• 8% (8) of inmates felt that the attitudes of healthcare staff towards inmates needed to be improved	●	
	• To be believed by healthcare staff - to go to them with a health complaint and not feel confronted.		●
	• More empathy and support from healthcare staff		●
Access	• 3% (3) felt that medication that they were prescribed on the outside needed to be continued in HMP Downview.	●	
	• Systems for reporting tests results to prisoners		●
	• 10% (11/101) of prisoners felt that the waiting times for healthcare could be improved	●	
	• If having an external appointment, appropriate preparation/communication		●
Communication	• Prisoners felt that the communication between prison staff and healthcare staff could be improved.		●

Annex 9 - Corporate results – healthcare staff and prison officers detailed outputs

What works well in healthcare?	Internal	External	Prison staff
Triage system	●	●	●
Communication from some healthcare staff	●		●
Communication between healthcare staff	●		
Healthcare team well established	●		●
Healthcare team have good support structures	●		
Leadership of the team	●		

What are the main health concerns of Prisoners in HMP Downview?	Internal	External	Prison staff
Substance misuse	●	●	●
Mental health- depression, low moods	●	●	●
Chronic pain		●	
Poor dental health	●	●	●
Poor diet- food is high in fat and poor in nutritional content	●	●	●
Not receiving medication on time		●	●
Missing external hospital appointments due to prison regime	●	●	●

Good examples of how the health needs of prisoners in HMP Downview are met	Internal	External	Prison staff
Health care triage is prompt and inmates are seen quickly	●	●	●
Healthcare look at long term health needs of the prisoner	●		

Lots of health services available that are more accessible than the outside	●		●
Gynaecologist visits and does family planning for women looking at long term contraception	●		
Well woman clinic in HMP Downview coordinated by a healthcare nurse	●		
Chlamydia screening kits readily available for under 25s	●		●
Reception screening works very well	●		●
Stop smoking clinic available	●		●

Views on Healthcare staff	**Internal**	**External**	**Prison staff**
Poor relationships between internal healthcare; and the external healthcare and prison staff	●	●	●
Healthcare staff are carrying out lots of administration work that reduces time with patients		●	
Nurses provide feedback and where necessary share information to support the delivery of treatment	●	●	
Healthcare staff work very hard	●	●	●
Some healthcare staff don't treat prisoners sympathetically			●
Prison staff do not understand that prison healthcare capability is limited, so that prisoners have to stay in hospital for medical reasons	●		
Healthcare staff are not prompt in providing support, or following up queries			●

Views on Prison staff / regime and food	**Internal**	**External**	**Prison staff**
Good partnership working between internal healthcare staff and officers	●		●
Governors are very supportive of the healthcare team	●		

Senior management are not supportive of healthcare (in terms of room allocation) and do not carry out essential works required to deliver a clinic within the regulations		●	
Prison staff do not promptly deliver appointment slips which results in a high DNA rate		●	
If short staffed the gym staff are deployed to the wings, so gym is closed	●		●
Sometimes prisoners miss hospital appointments due to prison staffing and the prison regime	●	●	●
Prison provide officers to do bed watch- funded by healthcare, however this leave the prison short staffed	●		●
Diet			
Food is very high in fat and lacks nutritional content	●	●	●
Lack of availability of fruit and vegetables	●		●
Medical diets inappropriately given to prisoners by canteen staff	●		●

	Internal	**External**	**Prison staff**
Mental health			
Prisoner based listener service is well organised	●	●	●
Prisoner based listener service is easily accessible and well used by prisoners	●		●
The “In reach team” work really well- readily offer support, advice and assistance	●	●	●
Self harm is <u>under reported</u> due to prisoners being able to self manage via first aid / dressing packs			●
Healthcare staff <u>don’t routinely follow up self harm</u>			●

Long term conditions	**Internal**	**External**	**Prison staff**

If prisoner is on treatment for HIV, procedures to ensure that they are kept with usual hospital if practicable	●		●
No structured support for prisoners with long term conditions such as diabetes, heart disease cancer		●	●

Other areas	**Internal**	**External**	**Prison staff**
Dentist			
Long waiting times	●	●	●
History of cancelled appointments	●		●
Medication			
Medication is taken from prisoners when they arrive in HMP Downview and re-prescribed by the doctor, as a result	●		●

some women go without medication for a few days			
The feeder prisons don't always prescribe similarly to the Surrey prisons preferred prescribing list - and the prescribing is patchy as a result, so some women are unable to continue their medication in HMP Downview. The doctor will then prescribe an alternative medication in line with the Surrey preferred prescribing list	●	●	
Optician			
Long waiting times, and prisoners are given glasses that they refuse to wear because the frames are "hideous"	●		●

	Internal	**External**	**Prison staff**
Why do you feel the health needs of prisoners in HMP Downview are not met?			
Health services are under-commissioned	●	●	
Healthcare staff do not do any regular preventative work		●	●
The poor cooperation from prison staff and healthcare management makes it hard to deliver good quality services		●	
Acute illnesses are not treated as priority		●	●
There are long waiting times to see a doctor	●	●	●
Prisoners wait too long to see a dentist	●	●	●
Prisoners wait too long to see an optician	●	●	●
prisoners often miss external appointments that they have waited a long time for due to short staffing at the prison, and security	●	●	●
There was a shortage of nurses to deliver smear tests, now catching up.	●		
Smear tests requested by women under 25, but unable to do them (unless exceptional circumstances) due to the guidelines	●		
Prisoners don't receive healthcare test results promptly	●	●	●

A & B wing, no officer during medication time and prisoners often cause a disruption resulting in healthcare staff for their safety, shutting the hatch	●		
Well woman clinic isn't advertised			●
The clinical areas are filthy		●	

What could be done to improve the health of prisoners in HMP Downview?	**Internal**	**External**	**Prison staff**
Improve the support by prison and healthcare management staff to visiting clinicians.		●	
Provide administration support to visiting clinicians		●	
Better management of healthcare appointment allocation and delivery of healthcare slips,		●	●
Better management of healthcare appointments for prisoners on ROTL and day release			●
Clinical areas and waiting areas to be cleaned regularly		●	
Awareness session for officers on the management of LTC such as diabetes	●	●	●
Awareness session for health care staff on the management of LTC such as diabetes		●	●
Better investigation of healthcare complaints		●	●
Give prisoners more information about test results		●	
Support prisoners to attend external hospital by addressing the current issues	●	●	●
Better continuity of healthcare- when prisoners enter and leave the prison		●	●
A system to meet the QOF targets in the prison		●	
Improved working between healthcare team and Disability Living Officer on a support plan for prisoners with disabilities.			●
Up to date healthcare board on every wing with information about health care services			●
Healthcare information in different formats in residential parts of the prison			●

Partnership working between healthcare team and the catering manager to support inmates that require a special diet.	●			●
Better diet- prepared in a healthier manner, and of better quality	●	●		●
Screening- smear needs to be information with the appointment letter				●
Evaluation and monitoring of the use of pre-prepared dressing / first aid packs, with set guidance on their use			●	
All staff promoting and reinforcing good mental health- e.g.: encouraging women to take pride in their appearance (in turn this will motivate them to being more proactive and improve MH and motivation)	●		●	
Inmates should have more opportunity to take more fresh air during the evenings and weekends.			●	

Authorship

Please ensure that this document is clearly referenced if used in future.