# HMP Coldingley
# Health Needs Assessment Refresh 2012

**NHS Surrey Public Health Team**

**October 2012**

# Contents

# Executive Summary

## Background

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

## HMP Coldingley

Coldingley was opened in 1969 as a Category B training prison. In 1993 it was re-designated as Category C training prison. Coldingley is focused on the resettlement of prisoners. It provides a framework to support the achievement of realistic resettlement goals by offering opportunities to prisoners willing to work hard and accept responsibility for achieving those goals.

There was a small decrease in the number of prisoners entering the prison in 2011- there were 603 new receptions. Prisoners at HMP Coldingley are mostly between 22-40 years old, although there were increases this year in prisoners aged 18-21 and over 50's (up to 8.5%). There is a high proportion of Black and Minority Ethnic prisoners (43%) although the number of foreign nationals has reduced to 4%.

## Methods

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

## Areas of Recommendation

### Long term conditions

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

### Communicable Diseases

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

### Oral Health

Dental waiting times are an ongoing problem. The data should be regularly reviewed and major service changes should be undertaken if the recommended waiting times cannot be met.

## Mental Health

It is recommended that the service should monitor data on ethnicity and the outcomes of referrals.

## Health Improvement

The Health Promotion Action Group should be improved and the action plan renewed. Smoking remains a problem with no service review having taken place since the 2010 HNA, and no data being submitted to the Surrey Stop Smoking Service. This should be a priority. More data on physical activity should be collected, and the new physical activity guidelines should be promoted. The coverage for bowel screening should be improved and the new AAA screening programme implemented. NHS Health Checks have been implemented successfully, and it is recommended that this programme continue.

# 1 Introduction

## 1.1 Background

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

## 1.2 Health Needs Assessment

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

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

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

## 1.3 Methods and Structure of this Paper

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

# 2. Prison Profile

There have been no significant changes to the number of prisoners (or capacity) in HMP Coldingley since 2010. The demographic profile can change for a number of reasons and it should be monitored regularly to ensure services are meeting the needs of prisoners.

In 2012 the population of HMP Coldingley was 493. The table below shows changes since 2005. Any differences in population in other sections of the document (e.g. physical health) are due to some prisoners still being counted on SystmOne although they have left the prison. There were 603 new receptions into HMP Coldingley in 2011, which is less than the 672 estimated receptions in 2010, indicating a slightly more stable population.

*Table 1: Changes in HMP Coldingley operational capacity & occupancy*

| | 2005 | 2010 | 2012 |
|---|---|---|---|
| **CNA** | 370 | 494 | 493 |
| **Operational capacity** | 390 | 513 | 513 |

Source: HMP Coldingley

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

### Age

The age of prisoners in HMP Coldingley has changed since the 2010 HNA, with decreases in prisoners age 22-30, and an increase in 18-21 and prisoners over 50 years old. The table below shows the age groups of prisoners in 2010 and 2012.

*Table 2: Prison population in % by age group*

| Age Group | 2010- estimated | | 2012 | |
|---|---|---|---|---|
| | Number | % | Number | % |
| 18-21 | - | - | 15 | 3% |
| 22-30 | 198 | 39% | 172 | 32.5% |
| 31-40 | 176 | 35% | 180 | 34% |
| 41-50 | 106 | 21% | 115 | 22% |
| 51-60 | 22 | 4% | 35 | 7% |
| 61-70 | 5 | 1% | 8 | 1% |
| 70+ | - | - | 3 | 0.5% |

Source: SystmOne (total population 528)

### Ethnicity

The BME population in HMP Coldingley is 43%, which is the same as the population in 2010. This is higher than the national prison BME population of 28%. After White British (58%), the most common ethnic groups are Black Caribbean (11%) and Other Mixed Background (8%).

When the 2009 HNA was completed the BME categories were different to the categories available for this refresh. Therefore no comparator had been made between the 2009 and current BME representation.

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

*Table 3: Prison population by ethnicity (number of prisoners)*

| Ethnicity | 2010 | 2012 |
|---|---|---|
| Black Caribbean | Data unavailable | 57 |
| Black African | data unavailable | 14 |
| Black British | data unavailable | 15 |
| Indian | 10 | 3 |
| Pakistani | 2 | 5 |
| Bangladeshi | 5 | 2 |
| Data Unavailable | 34 | 3 |
| White British | 290 | 302 |
| White Irish | 1 | 13 |
| Other white ethnic group | 20 | 15 |
| Other black ethnic group | 15 | 12 |
| Other Asian ethnic group | 15 | 2 |
| White and Black Caribbean | 2 | 15 |
| White and Asian | 1 | 1 |
| Other Mixed background | 3 | 43 |
| Caribbean - ethnic | 90 | 7 |
| African - ethnic | 20 | 6 |
| Chinese - ethnic | 0 | 1 |
| Other - ethnic | 1 | 4 |
| Mixed Asian | Data unavailable | 3 |

### Foreign Nationals

The most recent data available from the Ministry of Justice from December 2011, indicates the percentage of foreign national prisoners was slightly lower in 2010 at 4%, compared to 6.5% (33/510).

### Religion

No information was provided on religion.

### Disability

No information was provided on disability.

### Sexuality

No information was provided on sexuality.

### Sentence Length

In October 2011, 13% of the prison was serving a life sentence and 14.5% of prisoners were serving an indeterminate sentence. The number of prisoners serving life sentences has increased from 12% to 13% since the 2010 HNA.

## Recommendations

1. The demographics of the prison population should be regularly reviewed to ensure services meet the needs of prisoners.
2. All recording of ethnicity should use the standards set out in the 2011 Census.
3. Data on religion, sexuality and disability should be collected and collated in order to inform service planning and ensure health needs are met.

# 3. Physical Health Needs

## 3.1 Long term conditions

*Table 4: Observed and expected prevalence for physical conditions in 2012, compared to 2010*

| | 2009 | | | | | 2012 | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Expected | | Observed | | | Expected | | Actual | |
| **Disease** | **Overall prevalence** | **Expected no./501** | **Chronic Disease Register/501** | **Pharmacy data** | **Observed no. (range)** | **Overall prevalence** | **Expected no.** | **QOF/528 (19/03/2012)** | **Self-reported on reception/603 (2011 new receptions)** |
| Treated asthma (BTK)[1] | - | - | 5.8% (29) | 2.8% (14) | 14-29 | 5% | 4.36% (23) | 12.1% (64) | 11.9% (72) |
| COPD (UK)[2] | 1.5-6.3% | 8-32 | 0.2% (1) | 3 | 1-3 | 2.4% | 0.9% (5) | 0.9% (5) | 0.3% (2) |
| Epilepsy (BTK) | - | - | 0.2% (1) | 5 | 1-5 | - | 0.8% (4) | 1.1% (6) | 2.0% (12) |
| Diabetes (UK)[3] | 4.4% | 22 | 0.8% (4) | 8 | 4-8 | 6.3% | 7% (37) | 2.3% (12) | 2.0% (12) |
| Hypertension (UK)[4] | 12.8% | 64 | 21 | 27 | 21-27 | 31.5% | 22.9% (121) | 6.6% (35) | 1.8% (11) |
| Ischaemic heart disease (BTK) | 14% | 70 | 0.2% (1) | - | 1 | - | 0.6% (3) | 1.7% (9) | 0 |
| Hepatitis B (BTK) | - | - | - | - | - | 12% | 63 | | 0 |
| Hepatitis C (BTK) * | - | - | - | - | - | 7% | 37 | | 2.0% (12) |
| HIV (BTK) * | - | - | - | - | - | 1.2% | 6 | | 0 |

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

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

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

## Methodology

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

In 2010, the observed prevalence of diseases was taken from manually created and maintained paper registers. The 2012 prevalence of diseases is taken directly from SystmOne through QOF. The total population figures used in the calculations are slightly different to the figures from the prison, as they still include some prisoners who have left the prison recently.

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

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

## Asthma

| **2010 Expected** | **2010 Observed**<br><br>***Asthma Register*** | **2012 Expected** | **2012 Observed** | |
|---|---|---|---|---|
| | | | ***Asthma Register QOF*** | ***2011 receptions*** |
| *[5%, 25/501]* | 5.8% (29/501) | 4.36% (23/528) | 12.1% (64/528) | 11.9% (72/603) |

Of the new receptions in 2011, 11.9% reported asthma as a current problem when they arrived at the prison. This is a similar prevalence to those on the QOF asthma register, which includes only those prescribed medication for asthma in the last 12 months. This is higher than expected.
The data from the previous HNA indicates a lower prevalence more in line with the expected numbers, with 5.8% from the asthma register and 2.8% from pharmacy data.

Data from SystmOne indicates that 88.5% (54/61) of those diagnosed with asthma have had an asthma review in the preceding 15 months, and that 27.2% (12/44) were diagnosed and had measures of variability or reversibility. The first figure is very positive and suggests that those with a diagnosis are being monitored, however the second figure should be improved.

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

## Recommendations

4. Audit of clinical records to examine diagnoses of asthma patients against SIGN guideline 101[5].
5. Increase the percentage of patients who have a diagnosis with measures of variability or reversibility.
6. Audit of asthma reviews to ensure they cover the factors outlined in SIGN guideline 101.
7. Audit of asthma patients to ensure they all have an up to date asthma action plan in place.

### Chronic Obstructive Pulmonary Disorder (COPD)

| **2010 Expected** | **2010 Observed**<br><br>***COPD Register*** | **2012 Expected** | **2012 Observed** | |
|---|---|---|---|---|
| | | | ***COPD Register QOF*** | ***2011 receptions*** |
| 1.5-6.3% (8-32) | 0.2% (1/501) | 0.9% (5/528) | 0.9% (5/528) | 0.3% (2/603) |

Of the new receptions in 2011, 0.3% reported COPD as a current problem when they arrived at the prison. This is a lower prevalence to the COPD QOF register (0.9%), which may indicate prisoners do not report they have the condition or that they are diagnosed whilst in the prison. The number on the COPD QOF register is in line with the expected number.

There has been an increase in prevalence since the previous HNA, which is likely to indicate a better detection of the condition, as the increase in the older population is not sufficient to cause this increase.

All patients with COPD should have their diagnosis confirmed by post bronchodilator spirometry- data from SystmOne indicates that this had occurred in only 33% (1/3) patients. NICE clinical guideline 101 recommends that FEV1 and inhaler technique should be assessed at least annually for people with mild/moderate/severe COPD (and in fact at least twice a year for people with very severe COPD)- data indicated this had not happened for any patients (0/4). No patients (0/4) with COPD had had a review of their condition within the last 15 months. 50% (2/4) of patients with COPD had received a flu vaccination in the preceding flu season (September-March). This should be increased to 100%.

## Recommendations

8. Audit of all patients with COPD to ensure they have received a diagnosis confirmed by post bronchodilator spirometry, and a review of their condition including FEV1 and inhaler technique in the last 15 months.
9. 100% of patients with COPD should receive a flu vaccination.

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

### Epilepsy

| 2010 Expected | 2010 Observed<br><br>*Epilepsy Register* | 2012 Expected | 2012 Observed | |
|---|---|---|---|---|
| | | | *Epilepsy Register QOF* | *2011 receptions* |
| - | 0.2% (1/501) | 0.9% (5/528) | 1.1% (6/528) | 2.0% (12/603) |

Of the new receptions in 2011, 2.0% (12/603) reported epilepsy as a current problem when they arrived at the prison. This is a higher prevalence to the epilepsy QOF register (1.1%), which may indicate prisoners which may indicate prisoners reporting epilepsy for drug seeking reasons or due to misdiagnosis in the past. The number on the epilepsy QOF register is similar to the expected number, although higher than the previous HNA.

Data from SystmOne indicates that 80% (4/5) patients on the epilepsy register have a record of their seizure frequency taken in the last 15 months. No patients (0/3) were recorded as seizure free for 12 months, which may indicate that the management of medication could be improved although it is recognised that seizure control is often under the influence of factors outside medical control.

## Recommendation

10. Medication review of all patients with epilepsy on the register, to ensure the chances of patients being seizure free are maximised.

### Diabetes

| 2010 Expected | 2010 Observed<br><br>*Diabetes Register* | 2012 Expected | 2012 Observed | |
|---|---|---|---|---|
| | | | *Diabetes Register QOF* | *2011 receptions* |
| 4.4% (22/501) | 0.8% (4/501) | 7% (37/528) | 2.3% (12/528) | 2.0% (12/603) |

Of the new receptions in 2011, 2.0% (12/603) reported diabetes as a current problem when they arrived at the prison. This is a similar prevalence to the diabetes QOF register (2.3%). This is much lower than the expected prevalence (7%), meaning there could be up to 25 patients with undiagnosed diabetes in the prison.

The expected number in this HNA is now based on the age-adjusted prevalence for England[6]. The Birmingham Toolkit is based on community data for 1996, and the prevalence of diabetes has increased greatly since then; for example from 3% in 2004 to 5.5% in 2011. We may also expect the prevalence to be even higher given the high BME population at HMP Coldingley; at least 18% (94/528) of prisoners at HMP Coldingley are of an ethnicity with a higher risk of diabetes, as outlined below:

- Type 2 diabetes is up to six times more common in people of South Asian descent and up to three times more common among people of African and African-Caribbean origin.
- According to the Health Survey for England 2004, doctor diagnosed diabetes is almost four times as prevalent in Bangladeshi men, and almost three times as prevalent in Pakistani and Indian men compared with men in the general population.

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

Of the 13 diabetes indicators for QOF on SystmOne, 12/13 had scores above 75% which is excellent. The indicator lower than this is 'the percentage of patients with diabetes who have a record of micro-albuminuria testing in the preceding 15 months (exception reporting for patients with proteinuria)' which only 42% (5/12) were recorded as receiving. This is a recommendation of the NICE clinical guideline 87 (2010)[7].

## Recommendations

11. A programme for detection of undiagnosed diabetes should be set up at HMP Coldingley, including targeting prisoners of ethnic minorities who are at a higher risk of diabetes.
12. Audit of all patients on the diabetes register to ensure they have been had micro-albuminuria testing in the preceding 15 months.

## Cardiovascular Disease

### *Hypertension*

| 2010 Expected | 2010 Observed<br><br>*Hypertension Register* | 2012 Expected | 2012 Observed | |
|---|---|---|---|---|
| | | | *Hypertension Register- QOF* | *2011 receptions* |
| 12.8% (64/501) | 4.2% (21/501) | 22.9% (121/528) | 6.6% (35/528) | 1.8% (11/603) |

Of the new receptions in 2011, 1.8% (11/603) reported hypertension as a current problem when they arrived at the prison. This is a much lower prevalence to the hypertension QOF register (6.6%), which may indicate prisoners are being diagnosed with the condition in the prison. This is much lower than the expected prevalence (22.9%), meaning there could be up to 86 patients with undiagnosed hypertension in the prison. This is due to a high expected prevalence of hypertension in men aged over 35. However, this has increased since the last HNA indicating an improvement in detection levels.

97% (34/35) patients on the register had had their blood pressure taken in the preceding 9 months and78.5% (22/28) had a last blood pressure reading of 150/90 or less. This indicates excellent management of patients with hypertension.

### *Heart Disease*

| 2010 Expected | 2010 Observed<br><br>*Heart Disease Register* | 2012 Expected | 2012 Observed | |
|---|---|---|---|---|
| | | | *Heart Disease Register- QOF* | *2011 receptions* |
| 14% (70/501) | 0.2% (1/501) | 0.6% (3/528) | 1.7% (9/528) | 0 |

There were 1.7% of prisoners on the heart disease QOF register which is higher than the expected prevalence (0.6%). This is also much higher than the prevalence in the last HNA. No prisoners reported heart disease on reception.

[7] NICE clinical guideline 87 (2010). Type 2 Diabetes: The management of Type 2 diabetes. http://guidance.nice.org.uk/CG87

Of the 5 coronary heart disease indicators for QOF on SystmOne, 3/5 had scores above 75%. 44% (4/9) had a last measured total cholesterol reading (measured in the preceding 15 months) of 5mmol/l or less, and 56% (5/9) were prescribed a beta-blocker in the preceding six months.

***CVD Primary Prevention***

Data from SystmOne indicated 30 patients were on the Cardiovascular Disease Primary Prevention register (recorded a new diagnosis of hypertension, excluding those with pre-existing CHD, diabetes, stroke and/or TIA). SystmOne showed that 33% (4/12) of patients on the register had received a face to face cardiovascular risk assessment at the outset of diagnosis and 25% (5/20) had received lifestyle advice.

***Stroke, TIA and Atrial Fibrillation***

There were no patients recorded as having a stroke or TIA at HMP Coldingley, and one patient had a diagnosis of atrial fibrillation (treated with drug and with a specialist confirmed diagnosis).

## Recommendations

13. A programme for detection of undiagnosed hypertension should be set up at HMP Coldingley.
14. Audit of patients with heart disease who have a total cholesterol over 5mmol/l and those not current prescribed a beta-blocker, to see if they would benefit from further treatment.
15. Audit of those on the CVD register to ensure they have received a cardiovascular risk assessment and lifestyle advice.

### Other conditions

*Table 5: The prevalence of other conditions*

| Condition | Prevalence (Number) |
|---|---|
| Dementia | None |
| Heart failure | None |
| Hypothryroidism | None |
| Sickle cell* | 0.4% (2/528) |
| Cancer | 0.2% (1/528) |
| Renal Impairment* | 0.2% (1/528) |
| Chronic Kidney Disease | 0.2% (1/528) |

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

## 3.2 Communicable Diseases

### Hepatitis B

No prisoners entered HMP Coldingley with a diagnosis of Hepatitis B in 2011, and no new diagnoses were made. We would expect 63 patients to have a diagnosis of Hepatitis B at HMP Coldingley.

***Hepatitis B Vaccination***

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

There was no specific data in the previous HNA, but records indicate it was reported that for 2009/10-Q4 Coldingley achieved 38% coverage. The table and graphs below show some improvements in coverage since the last HNA and over 115 prisoners have been vaccinated in the last year, although this is very inconsistent. HMP Coldingley should however continue to focus on Hepatitis B to ensure that the coverage reaches 80% every quarter. Detailed below is also the percentage of prisoners who decline the vaccine, and the number who have not been offered the vaccine.

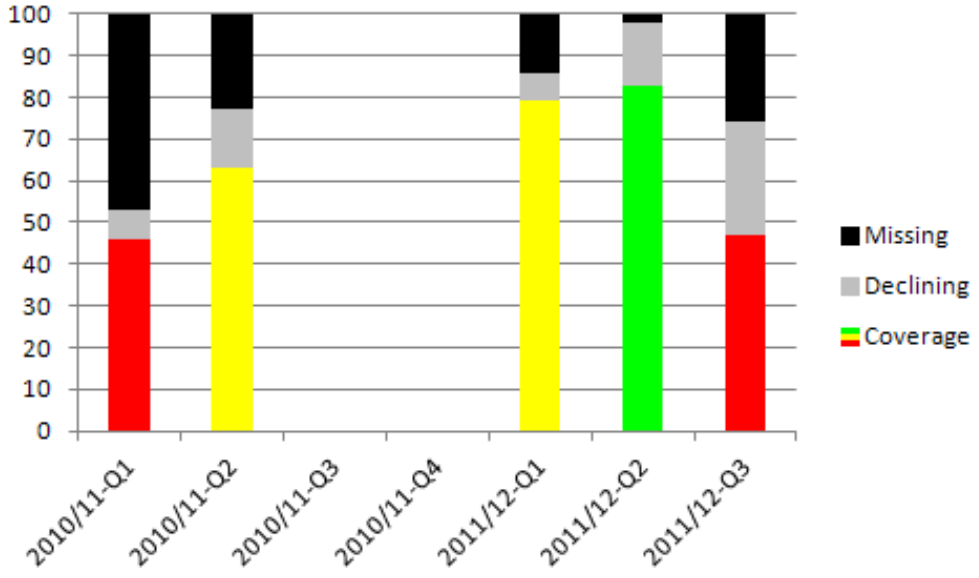
*Table 6: Rating, coverage, declining and not offered for Hepatitis B vaccinations*

| Year and Quarter | Rating and Coverage | Declining | Not offered |
|---|---|---|---|
| 2010/11-Q1 | *Red* 46% | 7% | 47% |
| 2010/11-Q2 | *Amber* 63% | 14% | 23% |
| 2010/11-Q3 | *Not reported* | *Not reported* | *Not reported* |
| 2010/11-Q4 | *Not reported* | *Not reported* | *Not reported* |
| 2011/12-Q1 | *Amber* 79% | 7% | 14% |
| 2011/12-Q2 | *Green* 83% | 15% | 2% |
| 2011/12-Q3 | *Red* 47% | 27% | 26% |

Source: PHPQI website

It is not clear why all prisoners are not being offered the vaccine.

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



## Hepatitis C

Of the new receptions in 2011, 2.0% (12/603) reported a diagnosis of Hepatitis C. No information was available on the current number of prisoners with Hepatitis C, although 4 were diagnosed while in the prison in 2011. We would expect to see 37 prisoners (7%) with a diagnosis of Hepatitis C. The data below indicates 88% (529/603) of new receptions did not know their Hepatitis C status, and 37% (195/529) of these prisoners were not offered a Hepatitis C test.

*Hepatitis C Tests*

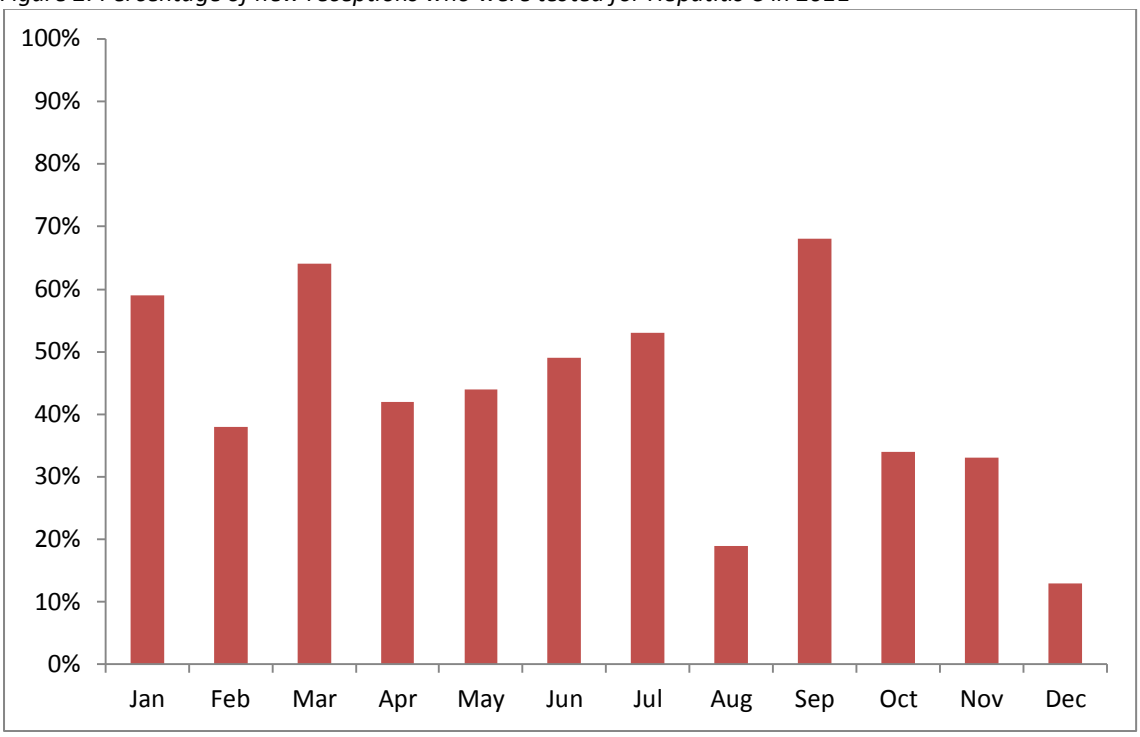
Hepatitis C testing is now reported on quarterly as part of the Prison Health and Performance Quality Indicators (PHPQI 3.2). The graph below shows the percentage of new receptions who were tested for Hepatitis C in 2011 within 31 days of reception; 201 prisoners were tested over the year. The uptake rate of Hepatitis C tests was 38% (tested/total receptions not previously tested) and the coverage rate for new receptions was 46% (already tested + tested/total receptions).
This data was not available in the previous HNA.

*Table 7: Hep C tests offered, already taken, declined or tested in HMP Coldingley*

| Receptions | Declined | Already tested +ive | Already tested -ive | Tested | Uptake % | Declined % | Already tested % | Coverage % |
|---|---|---|---|---|---|---|---|---|
| 603 | 133 | 12 | 62 | 201 | 38% | 25% | 12% | 46% |

Source: PHPQI website

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




Source: PHPQI website

## HIV

Of the new receptions in 2011, no patients reported a diagnosis of HIV- this is lower than the expected value of 1.2% (6/603).

No information was available on the current number of prisoners with HIV, although 1 was diagnosed while in the prison in 2011. Data from SystmOne indicated 171 patients accepted an offer

of a HIV test on reception and 180 declined an offer of testing. 53 patients reported they had received a negative test result. Data from SystmOne indicates 91% (550/603) of new receptions were unaware of their HIV status.

### Tuberculosis

Of the new receptions in 2011, 3 reported they had had possible contact with someone with TB, 8 were screened and no cases were detected.

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

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

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

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

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

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

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

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

## Recommendations

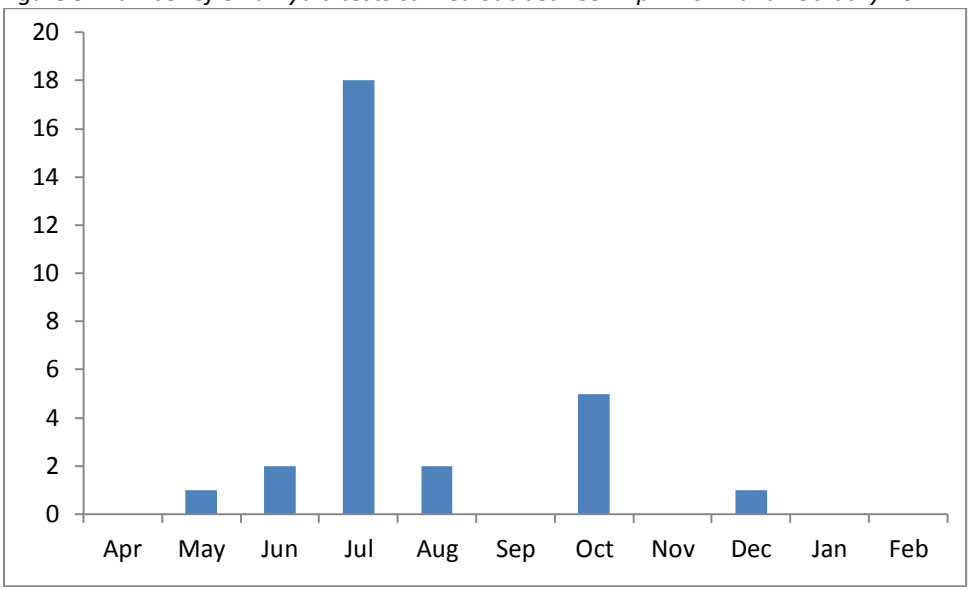
16. An audit should be carried out of all patients to ensure those ‘at risk’ were offered a HIV test on reception and later during their stay at HMP Coldingley.
17. An audit should be carried out of all patients to ensure those ‘at risk’ were offered a Hepatitis C test on reception and later during their stay at HMP Coldingley.

18. Develop a plan to improve the processes for Hepatitis B vaccination so all prisoners are offered the vaccine within 31 days of reception, and more vaccines are given. This plan should be reviewed after 3 months.
19. An audit should be carried out of all patients to ensure those 'at risk' were offered a Hepatitis B test on reception and later during their stay at HMP Coldingley.

### 3.3 Sexual Health

*Chlamydia Testing*
Data from the Surrey Chlamydia Testing Programme showed that in 11 months a total of 29 tests were carried out. HMP Coldingley has averaged 50 new receptions a month, so with the age profile outlined in the demographic section we would expect 10 tests to be offered a month.

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




Source: Surrey Chlamydia Screening Programme

Compared to the data in the previous HNA, the number of tests offered has increased, although this is very inconsistent and only 1 test was carried out in the four months from November 2011-February 2012.

*Table 8: Comparative number of Chlamydia tests carried out in two time periods*

| Time period | Number of Chlamydia Tests |
|---|---|
| April- October 2009 | 0 |
| April- October 2011 | 28 |

Source: Surrey Chlamydia Screening Programme

Although some improvement has been made on the number of prisoners being tested for Chlamydia, it would be of benefit to maintain this improvement and further increase the number being tested. There is also a high positivity for Chlamydia in this population which indicates the programme is of value within the prisons.

Using data from April to November 2011, a target was estimated which would encourage improvement; for Coldingley the target for 2012/13 is 92 tests. Given the age profile, this target should be achievable.

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

## 3.4 Oral Health

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

Three key access standards to prison dentistry have been identified:

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

**Dental Health Provision**

Data is not available for the first two months of this year (2011/12) but capacity in June appears to have been able to cope with demand. This situation has significantly deteriorated from that point with only 42% of patients being seen within an acceptable timeframe. Data has not yet been submitted for the remainder of the year but a significant effort needs to be made to deal with the backlog of prisoners waiting for routine treatment.

- No patients were referred for emergency treatment
- 100% of patients referred for urgent treatment were seen within 24 hours
- 42% of patients referred for routine treatment were seen within 6 weeks

*Table 9: Number of patients referred and seen within target times*

| | Jun-11 | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 | **Total** |
|---|---|---|---|---|---|---|---|---|
| Number of patients referred (emergency) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Number seen same day in hospital (emergency) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Number of patients referred (urgent) | 13 | 12 | 21 | 23 | 21 | 19 | 20 | **129** |
| Number of patients seen within 24 hours (urgent) | 13 | 12 | 21 | 23 | 21 | 19 | 20 | **129** |
| Number of patients referred (routine) | 40 | 33 | 17 | 27 | 16 | 26 | 14 | **173** |
| Number of patients seen within 6 weeks (routine) | 40 | 7 | 4 | 8 | 6 | 7 | 0 | **72** |

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

## Recommendation

21. Dental waiting times should be regularly reviewed and major service changes should be undertaken if the recommended waiting times cannot be met.

# 4. Mental Health and Learning Disabilities

## 4.1 Prevalence of Mental Health

Questions about mental health history, treatment and self harm are routinely collected at first reception.

*Table 10: Questions regarding mental health asked in the first reception screen*

| Question Asked | % Answering yes |
|---|---|
| Prisoner has received treatment from a psychiatrist outside prison | 14.39 |
| Prisoner has stayed in a psychiatric hospital | 6.06 |
| Prisoner has had a psychiatric nurse or care worker in the community | 6.44 |
| Prisoner has received medication for mental health problems | 22.16 |
| Prisoner has tried to harm themselves (within prison) | 9.28 |
| Prisoner has tried to harm themselves (outside prison) | 12.68 |
| Prisoner feels like self-harming or Suicide | 1.33 |

Source: SystmOne

## 4.2 Mental Health Provision

### Staffing

- Service Manager 0.25 Whole Time Equivalent
- Mental Health Practitioner 1.0 Whole Time Equivalent
- Support Time and Recovery Worker 1.0 Whole Time Equivalent
- Counsellor 0.6 Whole Time Equivalent
- Movement Psychotherapy 0.2 Whole Time Equivalent
- Consultant Psychiatrist 0.1 Whole Time Equivalent
- Consultant Psychologist 0.1 Whole Time Equivalent

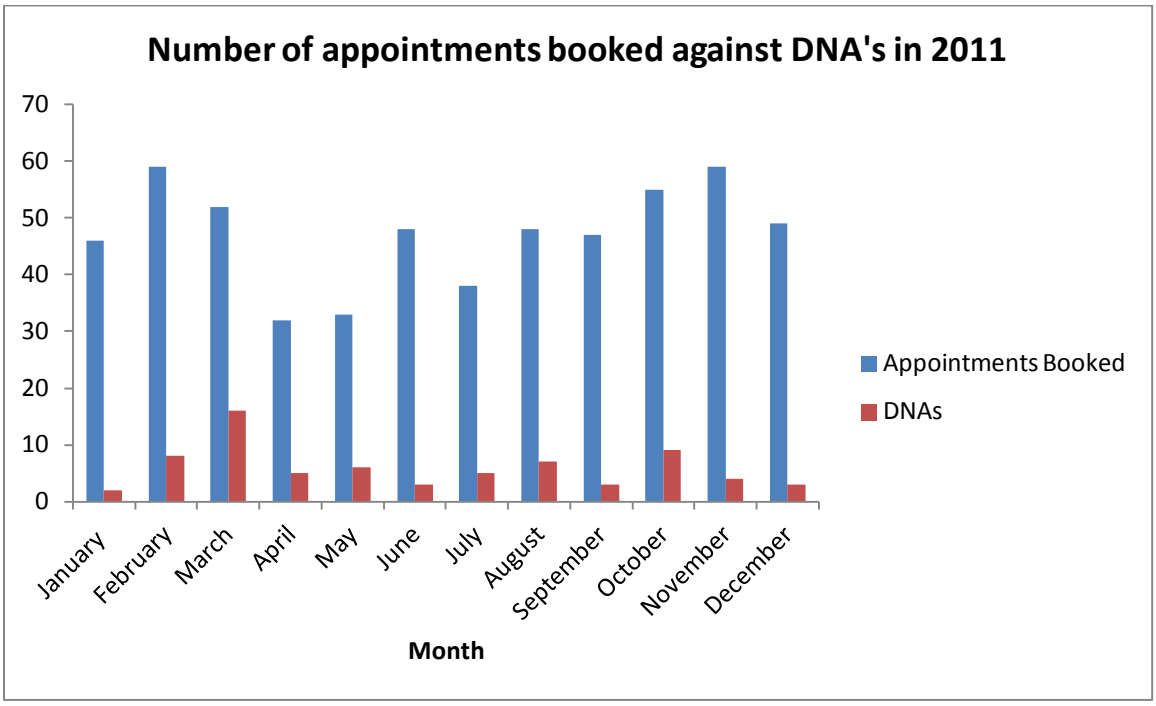
### Number of Services a Week

- 2 sessions of Movement Psychotherapy
- 8 sessions of counselling (2 by volunteer counsellors)

There is a small waiting list for each service.

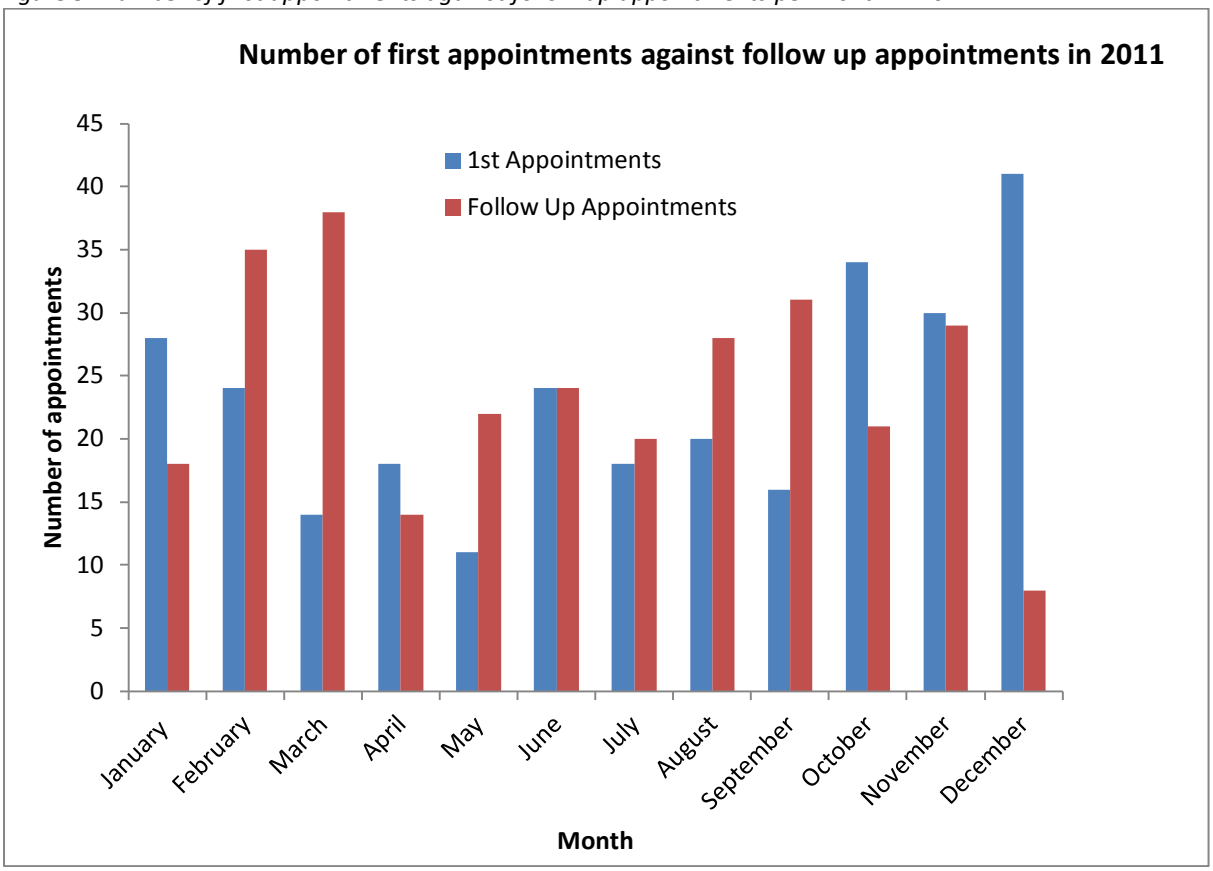
## Number of Appointments

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



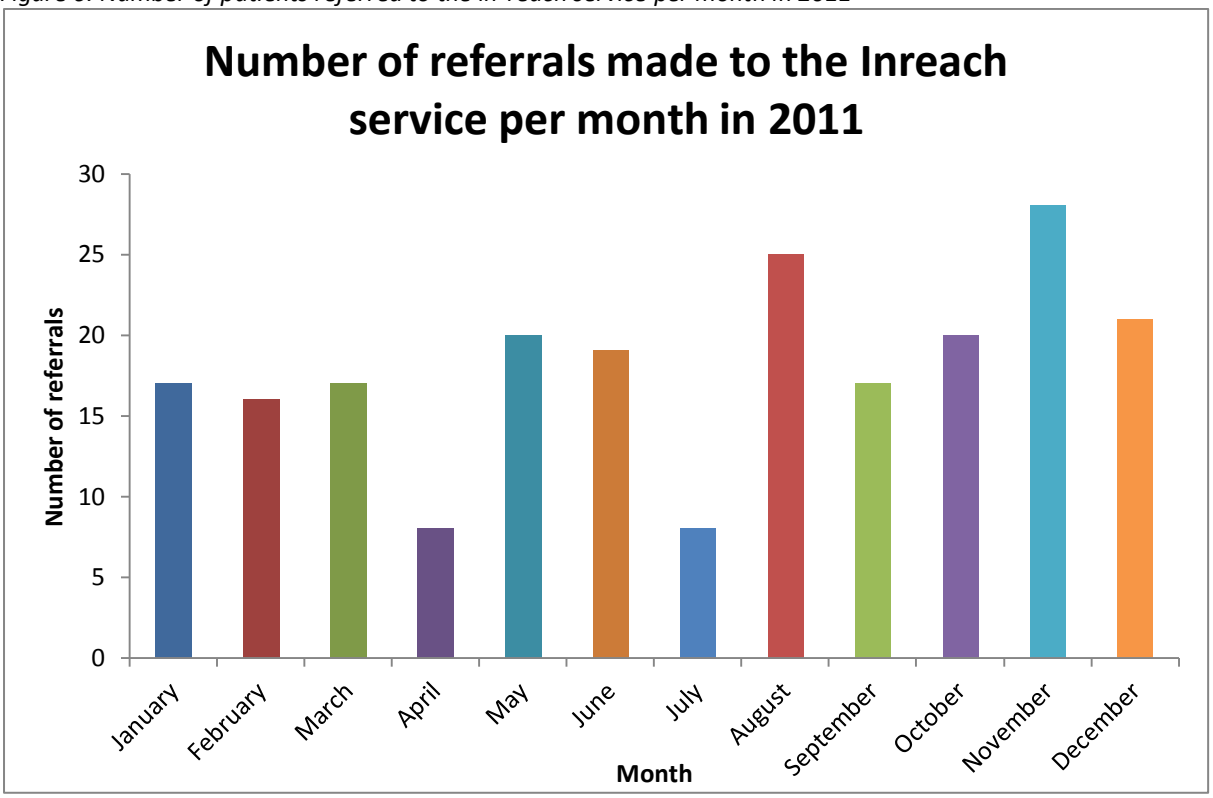

- On average 12.68% of appointments were not attended every month in 2011
- March had the highest rate of DNA's at 30.77%
- December had the lowest rate of DNA's at 6.12%

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



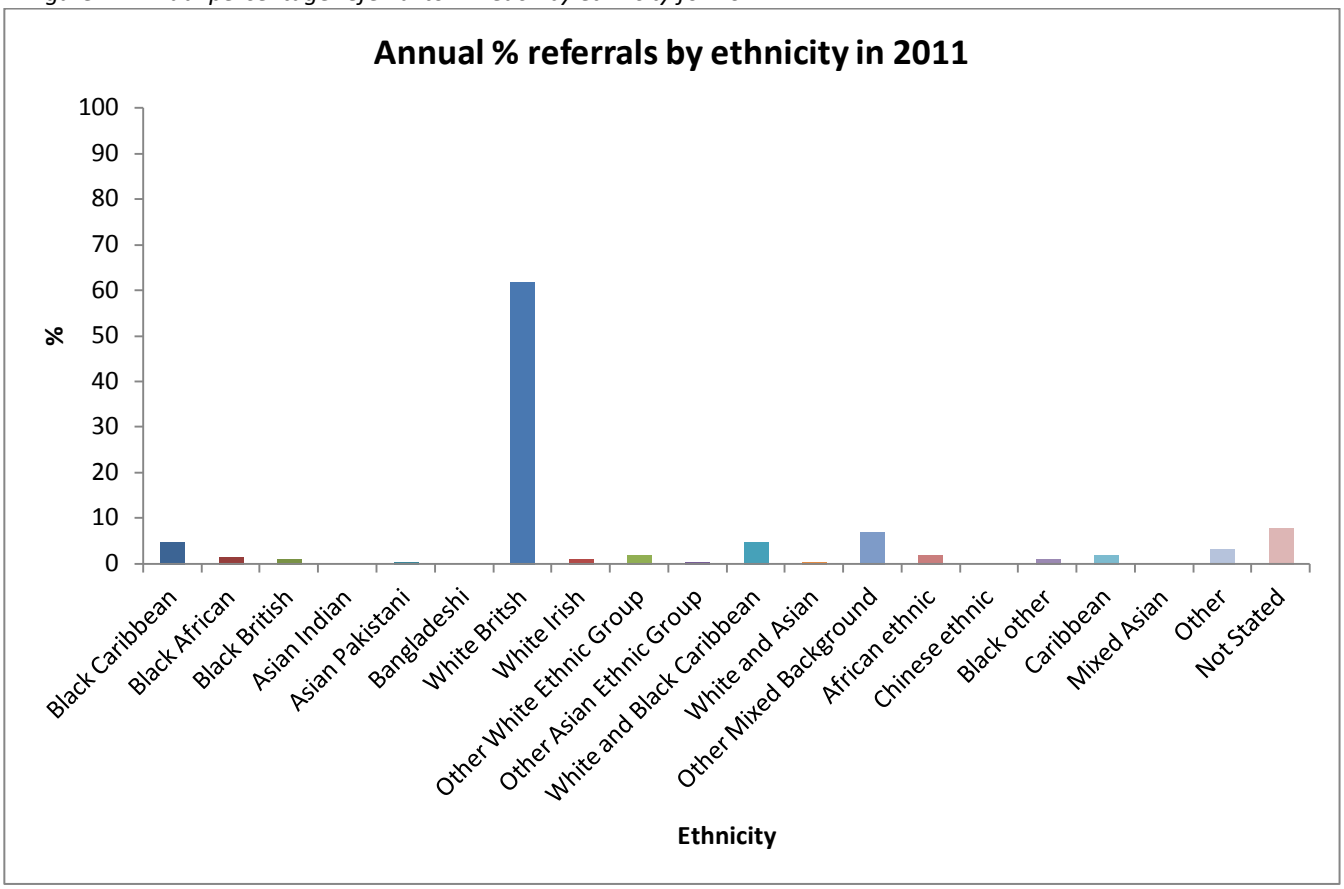

## Referrals to the Service

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



- On average 15.6 patients were referred to the in-reach service per month in 2011
- November had the highest number of referrals (28)
- April and June had the lowest number of referrals (8)

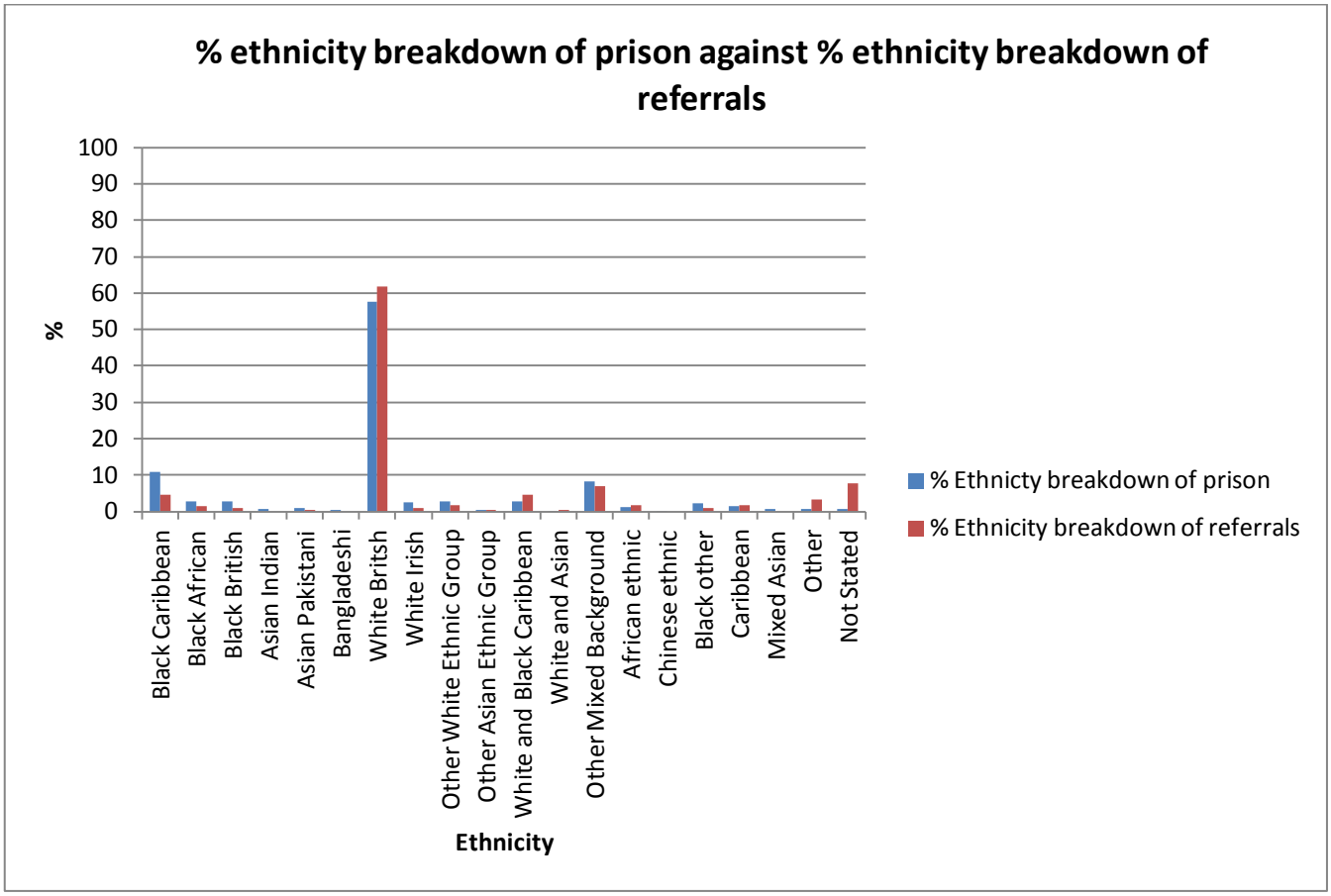
*Figure 7: Annual percentage referral to in-reach by ethnicity for 2011*




- The five most common ethnic groups to be referred in order were:
    - White British (61.75%)
    - Not Stated (7.83%)
    - Other Mixed Background (6.91%)
    - Black Caribbean (4.61%)
    - White and Black Caribbean (4.61)

- There were no referrals from Bangladeshi, Mixed Asian, Chinese Ethnic, Mixed Asian and Asian Indian ethnic groups

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

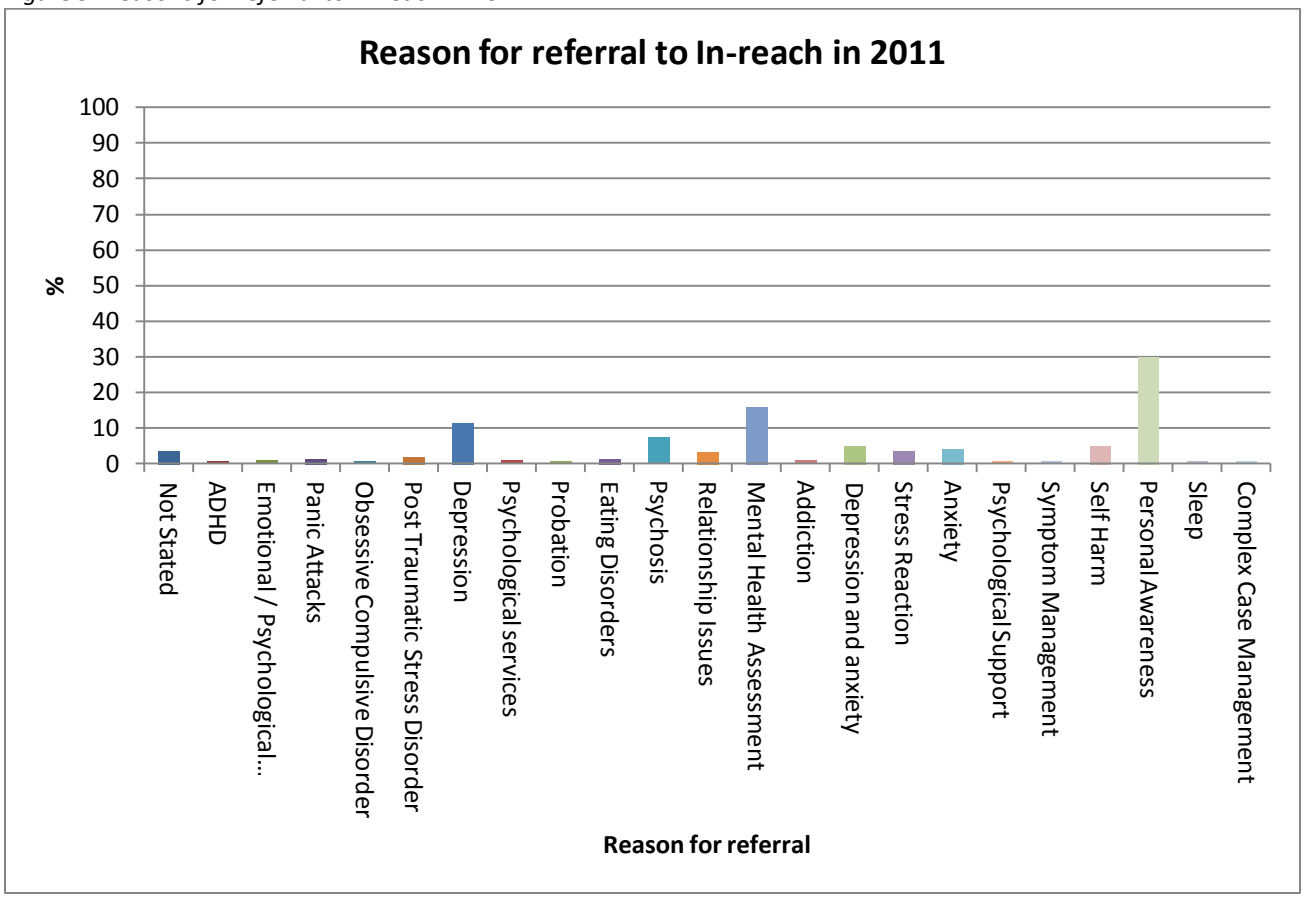



- The high representation of referrals from White British ethnic group ( 61.75% ) is relative to the proportion of that group in the prison ( 57.74% )
- There is an overrepresentation of referrals to in-reach from the following groups (More than 50% of this group are referred relative to their proportion in the prison)
    - White and Asian
    - African Ethnic
    - Not Stated
    - Other
- There is underrepresentation of referrals to in-reach from the following groups (Less than 50% of these groups are referred relative to their proportion in the prison)
    - Black Caribbean
    - Black British
    - Black Other
    - White Irish
    - Asian Pakistani

The 'Count Me In' census estimates that BME groups are 40% more likely to access mental health services via the criminal justice system and is a key routes by which BME groups (particularly young black men) enter mental health services. However there is evidence to suggest that BME groups are less likely to be referred for psychological therapies or early interventions across all mental health settings.

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

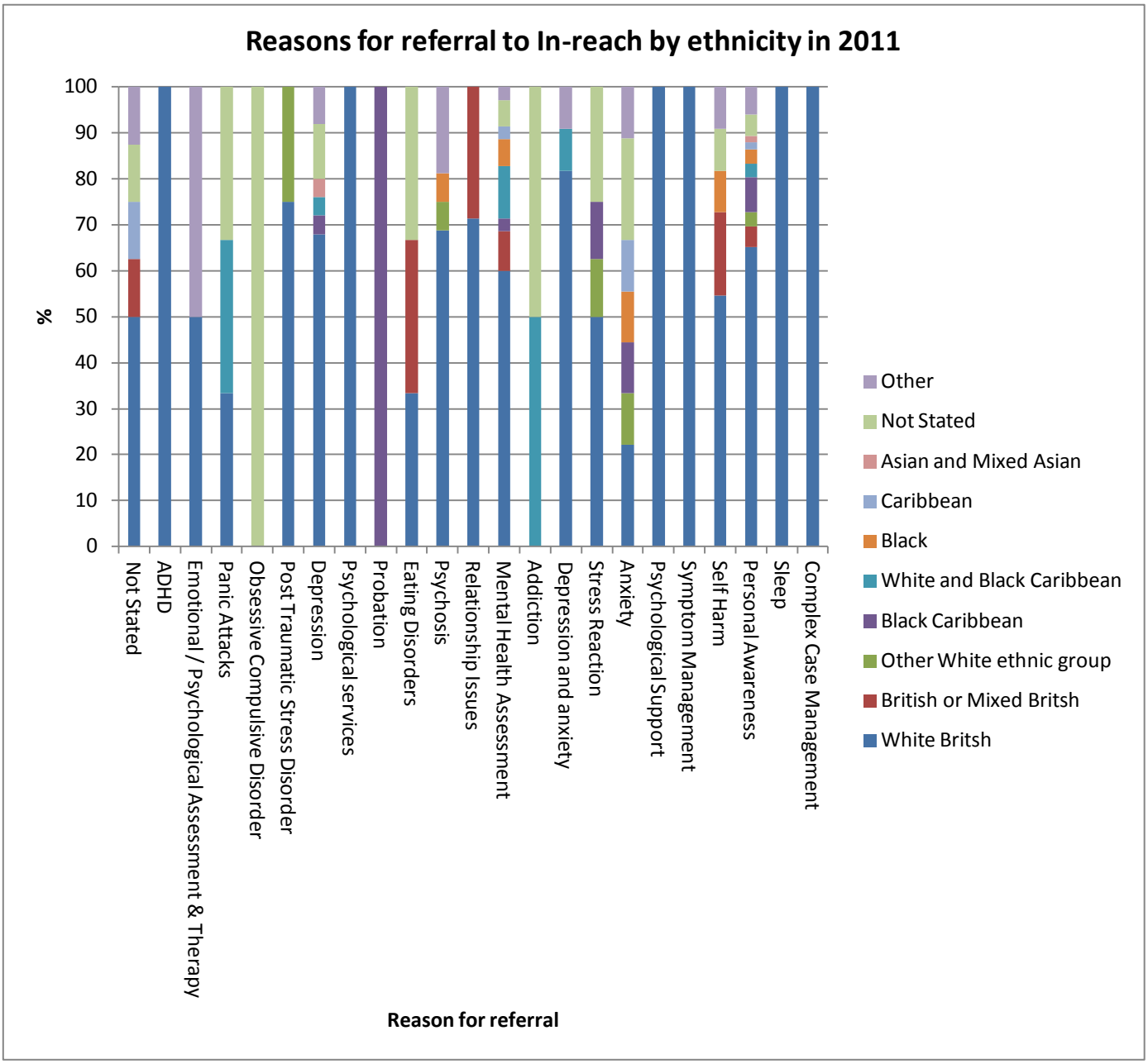
*Figure 9: Reasons for referral to in-reach in 2011*




- The five most common reasons for referral to in-reach in 2011 were:
    - Mental Health Assessment (15.91%)
    - Depression (11.36%)
    - Psychosis (7.27)
    - Depression and Anxiety (5%)
    - Self-Harm (5%)

- In the last health needs assessment in 2009, 25% of referrals were for diagnosed mental illness (depression, SMI, anxiety, PTSD, OCD) with depression and SMI the largest contributor to that sub group. 18% was for self-esteem/relationships and 11% for deliberate self-ham.

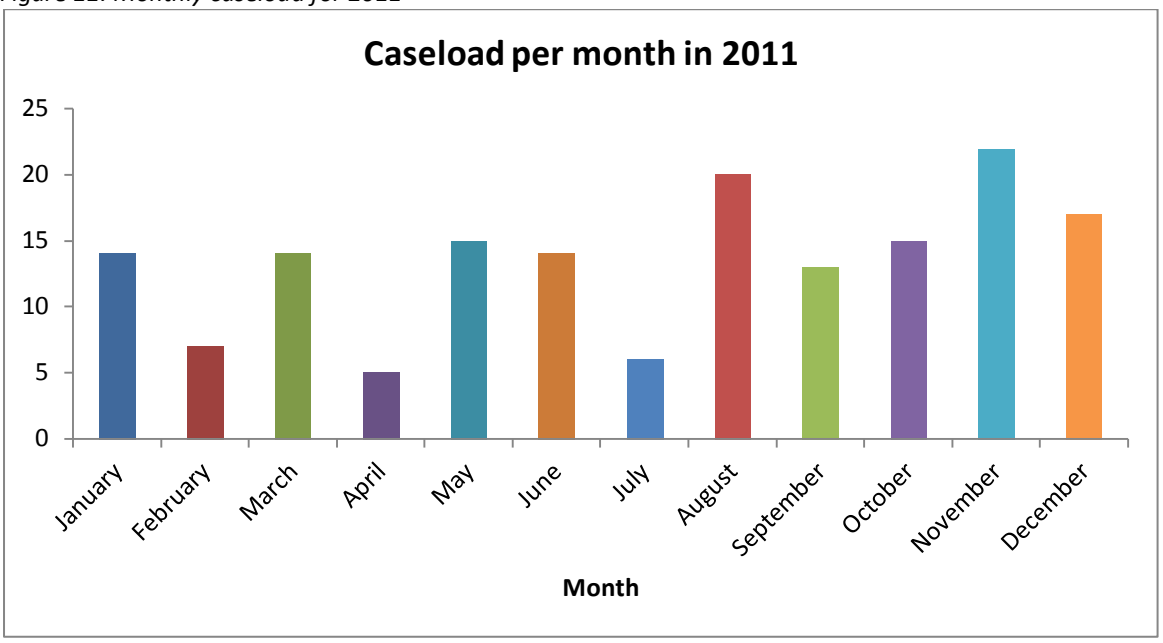
*Figure 10: Reasons for referral to in-reach in 2011 by ethnicity*




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

### In-reach caseload

*Figure 11: Monthly caseload for 2011*




- The average monthly caseload in 2011 was 13.5
- The caseload was highest in November (22) and lowest in April (5)
- This correlates with the number of referrals for those months

*Table 11: Breakdown of caseload in 2011*

| Service | Annual caseload by % in 2011 |
|---|---|
| Awaiting Counselling | 11.18 |
| Counselling | 27.95 |
| Mental Health In-reach | 51.55 |
| Psychiatric Outpatient | 5.59 |
| Psychology | 2.48 |
| Mental Health A | 1.24 |

- Mental Health in-reach makes up the largest caseload
- Mental Health A has the smallest caseload

## 4.3 Self Harm

Self Harm in HMP Coldingley is managed through a care pathway by the prison safer custody, Inreach and healthcare. The role of Safer Custody team is to ensure that the local suicide prevention strategy is fully integrated and compatible with the local violence reduction strategy, that a self-harm management strategy is developed, and that all other local policies, procedures and strategies reflect the holistic nature of the wider safer custody strategy In 2010, Safer Custody developed incident packs containing instructions and paperwork. These are readily available in all areas. The packs have improved the management and reporting of self harm.

An Assessment, Care in Custody, and Teamwork (ACCT)[9] is used to help identify and care for prisoners at risk of suicide or self-harm. It is designed to provide more flexible multi-disciplinary support to prisoners at-risk of harming themselves. The plan encourages staff to work together to provide individual care to prisoners in distress, to help defuse a potentially suicidal crisis or to help individuals with long-term needs (such as those with a pattern of repetitive self-injury) to better manage and reduce their distress.

Although further information should be available on self-harm from healthcare and safer custody, it was not available at the time of writing.

### Recommendations

22. Data on ethnicity should be regularly reviewed to ensure services are meeting the needs of prisoners from BME backgrounds.
23. Information on referrals accepted or rejected, and the outcomes of those referrals rejected, should be collected and collated and shared with healthcare and the prison to inform staff and service planning.

## 4.4 Learning Disabilities

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

A learning disability screening tool was implemented in September 2011. The screening tool being used is the Learning Disability Screening Questionnaire (LDSQ) developed by Karen Mckenzie and Donna Paxton[10]. The screening is undertaken by the Primary Health teams in each prison.

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

At the time of the HNA refresh, there was limited data on the prevalence of learning disabilities in the prison. No prisoners had received an annual health check or had a health action plan.

PHPQI 1.31 Services for people with learning disabilities specifies that there should be:

- Access to learning disability services specifically commissioned for prisoners
- 100% of prisoners identified as having a learning disability have a health action plan and an annual health check
- Joint partnership working focussed on the needs of people with learning disabilities between healthcare, DLO and Education and Discipline staff.
- Evidence that specific programmes/regimes relevant to the needs of those with a learning disability are in place.

[9] Her Majesties Prison Service (2007) *The ACCT Approach: Caring for people at risk in prison* http://www.hmprisonservice.gov.uk/assets/documents/10000C1BACCTStaffGuide.pdf
[10] http://www.gcmrecords.co.uk/gcm_records_latest_version_march_2012_007.htm

## 5. Substance Misuse

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

- 75% of new receptions during 2010/11 were identified as needing substance misuse intervention
- The most prevalent drug of choice is heroin, followed by cannabis, cocaine and crack.

For further information please see the combined substance misuse needs assessment, October 2011.

## 6. Alcohol

Prisoners' exhibit extremely high rates of both alcohol and substance misuse. The Office for National Statistics[11] reported a large proportion of both female and male prisoners were found to be drinking above lower risk levels as defined by the Alcohol Use Disorder Identification Test (AUDIT) in the year before entering prison.

If a prisoners presents with alcohol misuse the following care pathways in place:-

- Assisted alcohol withdrawal programmes (detox)
- Ongoing clinical assessment
- Referral onto the Alcohol awareness groups in conjunction with the CARAT team
- Alcohol Awareness/information available from IDTS staff (Group on unit weekly)

Since the 2010 HNA, Alcohol Use Disorders Identification Test (AUDIT) has become one widely used alcohol screening tool. Developed by the World Health Organisation it used around the globe to help identify drinking behaviours that may cause damage to health. The AUDIT tool is routinely used as part of the reception screening.

Research by MacAskill et al [12] found that 73% of prisoner AUDIT scores indicate an alcohol use of over 8. In HMP Coldingley only 18% of the population that undertook the AUDIT assessment had audit scores of over 8. AUDIT has its limitations as the assessment is based upon current drinking patterns and current perceptions of alcohol use.

AUDIT scores were available for 16% of the prison population. This is because originally AUDIT was not mandatory within the reception screen for all prisoners.

*Table 12: A snap shot of AUDIT outcomes for 2011*

| AUDIT Score | Category | % |
|---|---|---|
| 0-7 | Sensible drinking / Low Risk | 82% |
| 8- 15 | Hazardous Drinking / Increased risk | 10% |
| 16- 19 | Harmful Drinking / High Risk | 2% |
| 20+ | Dependent drinking | 6% |

[11] Office of National Statistics (1999) Health Statistics Quarterly - No. 3, Autumn 1999.

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

The above scores from AUDIT do not allow for any analysis to be made on drinking behaviours. An alcohol assessment tool that asks about alcohol use prior to sentencing might enable a better understanding and inform alcohol health promotion and intervention to support rehabilitation

## Recommendation

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

# 7. Health Improvement

## 7.1 Smoking

Around 21% of the adult population in England are smokers[13]. In 2011, at the first reception screen 54% of prisoners reported a smoking status. 51% of prisoners who reported a smoking status received smoking cessation advice. Healthcare reported a difficulty in delivering smoking cessation support during 2011. This was due to a reduction in the budget for nicotine replacement therapy. As a result prisoners were priorities for the services and prisoners with a longer term condition were given high priority. Other prisoners were offered support without prescribing.

Data from healthcare shows that in 2011, 34% of prisoners who reported a smoking status were referred to the smoking cessation clinic. No data has been provided on the number of prisoners that set a quit date and successfully stopped smoking, and no data is reported to the Surrey Stop Smoking Service.

### Recommendations

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

## 7.2 Obesity

No information was available on obesity.

## 7.3 Physical Activity

New UK-wide physical activity guidelines were released by the Department of Health in July 2011[14]. To stay healthy, it is recommended that adults aged 19-64 should try to be active daily and should do:

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

OR

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

[13] http://www.ic.nhs.uk/webfiles/publications/003_Health_Lifestyles/Statistics%20on%20Smoking%202011/Statistics_on_Smoking_2011.pdf

[14] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127931

OR

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

No information on prisoners' levels of physical activity was available.

### Recommendation

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

## 7.4 Health Promotion Action Group (HPAG)

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

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

A health promotion action group was set up in 2010. The group is chaired by a senior manager at HMP Coldingley. Representation on the group includes healthcare, gym, kitchens and Public Health (NHS Surrey).

In 2011/12 the group was not meeting on a quarterly basis and there was no evidence that the action plan was up to date. It is important that health promotion campaigns and interventions are measured for effectiveness. There is no evidence of any analysis of health promotion campaigns. A multidisciplinary health promotion action group was set up in 2010. This group was chaired by a senior manager from HMP Coldingley. Membership included IMB, healthcare, prisoner reps, gym and Public Health team.

No information is available on the outcomes of any health promotion in HMP Coldingley. HMP Coldingley were therefore rated AMBER in the 2012 PHPQIs.

### Recommendation

31. A plan should be put in place to improve the HPAG and renew the action plan (including evaluation planning). Regular updates should be provided to the Prison Health Partnership Board on progress.

## 7.5 Screening

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

*Table 13: Screening offered in HMP Coldingley*

| | | |
|---|---|---|
| Bowel Screening | Number of Eligible Patients | 16 |
| | Number offered Screening | 0 |
| | Number of completed screenings | 0 |
| | Number refusing Screening | 0 |
| | Coverage | 0% |
| Diabetic ROP Screening | Number of Eligible Patients | 15 |
| | Number offered Screening | 13 |
| | Number of completed screenings | 5 |
| | Number refusing Screening | 0 |
| | % Offered | 87% |
| | Coverage | 33% |

Of the 16 prisoners of bowel screening age, none had been offered or had received screening. It is vital that prisoners have access to this screening programme.

Data taken from SystmOne on the 19th March 2012 indicated that 83% (10/12) of patients with diabetes had received retinopathy screening, which is an improvement on the previous figures above.

The NHS Abdominal Aortic Aneurysm (AAA) Screening Programme is being introduced gradually across England and starts in Surrey from April 2012. Research has demonstrated that offering men ultrasound screening in their 65th year could reduce the rate of premature death from ruptured AAA by up to 50 per cent. HMP Coldingley is in the catchment area of the West Surrey & North Hampshire AAA Screening Programme. Demographic data indicates that 8 men would be eligible for this programme.

### Recommendations

32. All prisoners eligible for bowel screening should be offered it, and the coverage rate should be increased to 60%.
33. AAA screening should be implemented at HMP Coldingley in partnership with the West Surrey & North Hampshire AAA Screening Programme.

## 7.6 Health Checks

The aim of an NHS Health Check[15] is to help lower the risk of the four common but often preventable diseases: heart disease, stroke, diabetes and kidney disease through early interventions and detection.

The aim of an NHS Health Check[16] is to help lower the risk of the four common but often preventable diseases: heart disease, stroke, diabetes and kidney disease through early interventions and detection.

[15] NHS Choices (2011) *Health Check*: http://www.nhs.uk/Planners/NHSHealthCheck/Pages/NHSHealthCheckwhat.aspx

Based on the current prison population, 170 prisoners are eligible and in 2011/12 HMP Coldingley carried out 155 health checks.

## Recommendation

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

[16] NHS Choices (2011) *Health Check*: http://www.nhs.uk/Planners/NHSHealthCheck/Pages/NHSHealthCheckwhat.aspx

# 8. Recommendations

**Prison profile (demographic changes)**

1. The demographics of the prison population should be regularly reviewed to ensure services meet the needs of prisoners.
2. All recording of ethnicity should use the standards set out in the 2011 Census.
3. Data on religion, sexuality and disability should be collected and collated in order to inform service planning and ensure health needs are met.

**Long term conditions**

4. Audit of clinical records to examine diagnoses of asthma patients against SIGN guideline 101.
5. Increase the percentage of patients who have a diagnosis with measures of variability or reversibility.
6. Audit of asthma reviews to ensure they cover the factors outlined in SIGN guideline 101.
7. Audit of asthma patients to ensure they all have an up to date asthma action plan in place.
8. Audit of all patients with COPD to ensure they have received a diagnosis confirmed by post bronchodilator spirometry, and a review of their condition including FEV1 and inhaler technique in the last 15 months.
9. 100% of patients with COPD should receive a flu vaccination.
10. Medication review of all patients with epilepsy on the register, to ensure the chances of patients being seizure free are maximised.
11. A programme for detection of undiagnosed diabetes should be set up at HMP Coldingley, including targeting prisoners of ethnic minorities who are at a higher risk of diabetes.
12. Audit of all patients on the diabetes register to ensure they have been had micro-albuminuria testing in the preceding 15 months.
13. A programme for detection of undiagnosed hypertension should be set up at HMP Coldingley.
14. Audit of patients with heart disease who have a total cholesterol over 5mmol/l and those not current prescribed a beta-blocker, to see if they would benefit from further treatment.
15. Audit of those on the CVD register to ensure they have received a cardiovascular risk assessment and lifestyle advice.

**Communicable Diseases**

16. An audit should be carried out of all patients to ensure those ‘at risk’ were offered a HIV test on reception and later during their stay at HMP Coldingley.
17. An audit should be carried out of all patients to ensure those ‘at risk’ were offered a Hepatitis C test on reception and later during their stay at HMP Coldingley.
18. Develop a plan to improve the processes for Hepatitis B vaccination so all prisoners are offered the vaccine within 31 days of reception, and more vaccines are given. This plan should be reviewed after 3 months.
19. An audit should be carried out of all patients to ensure those ‘at risk’ were offered a Hepatitis B test on reception and later during their stay at HMP Coldingley.

**Sexual Health**

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

**Oral Health**

21. Dental waiting times should be regularly reviewed and major service changes should be undertaken if the recommended waiting times cannot be met.

**Mental Health**

22. Data on ethnicity should be regularly reviewed to ensure services are meeting the needs of prisoners from BME backgrounds.
23. Information on referrals accepted or rejected, and the outcomes of those referrals rejected, should be collected and collated and shared with healthcare and the prison to inform staff and service planning.

**Alcohol**

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

**Smoking Cessation**

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

**Obesity and Physical Activity**

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

**Health Promotion Action Group**

31. A plan should be put in place to improve the HPAG and renew the action plan (including evaluation planning). Regular updates should be provided to the Prison Health Partnership Board on progress.

**Screening**

32. All prisoners eligible for bowel screening should be offered it, and the coverage rate should be increased to 60%.
33. AAA screening should be implemented at HMP Coldingley in partnership with the West Surrey & North Hampshire AAA Screening Programme.

**Health Checks**

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