NHS Surrey

HMP High Down

Health Needs Assessment

Final report

2009

Executive Summary

Introduction

This HMP High Down Health Needs Assessment (HNA) forms part of a rolling programme of health needs assessments that are taking place across all Surrey prisons to inform the commissioning process during 2009/2010.

A HNA is a systematic method for reviewing the health issues facing 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 also links in to other key drivers relevant to HMP High Down:

- Prison Health and Performance Quality Indicators are collected on an annual basis by the Department of Health and the Ministry of Justice
- The Deaths in Custody Review 2008
- HMP High Down is undergoing major modification with the construction of two new house blocks. This is the first Health Needs Assessment (HNA) that has been undertaken since the development of the prison establishment

Demography

HMP High Down is a local male category B prison which opened in 1992 and is built on the site of a former psychiatric hospital in Banstead. The establishment serves the Crown Courts at Croydon and Guildford and the surrounding Magistrate's Courts. HMP High Down is also currently operating as an overflow for young offenders from HMYOI Feltham and HMP Chelmsford. There are no medical restrictions for reception.

HMP High Down has 6 house blocks. House blocks 1-4 were built in 1991 and are double and treble occupancy. Each house block has an operational capacity of 181. House blocks 5 and 6 were built in 2007 and all cells are single accommodation with an operational capacity of 178 each. There are 22 single cells on the Separation and Reintegration Unit. All cells have sanitary facilities.

The total prison population in HMP High Down at the time of the HNA was 1066. Of these 246 (23%) were foreign nationals or had no nationality recorded, 820 UK nationals (77%). There were a total of 2458 new receptions in that period – a substantial increase compared with the 958 receptions seen in the same period in 2007.

HMP High Down experiences a high turnover of prisoners. Of those sentenced, 19% were serving up to 12 months and 20% were serving between 1-4 years. Therefore, almost 40% of the sentenced prison population were serving sentences of 4 years or less. 91% of the prison population remain at HMP High Down for a year or less. There has been a significant shift in the number of prisoners serving shorter sentences compared with 2006 when 72.2% of prisoner at HMP High Down were serving sentences of less than one year [6].

Population by age
Local Inmate Database System (LIDS) data (recording new receptions by date of arrival) shows that over a 17 month period (Jan 08 – May 09) 50% of new receptions were under the age of 30 with the number of new receptions decreasing with increasing age, with only 4.4% of the population being aged 50+. When compared to 2006, the proportion of young offenders and the older age group is now slightly higher.

Population by ethnicity
HMP High Down has a higher BME population than the national average (47%). In the period Jan-Oct 2008, the majority of prisoners entering the jail were White British (53%), followed by Black Caribbean (13%) and Black African (7%).

This represents a slight decrease in the White British population compared to 2006 when 60% of prisoners defined themselves in that ethnic group. In 2006 Black African (9%) and Black Caribbean (7%) groups were the largest BME groups at the prison.

Foreign nationals
Foreign nationals make up 20% of the population of the prison. Nationally, this figure is 13.5% (this includes those held under the Immigration Act as well as those on remand and serving custodial sentences).

The majority of prisoners entering reception between November 2008 and May 2009 at HMP High Down gave English as their first language (33%). The most commonly spoken languages after English were French (1%) and Arabic (0.6%). A total of 19 languages apart from English were stated as first language by these prisoners.

Population by sentencing status
A snapshot of the current prison population at the week beginning 1/12/2008 indicated that 14% of the prison population were young offenders, of whom the majority (9%) were unsentenced. 86% of the population were adults, with 34% of those being unsentenced. Overall just over half the prisoners are sentenced (52.68%) with the majority of these serving determinate sentences. HMP High Down appears to have a larger proportion of unsentenced adults and a lower proportion of unsentenced young adults than the national average.

On average 33% of the prison population are discharged each month, indicating that the population of High Down is largely replaced almost every 3 months. Those completing their sentence and being discharged back in to the community make up the largest proportion of discharges each month. The majority of those discharged (81%) go to the South East, with most (43%) returning to London boroughs and 16% returning to Surrey.

An analysis of 6 months of reception health screenings at HMP High Down (Nov 08 – May 09) has shown that 21% of prisoners were homeless in the year before entering the prison. It is not clear whether these individuals are absorbed into Surrey upon their release.

Comparative Needs Assessment

The results from the comparative component of the needs assessment revealed that the provision of healthcare services in HMP High Down is comparable in structure and function to that at HMP Durham, HMP Forest Bank and HMP Elmley.

HMP High Down has a higher number of nursing staff across its healthcare system and more of these nurses have a mental health background than at any of the comparator prisons. However, nearly one in ten prisoners report not being seen by reception at healthcare (results were broadly similar across all comparator prisons),and access to healthcare in the first 24 hours was better in all prisons except HMP High Down where figures were significantly worse than local comparators. Offenders at HMP High Down appear to rate their healthcare provision more highly than in the other establishments.

All four prisons face challenges with supplying a dental service to meet the demand from prisoners. They also all need to improve provision to support prisoners with alcohol misuse problems – particularly those who are not drug dependant.
A review of Prison and Probation Ombudsman (PPO) reports into deaths in custody highlighted that improvements in chronic disease management, particularly around coronary heart disease and hypertension, could reduce the number of deaths from "natural causes" .

The two specific areas that HMP High Down could improve upon compared to comparators are Hepatitis B vaccination, where HMP Forest Bank performs better, and user involvement, record retrieval and discharge planning where HMP Durham has introduced innovative ways of working.

Service mapping

The NHS has been providing services at HMP High Down since 2005. The latest Independent Monitoring Board report describes the transfer as mainly 'advantageous' but describes some difficulties in communication, decision making and some areas of the budget.

NHS Surrey commissions Surrey Community Health (SCH) to provide the majority of general healthcare within the prison. SCH has prioritised mental health, substance misuse and communicable diseases in its Provider Service Plan 2007-09.
Services for mental health have been commissioned from Surrey and Borders Partnership NHS Foundation Trust since 2005.

GP services are commissioned from Secure Care who took over from Sussex Forensic Medical Services on 1st May 2009. Harmoni provides out of hours cover.
GUM services are commissioned from Ashford & St Peter's NHS Trust

Healthcare structures

HMP High Down provides 24 hour access to healthcare for prisoners. Healthcare is located in a purpose built facility near reception. Out patients is located on the upper floor and inpatients on the lower floor. There are 23 inpatient cells each of which can accommodate a disabled prisoner.

Healthcare provision is comprised of the following services:

- Primary care including GP sessions, nurse-led out patients clinics, nurse-led wing-based clinics
- In patient unit
- Step down unit
- Mental health in-reach
- Integrated Drug Treatment Service
- Dental service
- Podiatry
- Optometry
- Genito-urinary medicine (GUM) service
- Pharmacy
- Reception health screening.

The Inpatient facility currently provides 23 single cell beds offering care for acute mental and physical healthcare needs. Each patient has a named nurse and officer and patient management is discussed at daily handover meetings.

Reasons for admission to the in-patient unit during the 8 month period April – Nov 2008 were sampled. During this time there were 455 inpatient admissions. These figures were extrapolated to give an estimate of 780 admissions for the year. In the months sampled 64% of admissions were for mental health issues, 22% for physical health, 11% for substance abuse, 3% for lodging, and in 6% of cases the reason for admission was not stated. 51% of admissions were from reception, 47% from house blocks, and 3% are from other prisons/hospital.

Mental health patients had a mean length of stay of 6.5 days (median 3 days), while physical health and substance abuse patients had a mean length of stay of 3.5 days (median length of stay 1 day for both these sets of patients). The average bed occupancy was 87%, reaching a maximum of 96% in September and a minimum of 62% in April.

The Step Down unit is a new development for patients who are no longer acutely unwell but who may still not be sufficiently independent to cope on the residential wings.
The unit consists of 12 cells which are usually full, with reviews being carried out daily. There are normally 2-3 inmates on the waiting list for the unit. At the time of data collection there were no statistics available on turnover. It was estimated that the average stay was 24 – 48 hours. The conditions treated included hypertension, diabetes and respiratory problems.

The Daffodil Day centre offers a range of therapies to both inpatients and outpatients via the inpatient unit. Her Majesty's Inspectorate for Prisons praised the centre for providing 'meaningful and therapeutic care and activity'.

GP sessions are held three times and each session is held on a different house block. If a prisoner cannot see the GP when the house block is visited, he can be seen in out patients usually that afternoon. The GP also visits the Separation and Reintegration Unit twice a week. The current wait for the GP service is one week with emergencies seen on the same day. The IMB highlighted that the service provided was not consistent or timely.

The Wing based clinics provide a mechanism for triaging patients to other healthcare professionals. Emergency nurse practitioner clinics are held twice weekly on house block 3. The current waiting time to see a house block nurse is 2 days with emergencies seen the same day.

The following **Outpatient clinics** are provided. The majority of these clinics are nurse led and overseen by the primary care lead nurse and 'did not attend' (DNA) rates are registered as high.

Phlebotomy clinic	weekly
Hepatitis B immunisation	daily
Podiatry	2 x clinics per week
Dental	10 x sessions per week
Smoking cessation	2 x clinics a week
Asthma	2 x clinics a week
Diabetes	Bi-weekly
X-ray	2 x clinics a week
Sexual health	1 x clinic a week
Wellman	Weekly (includes dental health screening)
Flu vaccinations	annually between Oct – Nov
Physiotherapy	3 x clinics per week
Optometry	4 sessions per month (average

In the first six months of 2009 most **Out of Prison referrals** were to orthopaedics and the DNA rate for referrals was 34%.
In 2006 there were 325 referrals. The majority of these were described as general medical (14%), radiology (9%) and general surgery (7%). There may have been a reduction in referrals to some services in 2008 as they are now provided in house or quality of provision is better. GU medicine, diabetes care, occupational therapy, physiotherapy, chiropody, dental and rehabilitation referrals account for 7% of referrals in 2006 and as no referrals were made to them in 2008 services may have been developed or improved. A number of referrals in 2006 were cancer related (4%) and will reflect the needs of a specific population group within the establishment at that time.

Pharmacy
Medication is administered from the house blocks except for controlled drugs which are dispensed from out patients. Atypical medication may need to be brought in from outside the prison. Medication is issued twice a day with any night time medications dispensed by the night nurse. Over 85% of medications are in possession (weekly or monthly) and prisoners with diabetes are allowed their insulin in possession. For prisoners with low literacy levels medication is colour coded.

The top ten items prescribed by volume were:

1) Methadone
2) Suboxone
3) Fluoxetine
4) Mirtazapine
5) Citalopram
6) Diclofenac
7) Ibuprofen
8) Loratadine
9) Omeprazole
10) Salbutamol

The drugs prescribed reflect the high prevalence of substance misuse and mental health problems within the prison.

A number of over the counter (OTC) medications (e.g. ibuprofen) are available on the canteen list. The means of accessing OTC medication are the canteen, via pharmacy or homely remedies from the house block nurses.

If medication is changed the prisoner is provided with the medicine information leaflet contained with the new medication. An out of hour's drug cupboard can be accessed if necessary and pharmacy can be opened in an emergency.

Pharmacists run the asthma and smoking cessation clinics

The **Mental Health In Reach Team** are based in the prison and provide both primary and secondary mental health services. The service is a mixture of outpatient clinics, visiting prisoners on normal location and close liaison with the inpatient unit.

The consultant psychiatrist provides 4 sessions per week, the SpR in psychiatry provides 5 and the nurse prescriber one session.

There are 6 nurse outpatient clinics per week which are predominantly new patient and joint multi-disciplinary team reviews. There are also clinics in movement psychotherapy, psychotherapy, psychology and counselling, Capoeira session and eye movement desensitization and reprocessing (EMDR) therapy.

Care programme approach (CPA) is well established and is initiated or maintained according to need. CPA is also transferred on discharge and community teams are invited to CPA reviews to maintain continuity of care.

It is estimated that the mental health team will have between 140-160 contacts with patients per week. Some of these will include multiple contacts with the same individual and group contacts which account for 18% of contacts. Generally the in-reach team has 100-120 cases open at any one time.

The total number of referrals received by the mental health in reach team between February 2008 and February 2009 was 1108. The rate of referrals increased markedly from October 2008 in line with the increase in the prison population. Referrals are screened by a CPN each day. Of the 1108 referrals 822 (74%) were not accepted. Some referrals were refused due to lack of information. Others were referred on to other healthcare professionals (e.g. GP, house block nurse) for initial assessment or support.

The **Integrated Drug Treatment Service** provision at HMP High Down comprises of 120 beds on house block 3 with house block 4 taking the overflow. The team had several vacancies in nursing, healthcare workers and admin. Healthcare workers expressed concern that they were unable to engage in extra-therapeutic activities with patients. Additional funding has been allocated to HMP High Down for the IDTS service for the coming financial year. Whilst the number of new referrals and those starting detoxification have reduced over the periods compared, all other elements of the service have increased. This may imply that because the numbers on maintenance / continuation have increased significantly there is less capacity to deal with new IDTS clients requiring detoxification. A separate health needs assessment of the IDTS is carried out annually.

During the period January-October 2008 the **CARAT** team saw on average 178 clients per month. The number of clients referred to Drug Intervention Programmes (DIPs) by CARAT workers has increased by 42% during the period April-October 2007 and April-October 2008. The monthly average of referrals to DIP's has increased from 90 per month during April-October 2007 to 155 per month during the same period in 2008.These increases may again reflect the increase in the prison population generally and the high turnover over prisoners.

An alcohol detoxification programme is available and there are weekly AA meetings held at the prison. The CARAT team provides 1:1 counselling for multi-drug users. 313 patients were referred for alcohol detoxification in 2008 and all participants completed the programme.

Epidemiology

Many prisoners enter prison with chronic disease. The high prevalence rates of some conditions may partly be explained by the fact that half of all those sentenced to custody may not registered with a GP prior to being sent to prison and therefore miss out on basic primary care. These figures match those found at reception at HMP High Down where 50% of inmates were registered with a GP when they arrived. 26% of those questioned at reception had seen a doctor in the recent past.

In the last prisoner survey at HMP High Down 53.16% of inmates surveyed stated they had a mental health problem and 31.65% stated they had a physical health problem.

A database of the initial reception health screen has been piloted since November 2008. Data from the period November 2008 until May 2009 was used to provide a "snapshot" of self reported illness in men entering the prison. The database contained 995 entries. This averages at around 153 receptions a month. The highest number of reception screenings was in March 2009 (214).

Based on the demographics of the prison population the HNA makes a number of recommendations to address specific health needs.

The HNA report recommends that the following conditions identified at reception should lead onto a clinical assessment, confirmation of diagnosis and prescription of appropriate treatment. Compliance with this should be regularly audited. These conditions require a chronic disease register and their management should comply with the formal approach to managing long term conditions in prison.

Asthma/COPD

As it was not possible to elicit the underlying diagnosis and motives of inmates an assumption was made that all those using inhalers had a diagnosis of asthma. This gives an estimated prevalence of asthma of 4.1%. Studies have suggested that the prevalence of asthma among male prisoners is between 4% and 5.2%. This is not significantly different to the general population (5.7%).

Due to the higher prevalence of risk factors in the prison population e.g. smoking, low socioeconomic status the estimated HMP High Down may represent under diagnosis or under treatment as it is unlikely that the population of the prison is significantly different to the rest of the prison estate.

The likelihood of under diagnosis is supported by an analysis of the reception health screens, 107 inmates described themselves as being asthmatic, a prevalence of 11%. Previous studies at HMP High Down have suggested prevalence rates of treated asthma of 10.6% (2003/04) and 12.5 % (2005/06).

The community prevalence rate of COPD is 1.5% but this is likely to be an underestimate due to poor diagnosis. Limited data on prevalence of COPD in the prison population is available with many studies presenting rates for all respiratory diseases. One study has estimated the prevalence to be 6.3%. Specific epidemiological information on COPD was not collected but if the rates were applied there could be between 16 and 67 inmates in HMP High Down with the condition. COPD management will be soon be incorporated into asthma clinics.

Epilepsy
Based on the assumptions that most people with a formal diagnosis of epilepsy are prescribed anti-epileptic medication and that they are very rarely used in other conditions it was inferred from prescribing data that the prevalence of epilepsy was 1.3%. Prevalence of epilepsy at HMP High Down has remained stable with rates of 1.5% in 2003-04 and 1.4% in 2006-06. This is marginally higher than in the general population (0.6%) but lower than the figures in other establishments of between 2% and 4%.

At reception 5% of those questioned reported that they suffered from epilepsy or fits. It was not noted whether these were confirmed diagnoses. There can also be wide interpretation of what 'fits' are and a number of causes for them. During 2008, 15 seizures were reported.

Diabetes
The 19 recorded prisoners at HMP High Down on either insulin or oral hypoglycaemic represents a prevalence of 1.5%, with approximately 0.6% type 1 and 0.9% type 2. This figure will not include a 'diet controlled' sub-section.
These figures are significantly different from rates seen in previous years as demonstrated but close to that described at reception (2.2%). Although the current figures may be an accurate reflection of the current population the prescribing snapshot is likely to have excluded any diabetics who are diet controlled.

Prevalence estimates for diabetes in prison are not widely available. One US study has cited rates of 4.4% which is higher than current UK prevalence rates (3.9%). Prisoners are likely to have higher than average rates as high risk groups, particularly BME groups, are over represented in the prison population.

Coronary Heart Disease/Hypertension
A medication review was used to estimate prevalence, the review did not provide a detailed breakdown of the exact medications but identified 38 prisoners as being on 'cardiac drugs'. 25 of these were specifically taking cholesterol-lowering medication. Assuming that those people being prescribed these drugs had a diagnosis of established coronary heart disease or hypertension, then this equates to a prevalence of 3.1%. Previous needs assessments at the prison have suggested prevalence rates of between 8% (2003/04) and 11% (2005/06) despite there being no significant change in the middle aged and older population within the prison.

The estimated prevalence within the prison is very similar to that seen in the general population (3.7%) but differs significantly from prevalence rates seen in other prisons (14%) indicating there may be anything between 33 and 149 prisoners with CHD within the establishment.

The prevalence of hypertension in the UK is 12.8% which is higher than rates seen in some US studies (9.8%, 12%). The CARDIA study demonstrated that imprisonment is associated with increased risk of hypertension with rates of 12% compared with a control group prevalence of 7%. The association persists after adjustment for smoking, alcohol and illicit drug use. Using these prevalence rates there would be between 104 and 136 inmates with hypertension.

Serious Mental Illness
Evidence suggests that there are now more people with mental health problems in prison than ever before. Prisoners have significantly higher rates of mental health problems than the general public although the range of conditions and illnesses are broadly similar.

At reception screening 16% of prisoners reported that they had previous mental health problems and had received psychiatric treatment in the community. This figure is likely to be an underestimate of the overall prevalence of mental illness as many inmates may have not received any assessment or diagnosis of their psychiatric condition.

4% of those screened at reception had a community mental health nurse, 6% had been admitted to a psychiatric unit and 10% had received medication for mental health problems at any time.

The majority of referrals were made for anxiety or depression (22%). These referrals were in addition to those where the primary concerns were incidents of self harm or suicidal ideation/attempts (15%). The next most common presentation was (21%) severe mental illness including schizophrenia, bi-polar affective psychosis and those displaying psychotic symptoms or phenomena. These referrals were a combination of prisoners presenting with new symptoms and those with existing pathology. Personality disorder was the third most common treason for referral (9%).

The HNA also identified that due to the demographics of the population the following conditions would require active case finding through screening processes and clinical assessment. Appropriate clinical intervention should then be applied.

Hepatitis B, Hepatitis C and HIV
The risk factors within the prison population for contracting blood borne diseases such as Hepatitis B, C and HIV are more prevalent than in the 'outside' community. This is partly due to factors such as injecting drug use, tattooing with non-sterile/home made equipment and risky sexual practices as well as potential for initiation into first time injecting drug use whilst in prison.

The most recent survey of prevalence of HIV in prison found rates much higher than in the community The rate in male prisoners was 0.4% with a rate of 0.5% in drug using inmates. The rate in the community is 0.2%.

The national prevalence of HCV in the general population is 7% and is estimated to be 31% within the male drug using prison population.

The prevalence of hepatitis B is estimated as up to 20% in the prison drug using population. The general population prevalence is estimated as 8%. This would equate to an estimated 2 cases of HIV, 99 cases of Hepatitis B and 153 cases of Hepatitis C.

Suicide and Self harm
Prisoners are an extremely high risk group for both suicide and self harm. The prison suicide rate in 2007 was 114 per 100,000 prisoners compared to 8.3 per 100,000 in the general population and it is estimated that 30% of offenders have engaged in some form of self harm during their custody. At reception screening 3% of those questioned had self harmed in prison and 9% had self harmed in the community. 3% had thoughts of self harm at reception. It was not possible to analyse the overlap between these groups.

The last Her Majesty's Inspectorate of Prisons report described suicide and self harm prevention arrangements as satisfactory but there were 5 deaths in custody between December 2007 and November 2008. Three of these were young offender prisoners. One death was from natural causes.

Sexually Transmitted Infections (STI's). The high prevalence rates within prisons of STI's and the known benefits to the wider community by effectively intervening with this group should ensure that screening and treating prisoners for STI's should be a priority.

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. Screening for TB should be a priority and proactive measures should be taken to identify cases - such as asking specific questions related to TB symptoms at reception.

Alcohol.
Surveys of psychiatric morbidity in prisoners have suggested that 58% of male remand and 63% of male sentenced prisoners reported hazardous drinking and that 30% of all male prisoners had Alcohol Use Disorder Identification Test (AUDIT) scores indicating severe alcohol problems. Results from the HMP High Down Independent Monitoring Board (IMB) report concur with these estimates suggesting that 66% of prisoners entering the prison have issues with alcohol misuse.

Analysis of the reception database contained 489 responses on the use of alcohol. Of these 135 men (28%) stated that they drank at dangerous levels (50+ units per week), 50 (10%) stated they drank at hazardous levels and 58 (12%) drank at a safe level.

Corporate Needs Assessment

In assessing perceptions of health needs at High Down, a variety of stakeholders were asked to give their views. This included prisoners, health care staff and prison officers. A number of prisoner and prison staff focus groups were conducted and healthcare staff and prisoner questionnaires completed.

When asked what one thing you would improve in healthcare, prisoners responded as follows:

- Waiting Times: 31%
- Better food:17%
- Waiting Times Dentist:14%
- Better staff: 9%
- Waiting Times Dr: 8%
- More staff: 7%
- More access to exercise: 7%

A number of common themes in the responses from prisoners, prison staff and healthcare staff were identified:

Use of *agency staffing* was a concern for all responders.

It was clear that health service providers should formally seek the *views of prisoners* on a regular basis and be able to demonstrate that any concerns raised regarding standards of care and levels of respect served by healthcare staff towards prisoners are addressed.

A number of issues regarding the *organisation and administration of medication* were common concerns for prisoners
Prisoner confidence in the health care service also needs to be improved.

In line with the Prison Health Quality Indicators a *Health Promotion Action Group* should be established, which is tasked with ensuring that each prisoner has access to information on how to stay healthy in prison

Healthcare staff reported that at times they felt threatened. The NHS has a zero tolerance policy on *abuse against healthcare staff* and this should be supported within prison settings.

The *relationship between Healthcare and Prison staff* and a joint understanding of their respective roles and responsibilities should be actively improved.

Conclusion

This HNA report clearly demonstrates that any healthcare provision in HMP High Down needs to ensure it meets the needs of a young, male and ethnically diverse transient population.

Current service delivery does not completely meet the population's health need at the moment and redesign of service provision needs to be undertaken, with the aim of improving system processes between prisoners, prison and healthcare staff and improve prisoner health outcomes. This should also ensure that services are provided in the most cost and clinically effective way.

A significant number of recommendations have been made, the themes of which have been summarised below.

- Staffing
- Risk Management
- Prisoner engagement
- Improvement in clinical practice
- Cost effective use of health resources
- Professional standards
- Health Promotion
- Training
- Environment
- Proactive case finding
- Effective discharge
- Further needs assessment

The full HNA report identifies how these should inform the commissioning process and how these can be contractually performance managed.

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1 Introduction

1.1 Background

The NHS Surrey Public Health Directorate was asked to undertake a full health needs assessment (HNA) following the Deaths in Custody Review meeting held on September 24th 2008. The needs assessment was to focus on identifying the health needs of offenders in HMP High Down.

This needs assessment forms part of a rolling programme of needs assessments and refreshers that will be taking place 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 being collected on an annual basis by the Department of Health and the Ministry of Justice.

HMP High Down is undergoing major modification with the construction of two new house blocks. This will be the first health needs assessment (HNA) that has been undertaken since the development of the prison establishment. The report will be the foundation that future service developments will be built on.

1.2 Definition of Health Needs Assessment

A prison health needs assessment (HNA) will determine prisoners' ability to benefit from healthcare. The need for health care must be distinguished from both the supply and demand for health care. In general terms, need is what people might benefit from, demand is what people might wish to use, and supply is what is actually provided. Current service provision and demand are rarely markers for need.

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 can be achieved by reducing demand where it is deemed to be inappropriate (e.g. increasing potential for self-care) or stimulating demand where relevant (e.g. access to Hepatitis B vaccinations) or coping with demand more efficiently (e.g. revised methods for provision of medication). In addition, altering the supply of health care may require changes in resource or re-organisation of existing supply e.g. through skill-mix changes.

There are three main methods of HNA:

1. **Comparative approach**: Services are compared with those of other providers e.g. community services or those within other prisons.
2. **Corporate approach**: Stakeholders or others with a special knowledge are canvassed to determine their views on what is needed. This includes obtaining the views of offenders, prison and healthcare staff.
3. **Epidemiological approach**: The main approach through which health care needs are determined by considering three components:
    - incidence and prevalence of a problem
    - effectiveness and cost effectiveness of services
    - services available to deal with the problem.

1.3 Aim

The aim of prison health care is to give offenders access to the same quality and range of health care services as the general public receives from the National Health Service in the community. Improving the quality of care will also help reduce health inequalities between this vulnerable group and the rest of the population.

The aims of the health needs assessment are to:

- provide information in order to plan, negotiate and change services for the better and to improve health in other ways
- to build a picture of current services – a baseline.

There are five objectives of a health needs assessment:

- **Planning**: The central objective used to help decide services required; for how many people; the effectiveness of these services; the expected benefits and at what cost.
- **Intelligence**: Information gathering to determine the existing baseline; the population it serves and the population's health needs.
- **Equity**: Improving the allocation of resources between and within different groups.
- **Target efficiency**: Having assessed needs, measuring whether or not resources have been appropriately directed.
- **Involvement of stakeholders**: Carrying out a HNA can stimulate the involvement and ownership of the various players in the process.

The health needs assessment was conducted using the 'Toolkit for health care needs assessment in prisons'[1] developed by the University of Birmingham. A Prison Health Needs Assessment Steering Group was responsible for the needs assessment. The membership of this group is listed in Appendix A.

2 HMP High Down Prison Profile

2.1 Category, logistics and prison function

HMP High Down is a local male category B prison which opened in 1992 and is built on the site of a former psychiatric hospital in Banstead. The establishment serves the Crown Courts at Croydon and Guildford and the surrounding Magistrate's Courts. HMP High Down is also currently operating as an overflow for young offenders from HMP & YOI Feltham and HMP & YOI Chelmsford. There are no medical restrictions for reception.

The prison is undergoing a major building and refurbishment programme which includes the construction of two new house blocks – each with capacity for 180 prisoners. The expansion of other areas e.g. visits hall, reception, administration offices is being undertaken in order for HMP High Down to operationally accommodate the increase in numbers.

2.2 Accommodation

HMP High Down has 6 house blocks. House blocks 1-4 were built in 1991 and are double and treble occupancy. Each house block has an operational capacity of 181. House blocks 5 and 6 were built in 2007 and all cells are single accommodation with an operational capacity of 178 each. This includes two disabled cells on each house block. There are 22 single cells on the Separation and Reintegration Unit. All cells have sanitary facilities.

2.3 The national picture

The UK prison population has been rising steadily. Since June 1995 the prison population in England and Wales has increased by 60% and current projections suggest that this trend will continue. The population in custody on 31 March 2009 was 83346 - a rise of 1120 from a year earlier. The male prison population had increased by 2% (1330) to 78605.

Investment in prison health care has increased from £118m in 2002-03 to £200m in 2006-07.

2.4 Occupancy & changes in operational capacity

The March 2009 Ministry of Justice Statistics Bulletin states that the in use Certified Normal Accommodation at HMP High Down is 999 (this includes accommodation available for immediate use, excluding damaged cells and cells affected by building works or staff shortages). The total population is 1066. Of these 215 were foreign nationals, 820 UK nationals and 31 prisoners had no nationality recorded.

The last inspection by Her Majesty's Inspectorate of Prisons was in 2006 and as demonstrated in Table 2.1 there has been a significant increase in the prison community, mainly in the number of UK nationals. The tremendous pressure on the prison created by this rapid growth and the progress it has made were acknowledged in the last Her Majesty's Inspectorate of Prisons (HMIP) report.

Table 2.1 Changes in HMP High Down's operational capacity & occupancy between 2006 and 2009

	2006	2009	Change (%)
CNA	-	999	-
Total population	737	1066	+ 329 (45)
Foreign nationals	219	215	- 4 (- 1.8)
UK nationals	518	820	+ 302 (58)
Nationality not recorded	-	31	-

There is a high level of turnover or 'churn' within the prison population with as much as 77% of the population remaining in the prison for less than six months (31.9% less than one month and 44.6% 1-6 months). In 2006 83.1% of prisoners were at the prison less than 6 months with 21.9% of these staying less than one month.

2.5 Performance rating

The Ministry of Justice publishes quarterly performance ratings for prisons based on a combination of the Prison Performance Assessment Tool (PPAT) and the public prison weighted scorecard.

The ratings for HMP High Down and the three comparator prisons for Quarter 3 (08/09) are shown in Table 2.2.

Table 2.2 Ministry of Justice Quarterly ratings (Quarter 3, 2008/09)

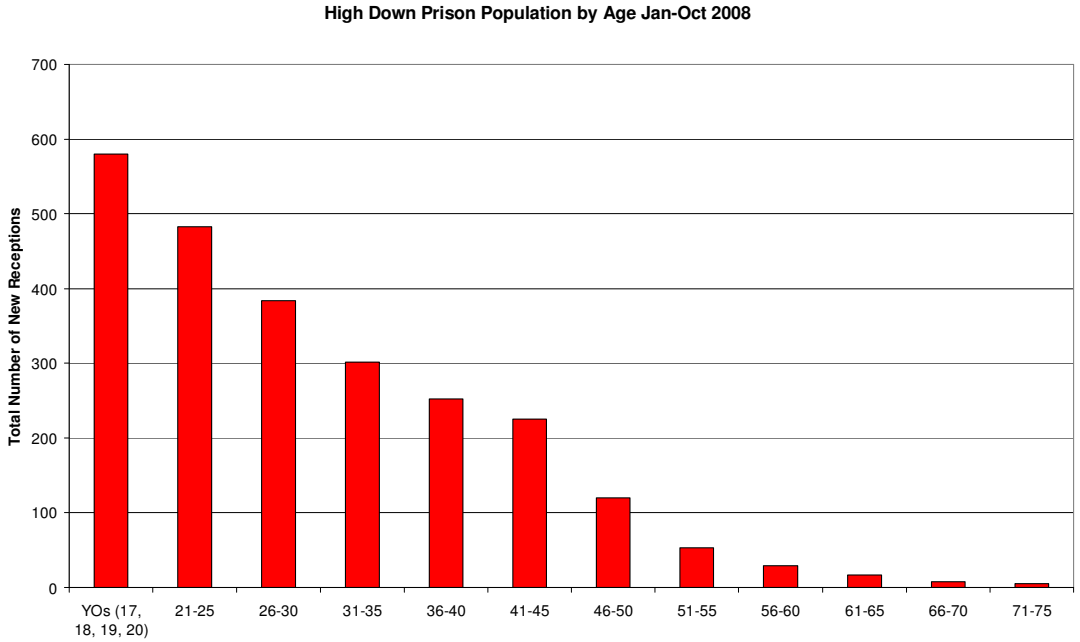
Establishment	Rating	Performance against last quarter
HMP High Down	2 (Requiring development)	Drop in performance
HMP Forest Bank	2 (Requiring development)	No change
HMP Durham	3 (Good performance)	No change
Sheppey Cluster (HMP Elmley)	3 (Good performance)	No change

Source : Ministry of Justice

2.6 Prison receptions by age

Due to the high turnover of inmates any demographic information can only provide a 'snapshot' of the population. Local Inmate Database System (LIDS) data (recording new receptions by date of arrival) shows that in the period Jan-Oct 2008 the majority of new receptions were young offenders aged between 17 and 20 years (24%), with 21-25 year olds (20%) and 26-30 year olds (16%) making up the next largest groups. There were a total of 2458 new receptions in that period – a substantial increase compared with the 958 receptions seen in the same period in 2007.

Figure 2.1 HMP High Down prison receptions by age (Jan-Oct 2008)



Source: LIDS, report number 22

Data from the health reception screening database for the period November 2008 to May 2009 showed a similar pattern with the largest proportion of prisoners aged 18-21 (17.4%), followed by those aged 26-30 (16.5%) although the third largest group was those aged 41-45 (12.2%).

Over the 17 month period (Jan 08 – May 09) 50% of new receptions were under the age of 30 with the number of new receptions decreasing with increasing age, with only 4.4% of the population being aged 50+.

The snap shot of the prison population in December 2008 mirrored the receptions into the establishment over the preceding year. 51.06% of the population were under the age of 30. Young offenders constituted 13.86% of the total prison population. The proportions of prisoners over 30 fell with increasing age with only 4% of the population aged over 50.

In 2006 the majority of prisoners were also aged under 30 (61.3%) but a smaller proportion of prisoners were young offenders (12.5%). The population of prisoners aged over 50 (2.4%) was smaller than at present [2].

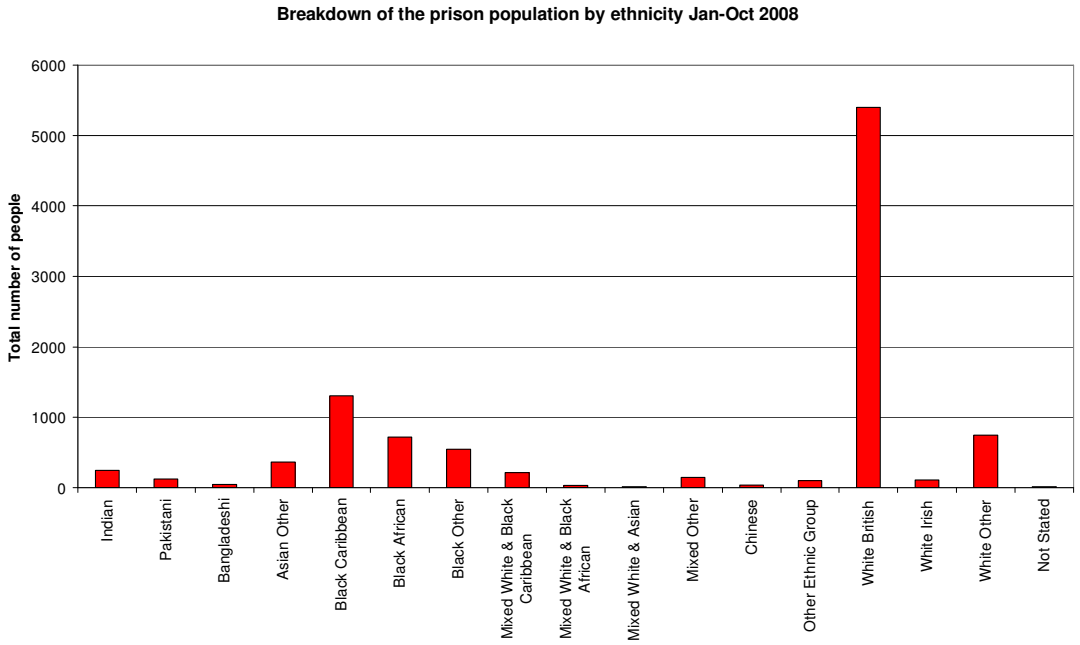
2.7 Population by ethnicity

A recent report by Race for Justice[44] states that black and minority ethnic (BME) groups account for 26% of the prison population although they constitute only 9% of the overall population of England and Wales. It also indicates that the over representation of BME groups in prison increases year on year.

HMP High Down has a higher BME population than the national average (47%). In the period Jan-Oct 2008, the majority of prisoners entering the jail were White British (53%), followed by Black Caribbean (13%) and Black African (7%) (Figure 2.4). This represents a slight decrease in the White British population compared to 2006 when

60% of prisoners defined themselves in that ethnic group. In 2006 Black African (9%) and Black Caribbean (7%) groups were the largest BME groups at the prison.

Figure 2.2 Ethnicity breakdown of reception prisoners to HMP High Down (Jan-Oct 2008)



Source: Diversity SMART Ethnic Data

Ethnicity data is available on 82.8% of prisoners passing through reception between November 2008 and May 2009. The proportions among the three main ethnic populations remained broadly similar with 50.8% of inmates classified as White, 9.2% as Black Caribbean and 7.7% as Black African.

2.8 Foreign nationals

As demonstrated in Table 2.1 foreign nationals make up 20% of the population of the prison. Nationally, this figure is 13.5% (this includes those held under the Immigration Act as well as those on remand and serving custodial sentences). The largest foreign national population in prison in England and Wales at 31 March 2009 were Jamaican nationals (9.7%) [3].

The majority of prisoners entering reception between November 2008 and May 2009 at HMP High Down gave English as their first language (33%) although this does not match the proportion who stated their ethnicity as White British. The most commonly spoken languages after English were French (1%) and Arabic (0.6%). A total of 19 languages apart from English were stated as first language by these prisoners.

2.9 Population by sentencing status

A snapshot of the current prison population at the week beginning 1 December 2008 indicated that 14% of the prison population were young offenders, of whom the majority (9%) were unsentenced. 86% of the population were adults, with 34% of those being unsentenced. Table 2.3 indicates that overall just over half the prisoners are sentenced (52.68%) with the majority of these serving determinate sentences.

National figures are provided in Table 2.4 for comparison. HMP High Down appears to have a larger proportion of unsentenced adults and a lower proportion of unsentenced young adults than the national average. Civil prisoners are those in prison for a non criminal matter e.g. not paying council tax.

Table 2.3 Current HMP High Down prison population by sentencing status (%)

	Unsentenced	Sentenced	Det***	Civil	Total
Adult	33.94	47.61	4.49	0.10	86.14
YO	8.60	5.07	0.19	0.00	13.86
Total	42.54	52.68	4.68	0.10	100.00

Source: LIDS 1/12/2008
*** Includes prisoners awaiting extradition

Table 2.4 National adult male prison population by sentencing status (%)

	Unsentenced	**Sentenced**	**Civil**
Adult	14.6	83.3	2.1
YO	20.2	78.7	1.1

Source: Ministry of Justice [3]

55% of prisoners who passed through reception between November 2008 and May 2009 had been in prison before.

2.10 Population by sentence length/length of stay

HMP High Down experiences a high turnover of prisoners. Of those sentenced, 19% were serving up to 12 months and 20% were serving between 1-4 years. Therefore, almost 40% of the sentenced prison population were serving sentences of 4 years or less. 91% of the prison population remain at HMP High Down for a year or less. There has been a significant shift in the number of prisoners serving shorter sentences compared with 2006 when 72.2% of prisoner at HMP High Down were serving sentences of less than one year[2].

Table 2.5 Length of stay of current prison population (%)

	<1 month	1 - 6 months	6 - 12 months	1 - 2 yrs	>2yrs	Total
sentenced	14.52	23.21	8.37	4.98	1.59	52.68
unsentenced	17.38	21.39	6.21	1.53	0.80	47.32
Total	31.90	44.61	14.58	6.51	2.39	100.00

Source: LIDS, 1/12/2008

On average 33% of the prison population are discharged each month (discharges include those sentenced and being discharged in to the community; transfers; unsentenced discharges; deportations), indicating that the population of HMP High Down is largely replaced almost every three months. Those completing their sentence and being discharged back in to the community make up the largest proportion of discharges each month.

The majority of those discharged (81%) go to the South East, with most (43%) returning to London boroughs and 16% returning to Surrey. An analysis of 6 months of reception health screenings at HMP High Down (Nov 08 – May 09) has shown that 21% of prisoners were homeless in the year before entering the prison. It is not clear whether these individuals are absorbed into Surrey upon their release.

3 Comparative health needs assessment

3.1 Summary

The results from the comparative component of the needs assessment revealed that the provision of healthcare services in HMP High Down is comparable in structure and function to that at HMP Durham, HMP Forest Bank and HMP Elmley.

HMP High Down has a higher number of nursing staff across its healthcare system and more of these nurses have a mental health background than at any of the comparator prisons. However, nearly one in ten prisoners report not being seen by reception at healthcare (results were broadly similar across all comparator prisons),and access to healthcare in the first 24 hours was better in all prisons except HMP High Down where figures were significantly worse than local comparators. Offenders at HMP High Down appear to rate their healthcare provision more highly than in the other establishments.

All four prisons face challenges with supplying a dental service to meet the demand from prisoners. They also all need to improve provision to support prisoners with alcohol misuse problems – particularly those who are not drug dependant.

A review of Prison and Probation Ombudsman (PPO) reports into deaths in custody highlighted that improvements in chronic disease management, particularly around coronary heart disease and hypertension, could reduce the number of deaths from "natural causes" [3].

The two specific areas that HMP High Down could improve upon compared to comparators are Hepatitis B vaccination, where HMP Forest Bank performs better, and user involvement, record retrieval and discharge planning where HMP Durham has introduced innovative ways of working.

3.2 Identification of appropriate comparators

Three main comparators were identified through discussion with prison authorities, public health colleagues and literature searching : HMP Durham, HMP Elmley and HMP Forest Bank. The choice of comparators was agreed with the Health Needs Assessment Steering Group.

3.2.1 HMP Durham

HMP Durham was built in the early 19th century. It is a Category B local prison serving the courts in the area. The operational capacity is 985 with accommodation in 7 wings. Prisoners are over 21 from the Tyneside and Cumbria areas (sentenced, convicted and on remand). 'Separation and reintegration' and healthcare facilities are present on site. The prison has been undergoing a major refurbishment programme during the last 10 years.

The health needs assessment (HNA) steering group decided that HMP Durham was an appropriate comparator as it has a broadly comparable population to HMP High Down due to its categorisation. The main difference is the absence of young offenders at HMP Durham.

3.2.2 HMP Elmley

HMP Elmley is purpose built local Category B/C prison serving all the courts in the county of Kent. The prison opened in 1992 and includes a Category C unit of up to 240 prisoners built in 1997. Elmley is one of six Bullingdon design prisons in England and is the largest of the three prisons within the Sheppey cluster. Operational capacity is 985 (926 adults and 59 young offenders) with 5 house blocks housing between 183 and 240 prisoners in single, double and treble cells. A sixth house block is currently under construction. The prison population are unsentenced and sentenced adult men and unsentenced male young offenders. The prison has a Vulnerable Prisoners Unit for remand and sentenced offenders.

The HNA steering group decided that HMP Elmley was an appropriate comparator as it has a large proportion of Category B prisoners and young offenders in its population. The main differences are the presence of Category C offenders at HMP Elmley and that its key function is as a training establishment. The local primary care trust was contacted for a copy of recent health needs assessments. A health needs assessment from 2007 was made available to inform this report.

3.2.3 HMP Forest Bank

HMP Forest Bank is a local Category B prison serving the courts of North West England. The prison has an operational capacity of 1160 and takes adult males from the Wigan, Leigh and Bolton courts and young offenders from all of the Greater Manchester courts. The prisoners are housed in 6 residential house blocks on 12 wings. The extension to HMP Forest Bank will provide an additional 264 adult male local places by February 2010.

The HNA steering group decided that HMP Forest Bank was an appropriate comparator due to its categorisation and the presence of young offenders in its population. The main difference is that Forest Bank is a privately run prison and Kalyx are responsible for the commissioning and the provision of healthcare services. The local primary care trust has a governance responsibility for the prisoners.

3.3 Information sources

A number of sources of information on healthcare were utilised:
- Independent Monitoring Board reports 2008
- the most recent report from Her Majesty's Prison Inspectorate
- relevant national guidance, legislation and policy
- academic papers.

3.4 Prison populations

Table 3.1 A comparison of key demographics between HMP High Down and comparator prisons

Characteristic	HMP High Down	HMP Durham	HMP Elmley	HMP Forest Bank
Operational capacity [4]	1066	938	945	1094
Lifers (%) [2 5 6 7]	32 (3)	20 (2)	105 (11)	48 (4)
Young offenders (%) [2 4 5 6 8]	150 (14)	-	59 (6)	138 (13)
Foreign nationals (%) [3]	215 (20)	85 (9)	148 (16)	86 (8)
Sentenced (%)[2 9 10 11 12]	562 (53)	594 (63)	399 (42)	678 (62)
White British ethnic group (%)[3]	565 (53)	847 (90)	782 (83)	983 (90)

Percentages in brackets

Table 3.1 demonstrates the differing profiles of the comparator prisons with HMP High Down. Although the prisons are of broadly similar sizes and the same security classification (apart from the unit at HMP Elmley) HMP High Down has the smallest proportion of lifers. All the prisons have White British as the predominant ethnic group but HMP High Down has a statistically significant smaller majority. This difference can be partially explained by the high proportion of foreign nationals in the establishment – the highest of all the prisons. Proportions of sentenced prisoners are comparable to the other prisons. Although the proportion of young offenders is the highest at HMP High Down it is not significantly different to HMP Forest Bank. Within all establishments the prison population and profile is rapidly changing and these figures only provide a snapshot.

3.5 Staff structure

The lack of appropriate medical and nursing skills and training amongst prison healthcare staff are frequently highlighted in investigations of serious untoward incidents (SUIs). Guidance on prison healthcare staff stresses the importance of a high quality, skilled and experienced workforce[13].

The numbers of whole-time equivalent (WTE) medical and general nursing staff are similar for doctors but HMP High Down has a higher number of WTE general nursing staff. Further analysis of the staffing structures reveals differences in the background of nurses employed with HMP High Down having the greatest proportion of nurses with a mental health background on their unit (Table 3.2).

The 2008 Independent Monitoring Board (IMB) annual report on HMP High Down highlighted the need for good quality, consistent staff after the use of a number of locum doctors and agency nurses. Concerns were raised about continuity of care, timeliness and prescribing. The last Her Majesty's Inspectorate of Prisons (HMIP) report on HMP Elmley raised similar concerns about nursing staff stressing that the staffing complement should include staff with qualifications, skills and competencies that correspond to patient need [11]. HMP Forest Bank also had concerns raised in its

2007 HMIP report about the 'detrimental effect' that staff shortages and vacancies were having on health services.

Table 3.2 Comparison of staffing in HMP High Down, HMP Elmley, HMP Durham and HMP Forest Bank

Area of health care provision	**HMP High Down**	**HMP Durham**	**HMP Elmley**	**HMP Forest Bank**
Staff structure				
No. of WTE general nursing staff	22 WTE	Not stated	16 WTE	13 WTE
Proportion of general nursing staff with a mental health background	50%	Not stated	40%	30%
No. of medical staff	Not stated	2 GPs (full time)	2 GPs (full time) Plus 2 sessions	1 senior medical officer (1.0 WTE) 1 locum medical officer

3.6 Inpatients

There is also variation in the number of inpatient beds (possibly suggesting the use of different health care models, although each prison provides 24 hour care). HMP High Down has 23 in patient beds, HMP Durham has 20 and HMP Forest Bank has 20 (incorporating two 4 bed wards, and a 2 bed observation suite). HMP Elmley has 26 beds, including two three bedded dormitories. However this space is used on a regular basis for segregated prisoners (R45) and the non-medical use of healthcare facilities creates difficulties for prisoners requiring admission for physical or mental health problems. In their 2008 report the Independent Monitoring Board (IMB) acknowledged the challenges facing Healthcare at HMP Elmley particularly the decrease in inpatient beds in a neighbouring prison, the large number of 'lodgers' and the fluctuations in the types of prisoners coming to the prison.

3.7 Out patients

There is variation in the number of commissioned GP, dental, optician and pharmacy sessions which may reflect the different capacities of the jails and their populations as well as historical arrangements. Best practice states that the range and capacity of primary care services should have been identified through a health needs assessment and service user involvement[14 15] and that Primary Care Trust boards should agree and sign off these services[16]. Primary Care Trust commissioned services in prison should be working towards chronic disease care being delivered at the standards specified in the relevant National Service Framework (NSF). The NSFs and National Institute for Health and Clinical Excellence (NICE) guidelines provide a good practice base to ensure that prisoners are receiving care that is equivalent to that offered in the community. A review of Prison and Probation Ombudsman (PPO) reports into deaths in custody highlighted that improvements in

chronic disease management, particularly around coronary heart disease and hypertension, could reduce the number of deaths from "natural causes" [3].

3.8 Dentistry

The 'Strategy for Modernising Dental Services for Prisoners in England' was published in 2003[17]. Among its priorities was the reduction of waiting lists and a recommendation that prisons should aim for one dental session per week for every 250 prisoners. Using this recommendation as a guide, only HMP Durham and HMP High Down are currently providing a dental service that meets the recommendations for their populations.

3.9 Pharmacy

The Department of Health guidance[18] states that prison pharmacy services should incorporate developments in medicines management in the NHS into their practice and that prisoners should have access to a pharmacist or pharmacy staff member for advice. They also suggest that pharmacy be fully integrated into healthcare.

At HMP Elmley the Prison Inspectorate noted that there was insufficient pharmacist time and that the pharmacist should be encouraged to take a more active role in health initiatives at the prison [11]. The pharmacy system at HMP Forest Bank was also criticised by HMIP [2].

3.10 Other services

HMP Forest Bank has two sessions a week provided by the primary care trust employed Tissue Viability Nurse. At HMP Durham some of the primary care nurses take responsibility for specific long term conditions; one nurse was the nominated lead for older people and another ran a minor ailments clinic three times a week. At HMP Elmley some staff had responsibility for prisoners with long term conditions but not all had recognised qualifications and clinics only took place when staff were available [11].

An analysis of the similarities and differences in the service provision across the prisons is provided in Table 3.3.

Table 3.3 Comparison of service provision in HMP High Down, HMP Elmley, HMP Durham and HMP Forest Bank

Area of health care provision	HMP High Down	HMP Durham	HMP Elmley	HMP Forest Bank
Number of inpatient beds	23	20	26	21
GP sessions per week	16	10	6 general	11
Dental sessions per week	10	4	2	2
Optician sessions per week	4 per month	Provided but number not stated	2 per month	As required
Physiotherapy sessions per week	3	Provided but number not stated	1	2
Chiropody/ podiatry sessions per week	2	Provided but number not stated	1	2 per month
Pharmacy	Full time in house	Full time in house. Most medication dispensed the same day	HMP Rochester team visited for 1 session/month Medicines usually issued within 24 hours	Provided by a national chain
Sexual health sessions	1 per week	Provided but number not stated	Not provided	Number not stated

3.11 Substance misuse services

3.11.1 Best practice

Drug treatment systems are an essential component of healthcare in most prisons and primary care trusts are urged to ensure their effective implementation[5]. All local prisons should provide detoxification for drugs and alcohol following evidence based protocols. The expected outcomes of Her Majesty's Inspectorate of Prisons (HMIP) are that prisoners with substance related needs (including alcohol) are identified at reception and receive effective treatment and support throughout their stay in custody. All prisoners should be safe from exposure to and the effects of substance use while in prison[5].

The National Treatment Agency (NTA) for Substance Misuse carries out a quarterly regional Integrated Drug Treatment System (IDTS) performance assurance appraisal that incorporates a number of quality indicators[19]. HMP Elmley, HMP High Down, HMP Durham and HMP Forest Bank are all IDTS establishments. Prisons should have integrated working with CARATs (Counselling, Assessment, Referral, Advice, Throughcare) and mental health teams.

A review of PPO reports into deaths in custody highlighted the need to ensure that people with substance misuse problems are identified, treated and monitored effectively, particularly in the first 72 hours [3].

3.11.2 Service provision

HMP High Down and HMP Forest Bank have separate wings/units that are used for initial detoxification while HMP Elmley has a stabilisation unit located on one house block. HMP Durham has no dedicated detoxification unit. All four prisons provide CARATs which includes interviewing, work packs, group sessions, referral and input into resettlement.

The multidisciplinary care team (CARATs, IDTS and Healthcare) at HMP Elmley has been recognised as an example of good practice by the NTA. At this jail IDTS operates in conjunction with the Crime Reduction Initiative (CRI) and Prisons Addressing Substance Related Offending (PASRO). It has been recommended that prisoners undergoing detoxification should be housed in a dedicated area[7].

At HMP High Down it is estimated that 71% of men entering the prison have a current drug misuse problem. IDTS, CARATs, Narcotics and Cocaine Anonymous groups run under the supervision of the Substance Awareness Team. However, despite the range of services available only 5% of inmates opt for detoxification with the majority of prisoners remaining on a maintenance regime of methadone or subutex [9]. As there is no cut off for maintenance many prisoners are discharged or transferred on these regimes. 5% of all drug tests are compulsory. There are around 90 voluntary drug tests a month and of these around 10% are positive.

The Her Majesty's Inspectorate of Prisons (HMIP) announced visit to HMP Durham in 2006 highlighted that CARATs had established ties with clinical services but they needed to further strengthen their links to the mental health in reach team. HMIP found that substance misuse services at HMP Forest Bank were limited due to staff shortages with services failing to provide flexibility and choice to offenders and the CARATs team not integrated into services. There was also little clinical support and training for prison staff [12].

3.12 Alcohol misuse services

3.12.1 Best practice

Harmful, hazardous and dependant drinking are all relatively common problems among people entering prison. Brief advice can help individuals with harmful or hazardous drinking but those with a physical dependence require more intensive treatment. All alcohol problems are ameliorated by a combination of medical, psychological and social interventions. All four prisons provided varying degrees of support for prisoners with alcohol problems but many of these services did not address the scale of the problem.

3.12.2 Service provision

At HMP High Down it is estimated that 66% of prisoners enter the prison with a current alcohol misuse problem. However, the 2008 Independent Monitoring Board (IMB) annual report stated that there is a lack of services for alcohol dependencies and related behaviour and alcohol treatment is only currently available for inmates who also have poly drug dependence [5]. A similar situation was described at HMP Durham where detoxification was available but there was no alcohol programme or

policy in place[10]. HMP Elmley had alcohol included in its substance misuse reduction strategy but its CARATs team only managed alcohol misuse if associated with multiple drug use [7]. Plans are in place to secure dedicated alcohol services for inmates there. HMP Forest Bank did not have an alcohol strategy but prioritised alcohol dependant prisoners as it felt they presented a higher risk than those with drug dependency. However CARATs workers only work with prisoners if they also have a drug dependency.

Table 3.4 Comparison of substance misuse services in HMP High Down, HMP Elmley, HMP Durham and HMP Forest Bank

Area of health care provision	**HMP High Down**	**HMP Durham**	**HMP Elmley**	**HMP Forest Bank**
Substance misuse				
Detoxification wing	Detoxification services centralised on one house block with 12 bed 'Step Down Unit'	Voluntary drug testing unit (VDT) on one wing	No (dedicated treatment area in one house block)	The unit runs in parallel with the normal prison induction to support prisoners coming off drugs and assist their integration
CARAT programme	Yes	Yes	Yes	Yes
Voluntary drug testing	Yes	Yes	Yes	Yes
National Treatment of Agency for Substance Misuse quarterly review status	Green	Not stated	Not stated	Not stated
Alcohol screening & treatment	Alcoholics Anonymous Drug & Alcohol awareness course Stabilisation Unit on House block 6 Alcohol detoxification CARATs	Alcohol detoxification	CARATS Alcoholics Anonymous	Alcoholics Anonymous

3.13 Mental health services

3.13.1 Best practice

Surveys have shown that as many as 90% of prisoners have a diagnosable mental illness, substance misuse problem or both. Mental illness can contribute to reoffending and problems of social exclusion.

A 2001 joint strategy between the Department of Health and the Prison Service[20] addressed implementation of the Mental Health National Service Framework [21] within a prison setting. The needs led provision of both primary and more specialised mental health services can contribute significantly to enhanced recovery and positive outcomes. The GP plays a pivotal role in access and provision, and primary care practitioners should be supported to provide a comprehensive service.

A review of Prison and Probation Ombudsman (PPO) reports into deaths in custody underlined the importance of applying NSF standards to inmates, particularly the application of the Care Programme Approach (CPA) for people with serious mental illness [3]. The review also highlighted that differences in the aims and cultures of the NHS and Prison Service may compromise working relationships, particularly around prisoner mental health. A more integrated approach to care with a willingness to share information will increase opportunities to spot potential 'warning signs' of deterioration[22].

3.13.2 Service provision

HMP Elmley appeared to provide the most limited primary mental health service with only basic screening provided. However there are plans to expand this service [3]. Secondary mental health care was provided by the local Social Care Trust with staff assigned to each house block. This enabled good working relationships to develop with staff. At HMP Durham it was estimated that approximately 27% of the prison's population were on the case load of the mental health team. Inmates could be referred by anyone or could refer themselves for a mental health assessment. If a prisoner was known to community mental health services they were referred directly to the Community Psychiatric Nurse. A major concern at HMP Durham highlighted by the Independent Monitoring Board (IMB) was the delay in transferring prisoners with severe mental illness to secure hospitals. Inspectors also noted that HMP Durham did not continue with Care Programme Approach (CPA) even if a prisoner required it [10]. The integration of the mental health in reach team and primary care mental health at HMP High Down was praised by HMIP.

Table 3.5 Comparison of mental health services in HMP High Down, HMP Elmley, HMP Durham and HMP Forest Bank

Area of health care provision	HMP High Down	HMP Durham	HMP Elmley	HMP Forest Bank
Mental health services				
Nurse led psychiatric clinics	Yes	Yes (4 sessions a week)	No	Yes
Access (according to need) to a wide range of specialist mental health services	Yes (secondary)	Yes (secondary and tertiary)	Yes (limited)	Yes
Primary mental health service available	Yes	Yes	Basic screening only	Limited

3.14 Health promotion

3.14.1 Best practice

In order to meet its responsibility that prisoners should have access to broadly equivalent services the NHS and the Prison Service should provide health education, prevention and promotion. Prison Service Order (PSO) 3200 [23] states that health promotion should be managed using a whole prison approach with a specific focus on mental health promotion, healthy lifestyles, nutrition, substance misuse and smoking. All prisoners should have access to disease prevention programmes and screening that mirrors national campaigns and meets NSF standards.

3.14.2 Smoking cessation services

Prevalence rates of smoking are much higher in the prison population than the community[24]- it is estimated that at least 80% of prisoners smoke compared to 24% in the community. HMP Elmley's healthcare staff delivered smoking cessation courses to prisoners and one of the workshop supervisors was also a smoking cessation adviser [25]. Although their quit rate was significantly below that achieved in the community, research suggests that higher quit rates can be achieved if there is flexibility in approach and organisational support from within the prison [25].

3.14.3 Physical activity

Physical education and facilities should meet the requirements of the specialist education inspectorate's Common Inspection Framework and are separately inspected. Prisoners are expected to be encouraged and enabled to take part in recreational physical education (PE) in safe and decent surroundings. The provision at HMP Forest Bank was praised for its facilities, access and the prominent role of health promotion in the department's work [2]. HMP High Down was also praised for its gym facilities and access to them. At HMP Elmley it was noted that despite good facilities and staffing levels, allocation to PE did not give all prisoners an equal opportunity to participate. At HMP Durham long term staff shortages had led to a reduction in provision [10].

Table 3.6 Comparison of health promotion in HMP High Down, HMP Elmley, HMP Durham and HMP Forest Bank

Area of health care provision	HMP High Down	HMP Durham	HMP Elmley	HMP Forest Bank
Health promotion				
Whole prison multi agency steering group	No	No Health promotion advisor – general advice and follow up of Hep C +ve prisoners	Yes	Not stated
Smoking cessation services available	Yes	Not stated	Yes	Yes
A range of physical exercise programmes available appropriate to prisoners health needs	Yes	No	Yes but a fair allocation system was not in place	Yes
Expert Patient programme in prison	No	No	No	No

3.15 Communicable disease control

3.15.1 Best practice

The impact of a communicable disease outbreak upon the population of an establishment spreads wider than the healthcare staff and can affect the operational integrity of the prison. It is important that prevention of outbreaks is seen as a priority by both healthcare and prison management.

Prisoners are a diverse population and differ by age, sex, ethnicity, country of origin and their experiences of health and disease. Primary prevention through immunisation against infections diseases is an essential pillar of good public health practice. Periods of imprisonment may therefore serve as a health promoting opportunity and should be used to identify the healthcare (including vaccination) needs of vulnerable prisoners.

3.15.2 Hepatitis B

All consenting prisoners entering prison, who have not already received at least three Hepatitis B vaccine doses (HBV), should complete a 0, 7 and 21 day HBV course within one month of their arrival [26]. Prisoners are at higher risk of contracting Hepatitis B due to their 'high risk' behaviours both inside and outside prison (e.g. tattooing, intravenous drug use). There are no up to date estimates of the prevalence of Hepatitis B in prison. However, the Health Protection Agency's 2006 Unlinked Anonymous Prevalence Monitoring Programme (UAPMP) survey of current and former intravenous drug users (IDU) in England, Wales and Northern Ireland showed

that 21% had antibodies to Hepatitis B core antigen (indicating past or current infection) [27].

Laboratory reports of acute Hepatitis B infection have increased among IDUs whilst decreasing in other population groups. It is estimated that half the standing prison population at any one time are problematic drug users and that most IDUs are incarcerated at least three times during their lifetime. Therefore prisons may have a significant number of inmates at risk of contracting Hepatitis B as well as a large number who are already infected.

Modelling has suggested that high coverage of Hepatitis B vaccine (HBV) will lead to a significant reduction in the risk of outbreaks of acute Hepatitis B amongst intravenous drug users in the community[28]. UAPMAP has consistently reported prisons as the single most important source of HBV for IDUs (significantly outperforming GPs, needle exchanges etc).

All the prisons in the comparator group had failed to achieve green status in the Health Protection Agency HBV surveillance programme. The full inspection at HMP Elmley discovered that vaccination clinics were irregular and that the rapid course of HBV was not being used in the prison [11].

3.15.3 Sexual health

Addressing the sexual health needs of prisoners is key in preventing the spread of communicable disease. Prisoners are identified in the national sexual health strategy as a high risk group due to their vulnerability and difficulties in accessing services[29].

There is a clear link between sexual ill health, poverty and social exclusion as well as a disproportionate impact of HIV on gay men and certain ethnic minority groups. Prisoners therefore need targeted sexual health information and prevention programmes underpinned by good clinical governance, health informatics and robust outcome measures[30].

Table 3.7 Comparison of communicable disease control in HMP High Down, HMP Elmley, HMP Durham and HMP Forest Bank

Area of health care provision	**HMP High Down**	**HMP Durham**	**HMP Elmley**	**HMP Forest Bank**
Communicable disease control				
Access to condoms & lubricant	Yes	Yes	Yes	No
HPA's Prison Infection Prevention Team's National Surveillance Programme Hepatitis B vaccine status (Jan – March 2009)	Red (Jan, Feb & March)	Red (Jan, Feb & March)	No return (Jan, Feb & March)	Red (Feb) Amber (Jan & March)
Chlamydia screening	No	Not stated	No	Not stated

3.16 User involvement

3.16.1 Best practice

Joint recommendations from the Healthcare Commission and HM Inspectorate of prisons stated that primary care trusts should regularly seek and record prisoners' feedback and complaints in order to improve their management systems[16]. This will also fulfil their statutory duty under Section 11 of the Health and Social Care Act (2001) which states that patients and the public should be involved in service planning, operation and change[31]. The Health and Social Care Act 2003 provides for the Secretary of State to make regulations to handle and consider complaints about the NHS. These formal procedures should ensure that patients feel involved in their care and are encouraged to comment[32].

Research has shown that prisoners identified accessing services, confidentiality, being seen as a 'legitimate' patient and living with a chronic condition as problems within the prison healthcare system[33].

3.16.2 Service provision

HMP Durham had established a free Patient Advice and Liaison Service (PALS) phone line that was well used by prisoners and promoted by the induction team [10]. Prisoners could call and speak to administrative staff for advice, support or information (e.g. appointment times) and to complain or suggest areas of improvement [10].

HMP High Down is at the early stages of introducing PALS to the prison and at present relies on internal prison and provider systems for obtaining feedback with no formal procedures to ensure involvement. At HMP Elmley the prison and NHS complaints systems were not linked. PALS was available but prisoners were not aware of this. At HMP Forest Bank complaints were dealt with only via the prison mechanism and not NHS complaints [2].

Table 3.8 Comparison of user involvement in HMP High Down, HMP Elmley, HMP Durham and HMP Forest Bank

Area of health care provision	**HMP High Down**	**HMP Durham**	**HMP Elmley**	**HMP Forest Bank**
User involvement				
Prisoners views on healthcare sought & acted upon	PALS not actively involved in prison at present but healthcare providers & prisons internal complaints process in place	PALS phone line for prisoner use	Prisoners unaware of PALS	Prison system only

3.17 Prisoner views of health and healthcare

As part of their inspection process Her Majesty's Inspectorate undertakes a voluntary, confidential and anonymous survey of a representative sample of the prisoner population in order to elicit their views on a number of areas of prison life. Prisoners are asked about their health and their views on healthcare and these findings are compared with responses from comparator prisons in the local area. Any significant vulnerable groups within the prison are sampled and analysed in addition to the main population.

3.17.1 Health problems on arrival

Questions were asked specifically about problems with drugs, alcohol, depression/ suicidality and general health on arrival. These questions were not asked at the last HMIP inspection at HMP High Down. The results for the other three prisons are in Table 3.9.

At reception in all three prisons, self reported problems with health were significantly lower than local establishments. HMP Forest Bank reversed the trend seen in the other two comparators by having significantly lower self reported alcohol problems than local prisons. All prisoners self reported higher levels of drug problems than other local prisons but only HMP Forest Bank reaches statistical significance. Results across all the prisons in each category are broadly similar with the exceptionally low levels of self reported alcohol problems at HMP Forest Bank and health problems at HMP Elmley.

Table 3.9 Percentage of self reported health problems on arrival at prison compared to local comparator

Area of self reported health problem	HMP High Down	HMP Forest Bank	HMP Durham	HMP Elmley
Drugs	Qu. not asked	27 (18)*	25 (23)	25 (23)
Alcohol	Qu. not asked	15 (22)*	36 (15)*	20 (17)*
General health	Qu. not asked	18 (25)*	21 (26)*	12 (25)*
Depression/suicidality	Qu. not asked	21 (24)*	25 (24)	29 (24)*

Figures in brackets are the average from local comparator prisons. Those marked * show statistically significant difference between the jail being inspected and the local prisons

3.17.2 Reception and the first 24 hours

Prisoners were asked whether they were seen by a member of healthcare staff at reception and whether they had access to healthcare within the first 24 hours. The results are shown in Table 3.10.

All four prisons had significantly better access to healthcare at reception than their local comparators. Results were broadly similar but indicate that nearly one in ten prisoners is reporting not being seen by healthcare at reception. Access to healthcare in the first 24 hours was better in all jails except HMP High Down where figures were significantly worse than local comparators.

Table 3.10 Percentage of prisoners with access to healthcare at reception and on Day 1 compared to local comparator

	HMP High Down	HMP Forest Bank	HMP Durham	HMP Elmley
Reception	88 (84)*	91 (85)*	90 (84) *	87 (84)*
Access in first 24 hours	57 (66) *	70 (67)	70 (66)	71 (66)*

Figures in brackets are the average from local comparator prisons. Those marked * show statistically significant difference between the jail being inspected and local prisons

3.17.3 Quality of healthcare

Questions were asked about the overall quality of healthcare, the service provided by various healthcare professionals and ease of access to them. Questions were also asked about in possession medication. No definitive trends were seen in any of these areas in or between any of the establishments so only views on overall quality of healthcare have been presented in Table 3.11.

HMP High Down was the only prison where there was a significantly higher proportion of inmates stating that healthcare was good or very good compared to local prisons. At the three other prisons fewer prisoners felt healthcare was good compared to their local jails. For HMP Forest Bank and HMP Elmley this was significantly lower. The positive experience of offenders at HMP High Down is echoed in their latest 'Measuring the Quality of Prison Life' (MQPL) report which continues the trend of increasing levels of satisfaction with healthcare over the past two years[34]. Considering the numbers overall it appears that even in the best performing prison a significant majority of prisoners do not rate the overall quality of healthcare as good or very good.

Table 3.11 Prisoners views on overall healthcare quality

	HMP High Down	HMP Forest Bank	HMP Durham	HMP Elmley
% stating overall quality of healthcare good/very good	39 (33)*	30 (34)*	32 (34)	25 (34)*

Figures in brackets are the average from local comparator prisons. Those marked * show statistically significant difference between the jail being inspected and local prisons

3.18 Examples of best practice from other prisons

- *Smoking cessation*
  HMP Elmley has an allocated healthcare worker (HCW) on one house block. The number of prisoners successfully quitting smoking at 4 weeks on that block contributed 40% of the total number of quitters in the prison in the preceding 12 month period. Although the number of successful 'quitters' is significantly below that achieved in the community the model of a dedicated HCW per house block may provide a practical platform for supporting the delivery of health promotion campaigns.

- *Discharge planning*
  HMP Durham produces a comprehensive discharge pack including a discharge summary and outstanding hospital appointments. As well as providing written information, a primary care nurse meets with all prisoners within a fortnight of their release date to discuss how to access health care services on release. At HMP Elmley work is underway to actively assess and facilitate access to a GP practice list as part of release planning for prisoners.

- *Record retrieval*
  At HMP Durham the efforts made by administrative staff to locate and retrieve previous prison clinical records, GP details and past medical histories was impressive. As a result, clinical staff had full details of a prisoner's previous health interventions and were able to plan care more effectively.

- *Service user involvement*
  The HMP Durham PALS phone line meant that prisoners were more involved in planning their own care and were easily able to access health services.

- *Reception*
  HMP Elmley provided its reception screen in a range of languages which helped to identify the immediate health needs of arriving prisoners.

- *Suicide prevention*
  At HMP Forest Bank the dates of case reviews for prisoners on ACCT were included in daily briefing to alert staff who wished to contribute to the process.

3.19 Examples of good practice at HMP High Down

- *Wing based care*
  Primary health care is provided at the nearest point to the patient. At each house block there is a dedicated named nurse who runs triage and dispensing sessions every day. All Inmate Medical Records (IMR) are kept in the wing based treatment rooms.

- *Community Development Workers*
  The community development worker post at the prison has been identified as an example of good practice in other prison needs assessments.

- *Day Care*
  The day care service provides a wide range of therapies in order to support vulnerable, discharged patients out on the wing providing them with support to prevent relapse and readmission. The service also targets those who may be having problems coping with life on the house blocks.

4 Corporate Needs Assessment

In assessing perceptions of health needs at HMP High Down, a variety of stakeholders were asked to give their views, including prisoners, health care staff and prison officers.

4.1 Prisoners

4.1.1 Focus Groups

Method

Focus groups were arranged through the prison staff, and one was scheduled to be held on each of the six house blocks. Although the staff were asked to put up posters and invite eight prisoners at random, most groups were made up of prisoners who were on the block at the time of the group. The advantage of this was that the prisoners were not pre-selected by staff and therefore the sampling could be considered less biased; however the numbers per group were often small. A few short individual interviews were carried out with prisoners who approached the facilitators wishing to give their views.

Five focus groups were carried out on the 28th January and the 9th and 10th February 2009; one was cancelled. The number of prisoners in each focus group varied from 2-7 prisoners and a total of 26 took part altogether. No demographic information was collected from the participants. Three of the focus groups were facilitated by the Safer Custody Advisor for HMPS South Central with a facilitator from the Public Health team assisting and note-taking, and two were facilitated and notes taken by staff from the Public Health team. Both facilitators had previous experience of leading focus groups.

All prisoners were informed that the purpose of the group was to gain information for the health needs assessment and to help improve services, and they were informed that their views would be confidential and anonymous. One prisoner chose not to take part. As recording equipment was not permitted in the prison, notes were taken at each group. No prison or health care staff were present during the focus groups. The same schedule was used for each group (Appendix C) and the questions were adapted from those used in the Bronzefield Health Needs Assessment (2007).

Results

The key themes from the prisoner focus groups are presented below.

Staff

- Prisoners felt that some staff did not treat them with respect, and this was particularly a problem at reception. They felt that some staff were not caring, would not listen to their issues and acted like they were only there to dispense medication.
- However, a number of prisoners highlighted staff they felt were excellent, and reported the main problem was with waiting times to see staff rather than the staff themselves.
- It was felt that there weren't enough staff members and the quality of staff wasn't good, especially agency staff. Some prisoners felt that the staff employed were not as good as healthcare staff working on the outside.

- Prisoners reported many problems with administration in healthcare, i.e. charts not being in the right place, applications or letters getting lost and this resulting in appointments being cancelled.
- They felt that because staff were often changing and they didn't know the agency staff, that there was a real lack of consistency in their care. Therefore when they went to the hatch they knew how the consultation would go, depending on who was working. There is also a lack of continuity between staff shifts, with medication orders not being placed or actions not being taken.

Medication

- Prisoners felt it was difficult to access basic medications for treating headaches, or cold/flu symptoms.
- They reported that they could not always get the medications they were prescribed because for example their chart was not there, or the repeat prescription had been ordered. This was also reported of medication for mental health problems such as schizophrenia, and serious physical health problems.
- They were concerned about medications being switched when they entered prison, and worried that the medications would be less effective.
- Prisoners reported not being told how to use their medications or what side effects to look out for. One prisoner had been on steroidal cream much longer than recommended.
- They reported being given the wrong medications at the wrong times, or the wrong amounts, and specific instructions on their chart not being following (e.g. in possession permission). One prisoner reported his detox drugs being taken away due to an argument with staff, and going into rapid detox.
- Prisoners reported medications for long-term conditions like diabetes were not available on entry to the prison, and so they had to go without.

Communication

- Prisoners felt that communication could be improved around a number of different issues. For example a prisoner who experienced heart problems was unaware of his diagnosis or treatment options.
- Prisoners were concerned that they didn't know if outside appointments were being booked, or re-booked after a cancellation as they were not informed.
- They felt that when they put an application in, they did not know where it had gone and were not confident it was being followed up. Some prisoners felt that prison officers kept the applications for longer than they should.

Access to Healthcare

- Prisoners reported that they often had to wait a long time to see healthcare, even if they were in serious pain, and that health problems therefore took a long time to get sorted out and often escalated. They reported that appropriate pain killers for injury are not available in the meantime.
- Extensive waiting times for the dentist were mentioned often, and prisoners were interested in having help for their dental problems and put in applications. Prisoners mentioned having been in severe dental pain for long periods and suffering from continual abscesses.
- Prisoners reported waiting a long-time to receive outside appointments with specialists.
- Prisoners felt that they were at a disadvantage compared to outside prison, as outside you could go and wait somewhere to be seen that day, and in prison you can wait weeks.
- If the doctor is late, or doesn't turn up appointments are cancelled and the prisoners have to wait even longer.

Healthy Lifestyles

- Prisoners felt that they were not given sufficient advice about how to stay healthy in prison.
- It was reported that exercise outside (association) was often cancelled due to inclement weather, and that access to they gym was difficult if you were in employment.
- Prisoners reported not being able to access 'remedial' gym for health problems they were experiencing and that when they did access the gym they weren't given proper health checks.
- Prisoners felt they would like more access to the gym to be healthier and to lose weight.
- They had many complaints about the food, especially at weekends, and did not felt it was a balanced diet with enough fruit and vegetables. Prisoners felt it was difficult to lose weight.
- Although the canteen sells bananas, the prisoners would like more options for fruit and healthy options, and felt that the healthy foods that were available were too expensive compared to crisps or chocolate.
- Delays in accessing smoking cessation services and access to nicotine replacement therapy were reported.
- Prisoners reported that they had either not been offered injections, or that the first was given (of Hepatitis B for example) and the treatment was not followed up, even after requests.

Other Issues

- Prisoners felt the healthcare at HMP High Down was inferior compared to outside and other prisons, as it was described as 'second-class medicine'. Prisoners felt that they should have the same care as in the community.
- Prisoners reported that the optician service was of poor quality and that there was only one choice for frames, compared to other prisons where more were available. Regular appointments were not offered to those with health problems e.g. diabetes.
- Prisoners reported complaining to their solicitors about problems with healthcare, but did not know where to make a complaint internally.
- Some prisoners did not know who to talk about mental health or emotional issues and didn't know how to speak to a Samaritans listener.
- Prisoners reported a lack of equipment available, i.e. blood pressure monitors and large arm cuffs.
- There were mixed opinions about mental health services, with some reporting an excellent service and other feeling it was difficult to access.

Improving Health

The focus group participants made a number of suggestions for how health could be improved in HMP High Down, and these are detailed below:

- better food
- more access to exercise
- more access to dental care
- better staff (more qualified, polite and caring)
- better consistency of care
- reduction in waiting times
- receiving the same care as offered in the community
- medical file travels with prisoner, so doesn't get lost and medication can be issued (to court, between prisons)
- more hatch time to relieve pressure and give nurses more time
- more health checks for people with long-term conditions

- an independent audit of the healthcare services
- more prison officer supervision at the hatch, to prevent bad behaviour cycles.

4.1.2 Questionnaires

Method

The questionnaire was based on questions from a number of sources including the results from the focus groups, Measuring Prisoner Quality of Life (MPQL) questionnaire, and the Prison Health Performance and Quality Indicators. The questionnaire was designed to be as easy to complete as possible, and was checked for clear English by an independent organisation who specialise in producing EasyRead information.

A poster was produced to inform prisoners about the health needs assessment, and to tell them who they could ask for help with filling in the questionnaire. The questionnaires were distributed in a number of ways. Firstly, a questionnaire was dropped in 15% of cells across the prison at random, and some spare questionnaires were left on each house block. Two house blocks were visited and prisoners were supported to complete questionnaires. Unfortunately, when visiting the other four house blocks the prisoners were on lock down and were restricted to their cells. Another random cell drop was then carried out on those four house blocks.

In total 90 questionnaires were filled out by prisoners, which equates to 8% of the total population (1066). The questionnaires were manually entered into SPSS (statistical computer package) and 10% were checked for accuracy. All percentages below are valid percentages based on the number of people who completed that question. The qualitative questions were analysed thematically and the most common responses reported.

Results

Perceptions of health
On a ten point scale with 1 being very unhealthy and 10 being very healthy, prisoners rated themselves an average of 6.58, and other prisoners an average of 4.85.

62% of prisoners rated themselves as healthier than other prisoners, 20% thought they were unhealthier and 19% thought they were the same.

Figure 4.1 Prisoner rating of own health

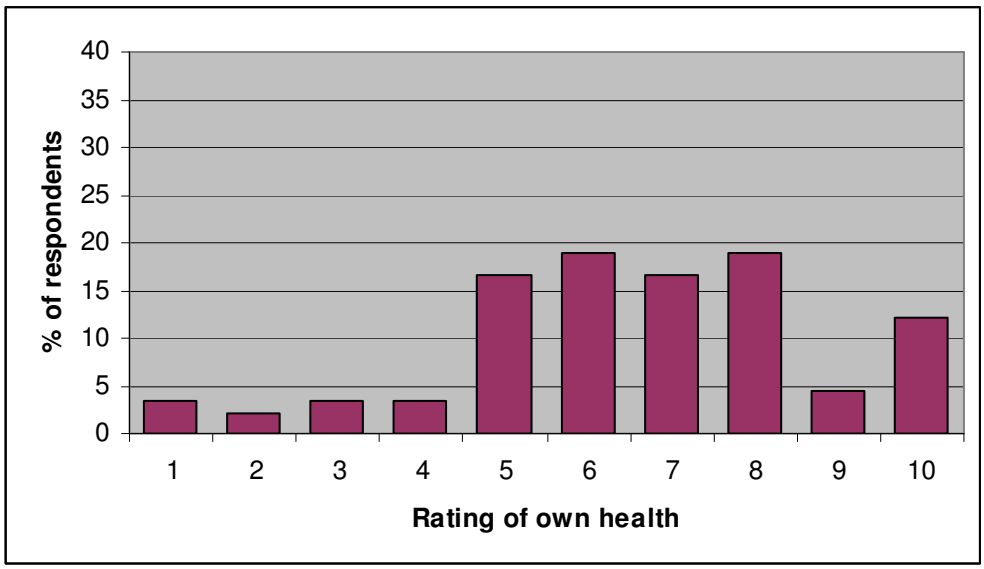
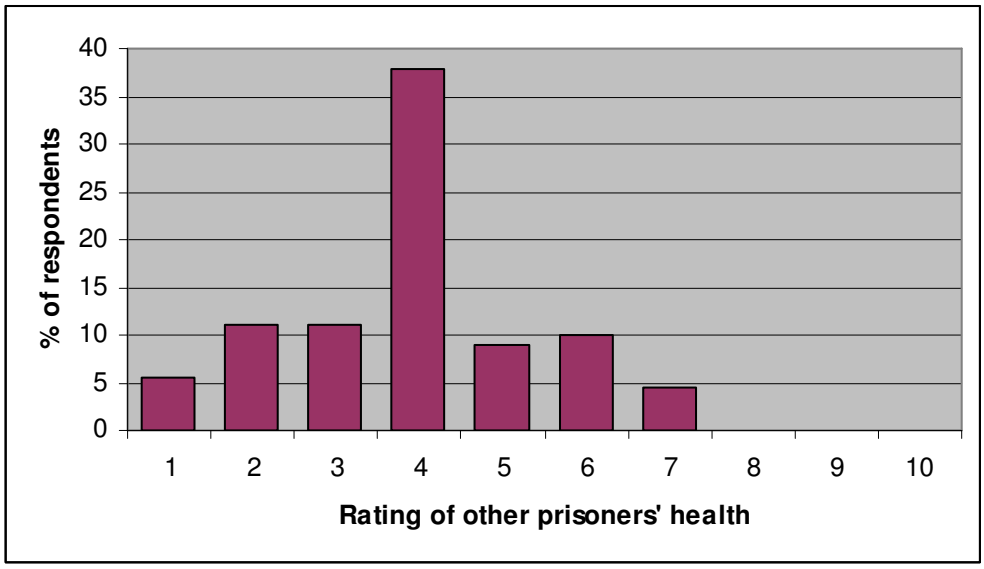


Figure 4.2 Prisoner rating of the health of other prisoners



Experiences of Healthcare at HMP High Down

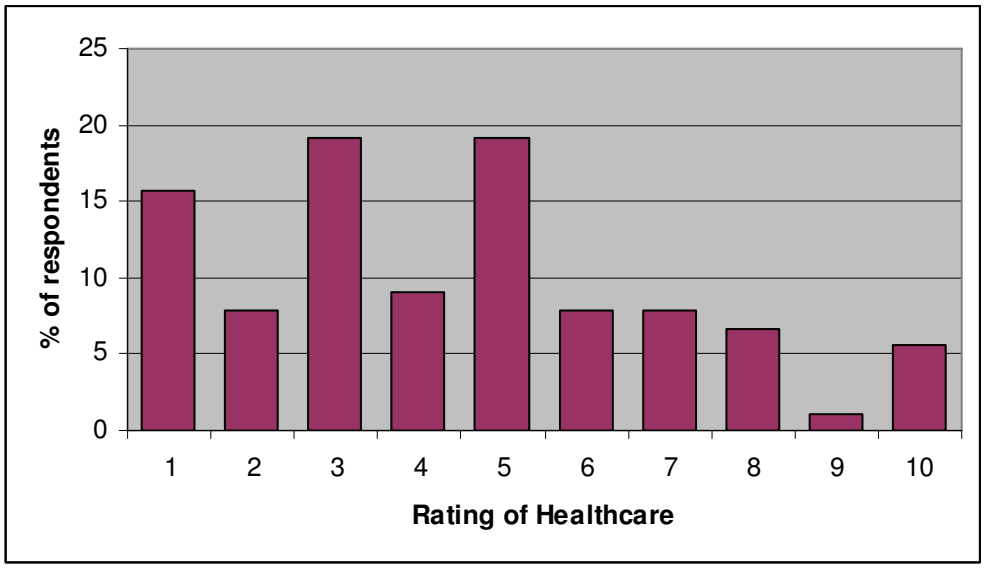
Table 4.1 Prisoner visits to healthcare professionals

Prisoners who had visited:	YES	NO
Doctor	69%	31%
Nurse	87%	13%
Optician	14%	86%
Dentist	25%	75%
Other healthcare professional	17%	83%

Most prisoners had seen a nurse (87%) or a doctor (69%) since they had come to HMP High Down, and only 25% had visited the dentist.

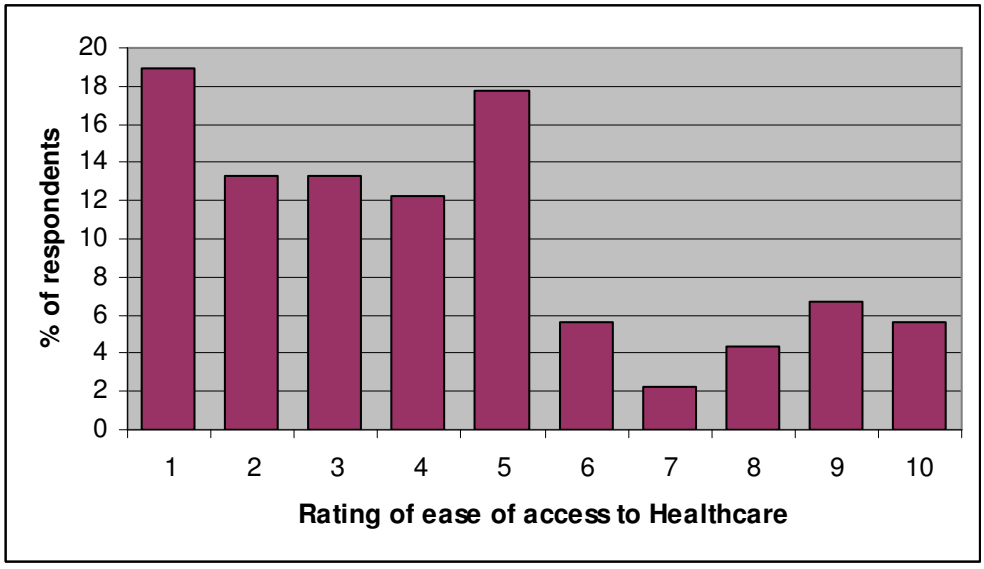
Prisoners rated healthcare as 4.43 on average, between 1 (very bad) to 10 (very good).

Figure 4.3 Prisoner rating of healthcare services



When asked about how easy it was for prisoners to see someone in healthcare, the average rating was 4.23 with 1 being very difficult and 10 being very easy.

Figure 4.4 Prisoner rating of ease of access to healthcare services



43% of prisoners reported that they were able to discuss all their health problems at reception, 27% felt they could only discuss little problems and 5% only big problems. 26% of prisoners did not feel they could discuss their health problems at reception.

What works well about Healthcare at HMP High Down
61 comments were received about what works well about healthcare at HMP High Down. 22 (36%) were positive comments about staff and 7 (11%) were about

receiving medication. 19 (31%) commented that nothing worked well, and the remaining 13 (21%) comments were about separate issues only mentioned once.

What could be better about Healthcare at HMP High Down
79 comments were received about what could be better about healthcare at HMP High Down. 47 (59%) of the comments were about waiting times, with 22 (28%) specifically mentioning the dentist and 9 (11%) mentioning the doctor. 7 (9%) would like improvements in the way staff treat prisoners, and 7 (11%) commented that many things need improving. 18 (28%) of the comments were about separate issues only mentioned once or twice.

Below are a list of statements about healthcare at HMP High Down, and the percentage of prisoners who said that they agreed with the statement, disagreed or said they didn't know.

Table 4.2 Degree of prisoner agreement with statements on healthcare

Statement	Agree	Disagree	Don't know
I feel cared for by staff on the healthcare unit	37%	33%	*30%*
Healthcare staff are interested in helping me with my physical health concerns	41%	32%	*27%*
The doctors in here believe me when I tell them about my health problems	42%	30%	*28%*
I am happy with the treatment I have received for my health problems	41%	36%	*23%*
Healthcare staff explain things clearly to me	55%	34%	*12%*
Healthcare staff show understanding for my mental health and emotional concerns	32%	23%	*36%*
I always get the medicine I have been prescribed when I should	48%	39%	*12%*
When I am given medicine I am told how to use it and problems to look out for	56%	32%	*12%*
If I was really ill, I would be seen quickly by healthcare	23%	46%	*31%*
Prisoners are treated with respect by health care staff no matter what their:			
race	61%	16%	*23%*
age	64%	13%	*23%*
religion	56%	15%	*29%*
sexual orientation	46%	19%	*35%*
disability	48%	18%	*34%*
I know where to make a complaint about healthcare if I need to	61%	28%	*11%*
My complaints about healthcare are listened to	19%	32%	*49%*
Prisoners are asked for their ideas on how health can be improved	19%	51%	*30%*
My privacy and confidentiality are respected:			
At reception	49%	18%	*33%*
At the hatch	49%	24%	*27%*
When I make an application for healthcare	44%	17%	*39%*
When I'm seeing a doctor or nurse	55%	14%	*34%*

Interaction with Healthcare Staff
Many of the statements about the interaction with healthcare staff had similar responses with around 40% of people agreeing and 30-35% disagreeing. A higher percentage of prisoners (55%) felt that healthcare staff explained things clearly to them, and that when they are given medicine they are told how to use it (56%). However, only 48% of prisoners felt that they got their prescribed medication when

they should. Only 32% of respondents agreed that staff showed understanding for their mental health concerns, however 36% selected 'don't know' which could indicate misunderstanding of the question or a lack of communication around mental health and emotional concerns.

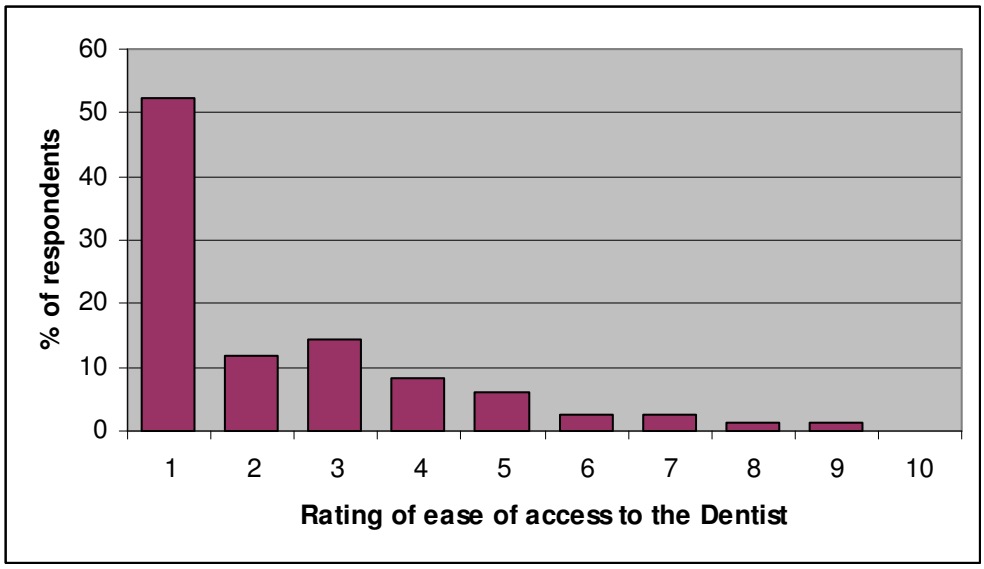
Only 23% of prisoners agreed that they would be seen quickly if they were really ill, and 46% disagreed with this statement. Although over 60% of respondents knew where to make a complaint, only 19% felt that their complaint would be listened to. Over 50% of prisoners felt that they were not asked for their ideas on how healthcare could be improved.

When prisoners were asked about how they were treated in relation to the different strands of diversity (age, race, religion, sexual orientation, disability), 34% believed that all prisoners were treated the same. The results indicated less people felt they would be discriminated against on the basis of age (13%), and more people on the basis of sexual orientation (19%) and disability (18%).

Around half of the respondents felt that their privacy and confidentiality were respected in different areas of healthcare, with the highest agreeing it was respected when seeing a doctor or nurse (55%) and highest disagreeing that it was respected at the hatch (24%).

Dental Services
When asked how easy it was to see a dentist the average score was 2.33, with 1 being very difficult and 10 being very easy. Over 64% of prisoners rated it 1 or 2.

Figure 4.5 Prisoners rating of ease of access to the dentist



34 prisoners said they had seen a dentist within a prison (38% of respondents). 59% of prisoners had seen a dentist in prison in the last 6 months, and 73% in the last year (see Table 4.3 below).

Table 4.3 Attendance at dentist in prison

	Frequency	Percentage
Less than one month ago	11	32.4
1-6 months	9	26.5
6 months- 1 year	5	14.7
1 year- 3 years	5	14.7
Longer than 3 years ago	4	11.8
Total	34	100.0

55 prisoners said they had seen a dentist outside prison (61% of respondents). 15% had seen a dentist outside prison in the last 6 months and 35% had seen one in the last year. 44% of prisoners had not seen a dentist in the last 3 years.

Table 4.4 Attendance at dentist outside prison

	Frequency	Percentage
Less than one month ago	1	1.8
1-6 months	7	12.7
6 months- 1 year	11	20.0
1 year- 3 years	12	21.8
Longer than 3 years ago	24	43.6
Total	55	100.0

27% of prisoners had last visited for a routine appointment and 73% because they were in pain or knew they had a particular problem. When asked when they last had pain from their teeth 21% reported in the last 24 hours and 14% in the last week. 80% of prisoners reported that they would like to see a dentist while they are in HMP High Down.

Table 4.5 Last reported incident of self reported dental pain

	Frequency	Percentage
Last 24 hours	18	20.9
Past week	12	14.0
Past month	12	14.0
Past 6 months	10	11.6
Longer	34	39.5
Total	86	100.0

Healthcare experiences outside HMP High Down
82% of prisoners were registered with a GP outside of prison. 80% had visited a doctor or nurse outside of prison and 81% of these prisoners reported that the care they received was better in the community. 17% reported that the care was the same as outside prison.

57% of prisoners had visited a doctor or nurse in another prison, and of these 38% reported the care they received was the same as at HMP High Down. 48% reported that it was better at another prison and 15% thought it was better at HMP High Down.

Health Promotion and Healthy Lifestyles
- 39% of prisoners did not feel they could get information and advice about how to stay healthy in prison.

- 41% did not believe that HMP High Down were good at helping people who felt low, and 24% felt the same about those who self-harm. 47% of people said they would know where to go for help if they felt low.

- 75% of prisoners said that they smoked, and 45% of those wanted to give up. Of those who smoked, 52% said they knew where to get help to give up if they needed it.

- Only 27% felt that the food in prison was good for them, and 54% said they could buy healthy foods from the canteen.

- 49% said they could exercise every day, and 38% believed they could get a special programme at the gym for health problems.

- 66% of prisoners believed help was available for a drug problem and 56% for an alcohol problem.

- 52% said they were offered the Hepatitis B vaccination when they entered HMP High Down.

Improvements
Prisoners were asked about whether they would like the following improvements. They are in order of the most popular suggestions:

1. More exercise (83%)
2. Healthier food (81%)
3. More information on how to stay healthy (66%)
4. Special gym programme for health problems (64%)
5. Help planning for going home (re. health) (63%)
6. Injections to stay healthy (62%)
7. Help dealing with emotions (46%)
8. Help with long-term health problem (43%)
9. Advice/information about sexual health (25%)

'One thing'
When asked about the one thing we could change to improve health at HMP High Down the most, 28 (31%) of the suggestion were about waiting times, with 13 (14%) relating to the dentist specifically and 7 (8%) to the doctor. The list of suggestions mentioned more than once is below:

- waiting times 31% (in total)
- better food 17%
- waiting times- dentist 14%
- better staff (including attitude, and listening more) 9%
- waiting times- doctor 8%
- more staff 7%
- more access to exercise. 7%

4.1.3 Demographics

The prisoners who completed the questionnaires were aged between 19-73 and the average age was 35. Compared to the figures from the Local Inmate Database System (LIDS) for the period of November 2008- May 2009, the respondents in the sample appear to be older than the general population. The LIDS figures show the highest percentage of people in the following age groups, compared to the questionnaire sample in brackets.

Largest	17-21	17.4% of reception screenings	(3.6%)
	26-30	16.5% of reception screenings	(11.9%)
	41-45	12.2% of reception screenings	(15.5%)

Figure 4.6 Age distribution of questionnaire respondents

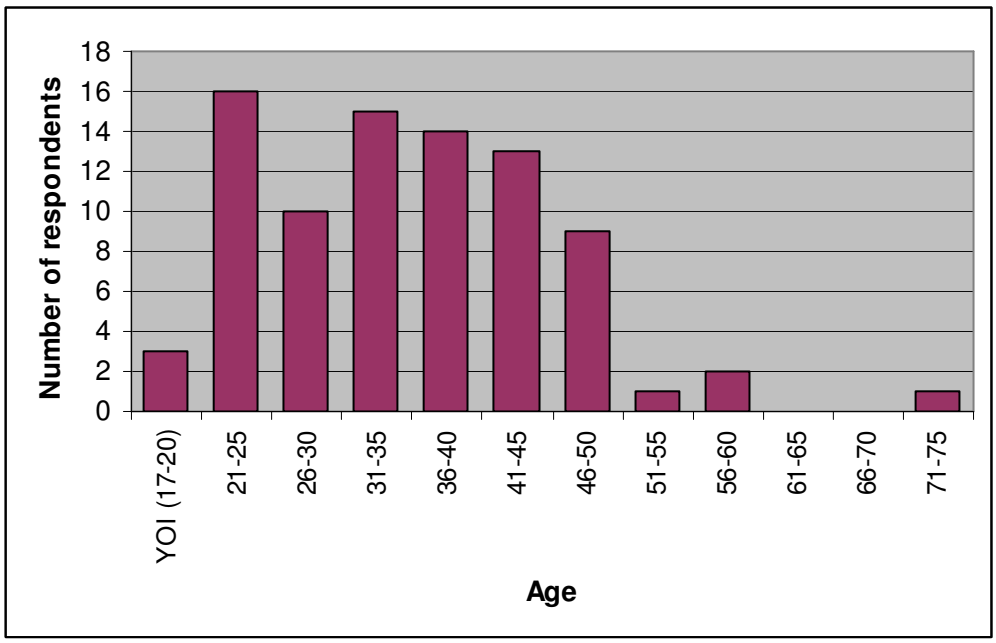
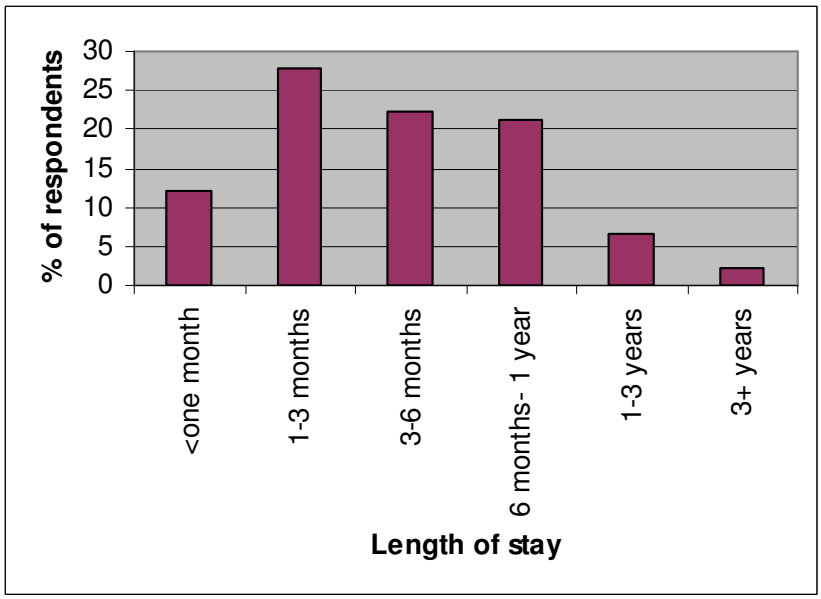


Figure 4.7 shows the length of stay in HMP High Down for the respondents of the questionnaire. 62% had been in HMP High Down for less than 6 months, and less than 10% had been in over a year.

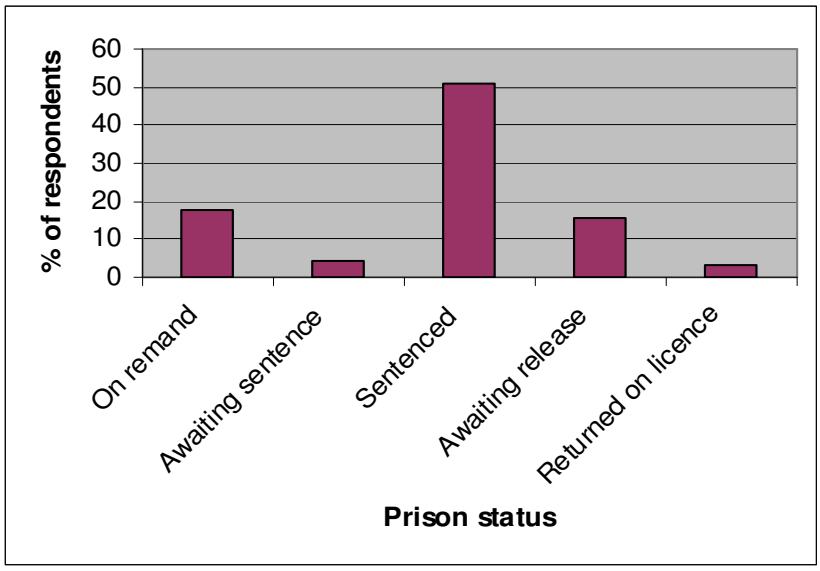
Figure 4.7 Length of stay in prison for questionnaire respondents



62% of prisoners classified themselves as White British and 38% were non-white. Of those who were non-white, 14% were Black African, 9% were White Other and other categories had less than 5% of prisoners. The questionnaire sample shows slightly higher numbers of White British prisoners than the data for HMP High Down (53%).

The majority of prisoners were sentenced (51%) with 18% on remand and 16% awaiting release. This is a similar number to in the general population.

Figure 4.8 Licensing status of questionnaire respondents



4.2 Healthcare Staff

4.2.1 Questionnaire

Method

The questionnaire was based on the prisoner questionnaire with many similar questions. The Prison Health Performance and Quality Indicators were also used to create questions.

A questionnaire with a covering letter and a freepost envelope was given to each member of clinical staff in healthcare and the mental health in-reach team. The staff were reminded via email, and a second questionnaire was sent to them 2 weeks after the original distribution.

In total 5 questionnaires were filled out by staff, which equates to approximately 7% of the total staff (70). The questionnaires were manually entered into SPSS. Because of the low number of questionnaires received, only some of the data is reported and may be based on individual responses.

Results

On a ten point scale with 1 being very unhealthy and 10 being very healthy, staff rated prisoners health as an average of 7.20, compared to prisoners own rating of 6.58.

Staff generally believed that the process for accessing most healthcare services works well, apart from to access the dentist. Most staff believed that there are not enough nurses, doctors or dentists, and that waiting times for the dentist were too long.

Staff were generally satisfied with their role (7.40 on a 10 point scale with 10 being very satisfied) and felt that they had access to support from their line manager if they need it. However, healthcare staff did not feel that all staff have the appropriate skills and training for their role, and most staff reported not receiving sufficient training in infectious diseases, mental health awareness, constant observation and management of patient information. Other training staff requested was on sexual health, nursing updates and mandatory courses. Staff also supported the idea of joint training with prison staff.

Staff rated communication with prison officers most effective (7.20/10 with 10 being very effective), followed by prisoners (6.60) with communication with other healthcare staff rated the lowest (5.80). Staff felt most able to deliver care sensitive to age (8.40/10, with 10 being very confident) and least able for care sensitive to sexual orientation (5.80). This result was also reflected in the results of the prisoner questionnaires.

Staff agreed with the 32% of prisoners who believed that prisoners were not involved in the planning, delivery and improvement of health services. About half the staff felt that they would not feel confident to deal with a patient at risk of self-harming. Staff did not feel that prisoners were able to access special programmes at the gym for specific health problems- 25% of prisoners agreed.

Staff felt that all the suggested improvements would be helpful, which included the top three from the prisoners- more exercise, healthier food and more information on how to stay healthy.

Staff reported that the following improvements could be made:
- more permanent staff
- increase staffing levels
- increase the number of clinics to cut waiting times
- improve the system through which prisoners get appointment slips to reduce 'did not attends'
- staff should undertake only duties that are within their own skill set and role
- give staff time to attend learning and development courses
- conduct exit interviews, and improve recruitment and retention
- health screenings should be carried out by qualified nursing staff
- reduce time-pressure from prison officers at reception to get patients through
- introduce modular working so staff specialise in one area (e.g. inpatient, house blocks)
- reduce the levels of abuse and threats of violence towards staff.

With regard to increasing the uptake of the Hepatitis B vaccine, staff suggested:
- have a visiting nurse to do Hepatitis B clinics
- give prisoners information on vaccine at reception
- shorten the time for the course of treatment.

4.2 Prison Staff

4.2.1 Focus Groups

Method

One focus group was arranged through the prison, and all prison officers were invited to attend. It was carried out on the 24th March and 4 prison officers attended. Three participants were male; three were Senior Officers and one was a Principal Officer. The focus group was co-facilitated and notes taken by Public Health.

All participants were informed of the purpose of the group- to gain information for the health needs assessment and to help improve services, and they were informed that their views would be confidential and anonymous. As recording equipment was not permitted in the prison, notes were taken at each group. The questions were a mixture from the prisoner focus groups and healthcare staff questionnaire.

Results

The main comments from the prison staff are detailed below.

- In comparison to other prisons the quality of the healthcare is not good.
- Some of the staff are of very poor quality, especially the agency nurses who they felt gave poor care.
- It was felt that the nurses don't understand the prison system.
- Some house blocks don't have a regular nurse and this results in poor continuity of care.
- The nurses are not usually involved in the review of patients who self-harm.
- Getting patients admitted to healthcare is very difficult.

- There is a clash of cultures between the prison staff and healthcare staff, 'prisoner' vs. 'patient', and this needs more understanding from both parties.
- The healthcare staff need to have jailcraft training to maintain the security of the prison, and to work within the guidelines of the prison service, for example around ACCT documents.
- There should be a more confidential system for making applications to healthcare (locked post box).
- Healthcare should involve the prison staff more, as they know the prisoners better.
- Medications have been given to the wrong prisoner on a number of occasions due to not following charts or not asking for ID.
- Incidents are not recorded in the incident log. Important information could be recorded in the Security Information Report.
- Nurses should attend the staff briefings that the prison staff have to improve communication, so they know what is going on.
- Sometimes when a prison officer requests medical help either for a prisoner or for injured staff, they refuse to help.
- There are some good staff, but they leave because it's too difficult to work there to make changes.

4.3 Corporate Needs Assessment Recommendations

The following recommendations are based on the evidence from prisoners, prison staff and healthcare staff detailed above.

- To ensure continuity and high quality of care, each area of the prison should employ permanent healthcare staff. This will also support the development and consolidation of professional relationships with prisoners enabling them to fully address their health needs. Health service providers should ensure that staffing vacancies are recruited to in a timely manner and reliance is not placed on agency staffing on a long term basis. This recommendation is particularly important for house block nurses.

- The NHS has a zero tolerance policy on abuse against healthcare staff and this should be supported within prison settings. Appropriate supervision of the hatch/ healthcare by prison staff should be standardised, to prevent abuse against healthcare staff. Any supervision process should ensure that it does not conflict with a prisoners' right for confidentiality when discussing health concerns.

- Health service providers should formally seek the views of prisoners on a regular basis and be able to demonstrate that any concerns raised regarding standards of care and levels of respect served by healthcare staff towards prisoners are addressed. NHS Surrey should monitor the effectiveness of attempts to gain prisoners views and how widely information on how to make a complaint about healthcare is publicised. Prisoner complaints, compliments and Patient Advice and Liaison Service (PALS) feedback should be monitored through the contract meeting.

- The system for movement of charts needs to be improved so that charts are in the right place at the right time, and medication continuity can be ensured. The installation of a prison IT system would support this but should not be considered the only intervention which will improve this problem.

- The recent development of the medication review clinic should be mainstreamed and developed to ensure that:
  Communication around medication changes (e.g. when changed to generic drugs) is improved and prisoners have a clear understanding about why their medication has been changed .

- Medication reviews are conducted regularly, linking into national performance indicators on increasing generic prescribing.

- Prisoners are aware of how to use their medications and any side effects to be aware of.

- There is regular audit of medication charts to ensure that prisoners are getting appropriate medication, in appropriate doses.

- Administration of medicines can be audited and any medication errors highlighted and formally reported through the health service providers' governance systems.

- Prison officers and healthcare staff should develop a co-ordinated approach to communicating medical appointments and the progress of referrals to prisoners. This process should ensure security considerations are taken into account but should not prevent the prisoner from having timely access to this information. Prison and healthcare staff should also work collaboratively to ensure that prisoners legitimately missing work for healthcare appointments are not penalised and that when appointments are scheduled attempts are made to ensure that they do not conflict with work times as much as possible.

- Did not attend (DNA) rates should be monitored by the NHS Surrey to monitor the effectiveness of this process.

- The application system should be completely confidential, so prison officers do not see applications (i.e. post box for applications only picked up by medical staff). Prison staff must be reminded that they should not take applications from prisoners.

- Health service providers should ensure that their triage system is clinically effective and provides confidence to prisoners that their health needs are going to be appropriately addressed. NHS Surrey should monitor this though prisoner feedback mechanisms and concerns should be raised and assurance sought that they are being addressed through the contract monitoring process.

- A dental triage system led by a dental nurse needs to be developed and implemented. Those most in need should be prioritised. Self care alternatives to seeing a dentist should be considered in all routine cases and appointments for non-urgent needs should be effectively managed. NHS Surrey should monitor dental waiting times to measure effectiveness of this.

- Healthcare providers and the prison should actively consider how improvements can be made across all areas where healthcare is delivered, especially during the reception process, which ensures that prisoner confidentiality in relation to health concerns can be maintained.

- Healthcare staff should report any instances in reception where information could not be collected and processed due to time pressures and these incidents collated, investigated and reported back to each Prison Health Partnership board.

- In line with the Prison Health Quality Indicators a Health Promotion Action Group should be established, which is tasked with ensuring that each prisoner has access to information on how to stay healthy in prison. Innovative delivery mechanisms for this information should be considered and developed, with input from prisoners.

- The Health Promotion Action Group should also report to the Prison Health Partnership Board on action taken and progress made against the following areas:

    - A review of the use of the gym; including prisoner access (including access for those who work) and ensuring that prisoners are able to use the gym to maximum effect.

    - A review of the use of Gym equipment within in the in-patient healthcare setting in order to improve access to physical activity for this group.

  - Improving access to remedial gym, including for those with mental health problems and those trying to lose weight.
  - Measure accessibility and the effectiveness of smoking cessation services within the Prison.
  - A mental health promotion campaign which also informs prisoners on how to access support for mental health concerns.
  - Improving the availability of healthy food and ensure that healthy alternatives are effectively highlighted.
- The Health Action Group should seek feedback from prisoners on a regular basis to gain their views and evaluate the effectiveness of interventions.
- The health service provider should review the effectiveness of the current immunisation and screening programme - in particular, addressing the poor uptake of Hepatitis B vaccination. This should be formally monitored though the contract process.
- With the aim of increasing understanding between Healthcare and Prison staff of their respective roles and responsibilities and the promotion of more productive working relationships, the following interventions should be implemented or improved:
- The security induction of healthcare staff should be reviewed in order to ensure that there is sufficient input on what it means to work within the prison system and how best to maintain security. Any healthcare staff found to be beaching security protocols should attend refresher training.
- All prison staff should be educated on the professional standards expected of those working in healthcare, the importance of prisoners receiving effective healthcare and the importance of confidentiality in the health care setting. Updates should be made available for all staff when appropriate.
- A formal process should be developed which monitors any issues between prison and healthcare staff which prevent effective healthcare or pose security risks. Problems raised and action taken to address such problems should be reported to the Prison Health Partnership Board.
- More joint training should be undertaken between health and prison staff.
- Internal information sharing policies should clearly outline what information can and should be shared between agencies and in what circumstances. This may include using joint incident log books and having joint briefings.
- Ensure that all prison staff have up to date Safeguarding training appropriate to their position within the organisation. NHS Surrey should receive an annual update on this training.

5 Epidemiology health needs assessment

5.1 Information and data sources

HMP High Down is currently using a paper records system in healthcare whilst awaiting the installation of a computerised patient data system. Therefore, a combination of information and data sources has been used to estimate the prevalence and incidence of common health conditions:

1. Local Inmate Database system (LIDS)
2. Healthcare activity sheets e.g. waiting lists
3. '213' Accident reports (including self harm reports)
4. Referrals to psychiatric services
5. Collated attendance figures from specific departments e.g. sexual health
6. Literature review

Reception database
A database of the initial reception health screen has been piloted since November 2008. Data from the period November 2008 until May 2009 was used to provide a "snapshot" of self reported illness in men entering the prison. The database contained 995 entries. This averages at around 153 receptions a month. The highest number of reception screenings was in March 2009 (214).

Prescribing data
A prescribing 'snapshot' was collated for a number of conditions over a 24 hour period in December 2008 by the Senior Pharmacist.

5.2 The health of prisoners

Many prisoners enter prison with chronic disease. One national survey found over a quarter of newly sentenced prisoners reporting a long standing physical disorder or disability. Musculoskeletal and respiratory complaints were most commonly reported.

In a different survey 24% of prisoners reported they had a disability with hearing and arthritis the most common causes. The high prevalence rates of some conditions may partly be explained by the fact that half of all those sentenced to custody may not registered with a GP prior to being sent to prison and therefore miss out on basic primary care. These figures match those found at reception at HMP High Down where 50% of inmates were registered with a GP when they arrived. 26% of those questioned at reception had seen a doctor in the recent past.

In the last prisoner survey at HMP High Down 53.16% of inmates surveyed stated they had a mental health problem and 31.65% stated they had a physical health problem.

Recommendations

- Screening of new prisoners should be comprehensive and not restricted to being conducted only at reception. House block based nurses should be responsible for ensuring that all prisoners on their block have a comprehensive health assessment, that health promoting information and intervention has been provided and referrals and access to appropriate services have been made. The health service provider should develop an auditable process to measure compliance with this requirement and regularly report compliance through contract monitoring meeting.

- Review and update of information provided to prisoners on release in order to ensure that they have sufficient information to contact and register with a local GP.

- Education department to review all discharge information to ensure that it is suitable for literacy levels within the prison.

- Education department to run courses on basic form completion with all prisoners prior to release.

5.3 Asthma

A twice weekly nurse-led asthma clinic is held in HMP High Down but there is currently no prison asthma register – partly due to the lack of IT facilities. Therefore secondary data was used to estimate asthma prevalence. A medications review captured all 'in possession' and 'not in possession' medications in use throughout the establishment on a single day in December. The distribution of inhalers across the prison is demonstrated in Table 5.1.

Table 5.1 Distribution of inhalers

Location	Number of inhalers
House Block 1	12
House Block 2	12
House Block 3	4
House Block 4	9
House Block 5	8
House Block 6	2
Step Down Unit	1
Healthcare Centre	0
Segregation	2
Total	50

The use of an inhaler does not automatically infer a diagnosis of asthma. Some asthmatics may not use an inhaler and there may be other conditions for which these medications are also prescribed e.g. Chronic Obstructive Pulmonary Disease (COPD). Some inmates may seek inhalers as bronchodilators can be used to

augment the 'high' of some inhaled illicit drugs and metered dose inhaler devices can also be used for concealment of other drugs.

As it was not possible to elicit the underlying diagnosis and motives of inmates an assumption was made that all those using inhalers had a diagnosis of asthma. This gives an estimated prevalence of asthma of 4.1%. Studies have suggested that the prevalence of asthma among male prisoners is between 4% and 5.2%. This is not significantly different to the general population (5.7%) due to the higher prevalence of risk factors in the prison population e.g. smoking, low socioeconomic status. Therefore the estimated HMP High Down may represent under diagnosis or under treatment as it is unlikely that the population of the prison is significantly different to the rest of the prison estate.

The likelihood of under diagnosis is supported by an analysis of the reception health screens, 107 inmates described themselves as being asthmatic, a prevalence of 11%. Previous studies at HMP High Down have suggested prevalence rates of treated asthma of 10.6% (2003/04) and 12.5 % (2005/06).

The HMP High Down prevalence figure may indicate the impact of robust medications monitoring impacting positively on the abuse of inhaler devices. It may also reflect inaccurate or inconsistent recording of medication.

Recommendations

- Asthma should be considered one of the conditions which requires a chronic disease register and management of this condition should comply with the formal approach to managing Long term conditions in prison.
- A report of asthma at reception should lead onto a clinical assessment, confirmation of diagnosis and prescription of appropriate treatment. Compliance with this should be regularly audited.
- A review of asthma prescribing and a programme seeking and identifying those prisoners with unmet need should be undertaken.
- Smoking cessation should be proactively promoted to all those with asthma and prisoner response recorded.
- Exposure to environmental tobacco smoke should be reduced, especially in reception.

5.4. Chronic Obstructive Pulmonary Disease (COPD)

The community prevalence rate of COPD is 1.5% but this is likely to be an underestimate due to poor diagnosis. It is known that the prevalence increases with age with 10% of all men aged over 75 suffering with the condition. Limited data on prevalence of COPD in the prison population is available with many studies presenting rates for all respiratory diseases. One study has estimated the prevalence to be 6.3%. Specific epidemiological information on COPD was not collected but if the rates were applied there could be between 16 and 67 inmates in HMP High Down with the condition. COPD management will be soon be incorporated into asthma clinics.

Recommendations

- COPD should be considered one of the conditions which requires a chronic disease register and management of this condition should comply with the formal approach to managing long term conditions in prison.
- Smoking cessation should be proactively promoted to all those with COPD and prisoner response recorded.
- Exposure to environmental tobacco smoke should be reduced, especially in reception.

5.5 Epilepsy

Due to the lack of a register, a specific clinic and computerised records a medication review was used to estimate the prevalence of epilepsy. On the review date 14 prisoners were taking anti-epileptic drugs. Based on the assumptions that most people with a formal diagnosis of epilepsy are prescribed anti-epileptic medication and that they are very rarely used in other conditions it was inferred that the prevalence of epilepsy was 1.3%. Prevalence of epilepsy at HMP High Down has remained stable with rates of 1.5% in 2003-04 and 1.4% in 2006-06. This is marginally higher than in the general population (0.6%) but lower than the figures in other establishments of between 2% and 4%.

At reception 5% of those questioned reported that they suffered from epilepsy or fits. It was not noted whether these were confirmed diagnoses. There can also be wide interpretation of what 'fits' are and a number of causes for them.

An audit of the care of male prisoners with suspected epilepsy found major discrepancies between the NICE guidelines and the service on offer. 61.5% had not had their epilepsy diagnosed by a specialist and 30.8% had not had appropriate imaging. After further investigation 57% of those reporting epilepsy actually had the condition but just over half of these prisoners had not had a medical review in the previous year and nearly two thirds required review of their anti-epileptic medication.

Recommendations

- Epilepsy should be considered one of the conditions which requires a chronic disease register and management of this condition should comply with the formal approach to managing Long term conditions in prison.
- A report of epilepsy at reception should lead onto a clinical assessment, confirmation of diagnosis and prescription of appropriate treatment. Compliance with this should be regularly audited.

5.6 Diabetes

A nurse-led diabetes clinic runs bi-weekly. No diabetes register is maintained at the prison so prevalence figures were again based on a medication review. The review showed 8 people taking medication for Type 1 diabetes and 11 taking it for Type 2 diabetes. This number may not be a true reflection as some Type 2 diabetics may be 'diet controlled' and some may have started on insulin therefore blurring the

distinction between the two sub-groups. Age breakdown and ethnicity data were not available.

The 19 recorded prisoners at HMP High Down on either insulin or oral hypoglycaemics represents a prevalence of 1.5%, with approximately 0.6% type 1 and 0.9% type 2. This figure will not include a 'diet controlled' sub-section. These figures are significantly different from rates seen in previous years as demonstrated in Table 5.2 but close to that described at reception (2.2%). Although the current figures may be an accurate reflection of the current population the prescribing snapshot is likely to have excluded any diabetics who are diet controlled.

Table 5.2 Trends in estimated prevalence of diabetes in HMP High Down

	2003/04	2005/06	2008
Insulin dependant	1%	2.4%	0.6%
Non insulin dependant	3.9%	5.2%	0.9%

Prevalence estimates for diabetes in prison are not widely available. One US study has cited rates of 4.4% which is higher than current UK prevalence rates (3.9%). Prisoners are likely to have higher than average rates as high risk groups, particularly BME groups, are over represented in the prison population. Diabetes care can also be compromised due to lack of access to medication, timing and quality of meals, poor understanding or misinterpretation of symptoms by prison staff.

Recommendations

- Diabetes should be considered one of the conditions which requires a chronic disease register and management of this condition should comply with the formal approach to managing long term conditions in prison. The register should ensure that the age and ethnicity of the prisoner is recorded. These variables should be included in any activity reporting.
- Given the high proportion of BME prisoners in HMP High Down and higher prevalence estimates from previous assessments, the low estimated prevalence of diabetes could indicate undiagnosed/untreated diabetics. This unmet need should be addressed by proactive screening and identification of prisoners who may have undiagnosed or diet controlled diabetes and appropriate intervention provided.
- Health care providers should raise awareness of the signs and symptoms of diabetes amongst prisoners and prison staff.

5.7 Coronary heart disease (CHD) and hypertension

As no register has been developed for CHD a medication review was used to estimate prevalence. The review does not provide a detailed breakdown of the exact medications. 38 prisoners were on 'cardiac drugs'. 25 of these were specifically taking cholesterol-lowering medication. Assuming that those people being prescribed these drugs had a diagnosis of established coronary heart disease or hypertension, then this equates to a prevalence of 3.1%. Previous needs assessments at the prison

have suggested prevalence rates of between 8% (2003/04) and 11% (2005/06) despite there being no significant change in the middle aged and older population within the prison.

The estimated prevalence within the prison is very similar to that seen in the general population (3.7%) but differs significantly from prevalence rates seen in other prisons (14%) indicating there may be anything between 33 and 149 prisoners with CHD within the establishment.

The prevalence of hypertension in the UK is 12.8% which is higher than rates seen in some US studies (9.8%, 12%). The CARDIA study[35] demonstrated that imprisonment is associated with increased risk of hypertension with rates of 12% compared with a control group prevalence of 7%. The association persists after adjustment for smoking, alcohol and illicit drug use. Using these prevalence rates there would be between 104 and 136 inmates with hypertension.

Chest pain was described as a symptom in 5% of those entering reception but the aetiology of this pain was not clear and may not have been cardiac in origin. Very small numbers of prisoners reported a clustering of symptoms such as chest pain and diabetes (2) or chest pain and asthma (12). Only 2 inmates reported chest pain, diabetes and asthma.

Recommendations

- Coronary Heart Disease should be considered one of the conditions which requires a chronic disease register and management of this condition should comply with the formal approach to managing Long term conditions in prison.

- Given the higher prevalence estimates from previous assessments and the low estimated prevalence of CHD currently, this could indicate undiagnosed/untreated CHD. This unmet need should be addressed by proactive screening and identification of prisoners who may have undiagnosed CHD and appropriate intervention provided.

- Healthcare staff should be made aware of the potentially increased risk of hypertension associated with imprisonment.

5.8 Hepatitis B, Hepatitis C and HIV

The risk factors within the prison population for contracting blood borne diseases such as Hepatitis B, C and HIV are more prevalent than in the 'outside' community. This is partly due to factors such as injecting drug use, tattooing with non-sterile/home made equipment and risky sexual practices as well as potential for initiation into first time injecting drug use whilst in prison. Sharing drug use 'paraphernalia' within prison can also increase the risk. In an attempt to reduce this risk, there has been a move to install sterilising tablet dispensers within prison establishments across the country. Currently there is no needle exchange service within English and Welsh prisons.

All offenders attending the genito-urinary medicine (GUM) clinic at HMP High Down are offered a comprehensive sexually transmitted infection screen. During a six-month period the screen was taken up by 61% of clinic attendees (n=118). In addition

59 Integrated Drug Treatment Service (IDTS) clients were tested for the Hepatitis C virus (Jan-Sep 2008). 12 people were diagnosed with HIV, 8 with Hepatitis C virus (HCV) and no Hepatitis B cases were recorded. It is not possible to calculate the prevalence of HIV or HCV as only a small subsample of the prison population were tested and the rates of pre-existing disease are not known. The most recent survey of prevalence of HIV in prison found rates much higher than in the community. The rate in male prisoners was 0.4% with a rate of 0.5% in drug using inmates. The rate in the community is 0.2%.

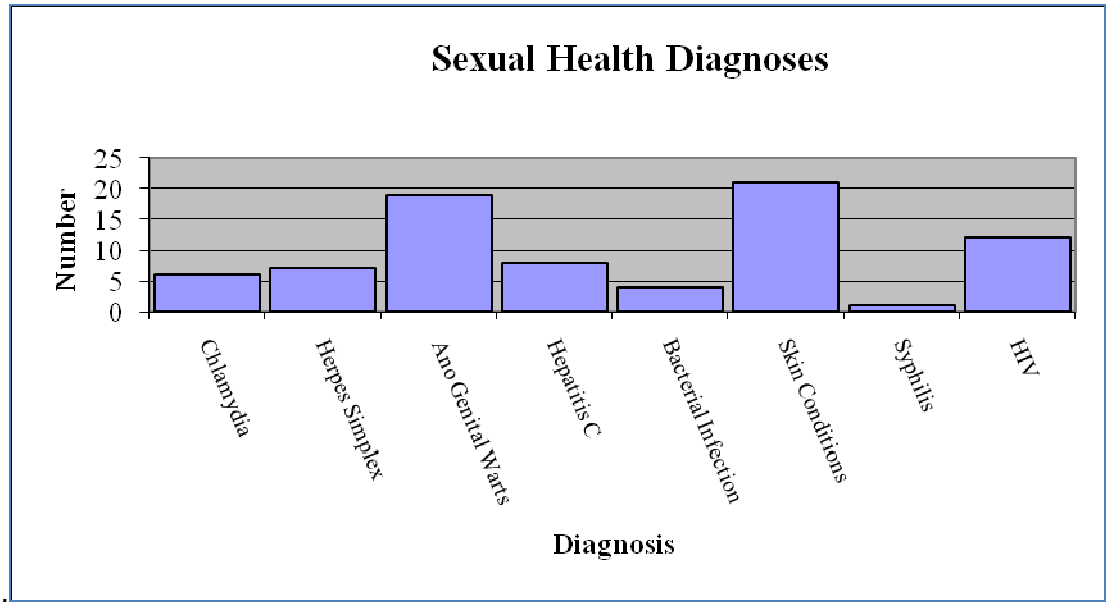
The national prevalence of HCV in the general population is 7% and is estimated to be 31% within the male drug using prison population. The prevalence of hepatitis B is estimated as up to 20% in the prison drug using population. The general population prevalence is estimated as 8%. This would equate to an estimated 2 cases of HIV, 99 cases of Hepatitis B and 153 cases of Hepatitis C.

5.9 Sexually transmitted infections (STIs)

Prisoners are one of the groups who are considered to be at greater risk of poor sexual health and/or require additional support to access services.

HMP High Down has a sexual health clinic that runs once a week and is provided by Ashford & St Peter's NHS Trust. Figure 5.1 displays the number of patients seen in the sexual health clinic and their diagnoses over the six-month period July 2008 – December 2008.

Figure 5.1 Number of patients seen in sexual health clinic and their diagnoses (July 2008 – Dec 2008)



A total of 194 patients were seen, with a further 51 recorded as 'did not attend' (DNA). With this data, it is not possible to calculate the prevalence of STIs within the prison as there are likely to be large numbers of inmates who do not present to the service. It is also impossible to ascertain whether these were established or new infections.

It is known that custodial institutions particularly those with a high turnover of young men are potential reservoirs of Chlamydia and other STIs passing infections back into both the adult and teenage communities. Studies have found positivity rates of between 4% and 12% in male prisoners tested for Chlamydia. Rates of genital warts were also 4%. Another study of young offenders attending a prison GUM clinic found that 51.75% tested positive for an STI. Similar testing on adults prisoners in France found that 16% had at least one STI. If these figures were applied to the HMP High Down 77 young offenders and 147 adults may have an STI. Between 43 and 128 offenders (of all ages) may have Chlamydia.

Recommendation

- Due to the high prevalence rates within prisons and the known benefits to the wider community by effectively intervening with this group, screening and treating prisoners for STIs should be a priority.
- Due to the high numbers of young men in this prison the Chlamydia screening programme should be formally introduced and compliance monitored.

5.10 Tuberculosis (TB)

This high throughput of prisoners at HMP High Down could potentially increases the risk of spread of TB. Therefore vigilance, screening and early diagnosis are essential cornerstones of good practice. The Primary Care Manager is the lead for communicable diseases and liaises with the Health Protection Agency (HPA), Surrey Community Health and the TB Nurse Specialist for advice as necessary.

Screening questions for TB are part of the initial health screen when an offender arrives at reception at HMP High Down. The question asked on the screening form is non-specific and is included in the same question asked for other diseases such as asthma and diabetes. There are no specific questions such as recent sudden weight loss, night sweats or fever. However, if a prisoner does report a previous history or contact with TB they are referred to the GP or clinical nurse lead for follow up. At reception 5 prisoners reported previous problems with TB (0.5%) over a 6 month period.

The population prevalence in the UK is estimated to be 14 per 100, 000 (0.014%). However some urban populations such as London have much higher rates (208/100, 000). In London it is estimated that homeless people, drug users and prisoners account for 17% of these cases. The study found that imprisonment was significantly associated with being part of an outbreak and poor adherence to medication.

Recommendation

- 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. Screening for TB should be a priority and proactive measures should be taken to identify cases - such as asking specific questions related to TB symptoms at reception.

5.11 Accidents and self harm incidents

8% of prisoners reported a recent physical injury on arrival at reception. A 20% sample of entries in the register of accidents from the period December 2007 – December 2008 was taken in order to examine the scale and nature of injuries that occurred in the prison. The accident register is held in the Orderly Office.

Through extrapolation from the sample it is estimated that approximately 2840 injuries were treated in the 12 month period – this averages out at around 2.6 injuries per prisoner per year. 5.6% of the injuries reported were maxillo facial, 5.8% were self harm, and 2.5% required a referral. The most common injury types were cuts, an estimated 255 of which were treated (9%). The second most common injury was where force was used but no injuries sustained 3.0% (85 incidents). It is estimated that there were 45 head injuries, 15 seizures, 15 burns, and 5 eye injuries. There were an estimated 20 medication overdoses.

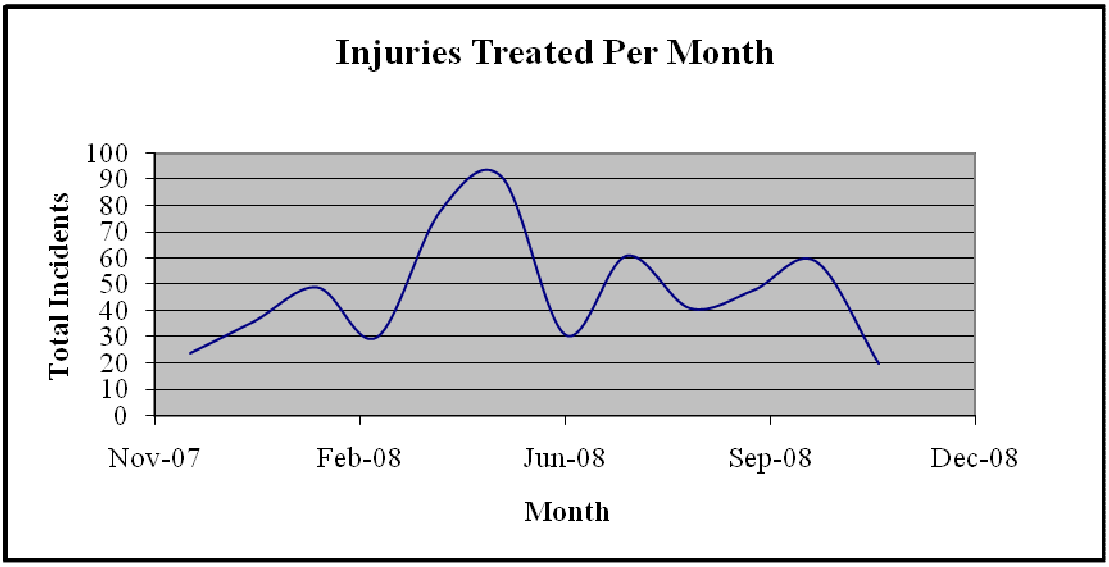
Minor injuries are usually treated by the house block nurses using homely remedies (medication that can be administered which has not been prescribed by a doctor). Homely remedies can only be used for a restricted period of time and if necessary the nurse can make a referral to another healthcare professional for further assessment or treatment. A prisoner can also make a direct application to the emergency nurse practitioner (who can also prescribe).

The prison management are obliged to complete a F213 form when an accident occurs and an F213SH if self harm is suspected. The aim of the F213SH is to improve the recording of self-harm incidents in order to provide a better understanding of where, when and why incidents occur and to obtain early warnings of any developing trends.

The risk of overdose can be minimised by good medicines management when prescribing and dispensing and efficient observation when patients take their medication. Psychological input may also be beneficial.

There was a significant variation in the number of injuries treated per month as demonstrated in Figure 5.2.

Figure 5.2 The number of injuries treated per month at HMP High Down (Nov 07-Dec 08)



Recommendations

- Ensure appropriate prescribing and efficient observation when patients take their medication.
- Audit of F213 and F213SH against accident register.
- Further questions about previous self harm and/or suicidal attempts should be asked at reception.

5.12 Oral health

No specific epidemiological information on oral health was collected from HMP High Down. Several studies have been undertaken in UK prisons to assess the oral health of prisoners and their findings are applicable. The Scottish Prison's Dental Health Survey[36] found that dental health was significantly worse in prisoners than in the general population. Prisoners had significantly more decayed teeth, fewer filled teeth and fewer natural teeth than the general population. The prevalence of severe decay (decay which extends into the dental pulp and usually requires extraction of the tooth), was three times higher in the prison population than in the general population.

A similar study at HMP Brixton found that there were higher levels of tooth decay and lower numbers of missing and filled teeth compared to the general population. There was no significant difference between the oral health of remand and sentenced prisoners and all had high rates of accessing emergency dental treatment.

Poor oral health is linked to the abuse of opiates and other drugs. Prolonged abuse is often associated with self-neglect and the adoption of a diet which promotes tooth decay.

Recommendations

- Access to a dentist is the main cause of complaint by prisoners in HMP High Down and in response to this a dental health needs assessment has been commissioned.

- A dental triage system led by a dental nurse should be developed and implemented. Those most in need should be prioritised. Self care alternatives to seeing a dentist should be considered in all routine cases and appointments for non-urgent needs should be effectively managed. NHS Surrey should monitor dental waiting times to measure effectiveness of this.

5.13 Other physical health problems

Reception screening highlighted 6 inmates with sickle cell over a 6 month period. It is not clear from the database whether this was sickle cell disease or trait. There was also a significant prevalence of allergy (12%) reported at reception.

Recommendation

- Due to the high proportion of BME prisoners in HMP High Down, any reporting of sickle cell disease or trait at reception should be proactively followed up and appropriate intervention offered.

5.14. Mental health

Evidence suggests that there are now more people with mental health problems in prison than ever before. Prisoners have significantly higher rates of mental health problems than the general public although the range of conditions and illnesses are broadly similar. The differences in prevalence are shown in Table 5.3.

Table 5.3 Rates of mental health problems in prisoners and the general public

Mental health problem	Prisoners	General population
Schizophrenia & delusional disorder	8%	0.5%
Personality disorder	66%	5.3%
Neurotic disorder e.g. depression	45%	13.8%
Drug dependency	45%	5.2%
Alcohol dependency	30%	11.5%

Source : Singleton et al 1998, Singleton et al 2001

The same study suggested that over 90% of prisoners had one or more of the five psychiatric disorders studied (psychosis, neurosis, personality disorder, hazardous drinking and drug dependence) and that remand prisoners had higher rates of mental disorder than sentenced prisoners. Around 20% of male prisoners have previously experienced an acute psychiatric admission to hospital.

It is also widely accepted that prison has a detrimental effect on mental health. One study showed that 28% of sentenced male prisoners with mental health problems spent more than 23 hours a day in their cell. This was more than double the rate in prisoners without mental health problems.

At reception screening 16% of prisoners reported that they had previous mental health problems and had received psychiatric treatment in the community. This figure is likely to be an underestimate of the overall prevalence of mental illness as many inmates may have not received any assessment or diagnosis of their psychiatric condition.

4% of those screened at reception had a community mental health nurse, 6% had been admitted to a psychiatric unit and 10% had received medication for mental health problems at any time.

Ethnicity
Admission rates of black people to the mental health system are three or more times higher than those of all other groups. The 'Count Me In' census estimated that BME groups are 40% more likely to access mental health services via the criminal justice pathway. A study by Nacro also concluded that the criminal justice pathway is one of the 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.

Ethnicity data is often poor as forms are not completed fully by the referrer. The in reach team extrapolated ethnicity data using completed forms. They estimated that the majority of those referred (49%) were White British but comprised only 41% of those accepted for assessment. There was a high proportion of Other White prisoners accepted for assessment which may reflect the increased number of prisoners from Eastern Europe. The ethnicity of prisoners referred and accepted for assessment is in Table 5.4.

Table 5.4 Ethnicity of prisoners referred and accepted for mental health assessment

Ethnic group	**% referred (n) Total = 1108**	**% accepted (n) Total = 286**
White British	49 (542)	41(116)
Any other white	10 (112)	18(50)
Asian/Asian British	5(57)	8(23)
Black/Black British	25(280)	22(63)
Mixed race	5 (53)	7(20)
Any other/unknown	6 (64)	5(14)

Reasons for referral
The majority of referrals were made for anxiety or depression (22%). These referrals were in addition to those where the primary concerns were incidents of self harm or suicidal ideation/attempts (15%). The next most common presentation was (21%) severe mental illness including schizophrenia, bi-polar affective psychosis and those displaying psychotic symptoms or phenomena. These referrals were a combination

of prisoners presenting with new symptoms and those with existing pathology. Personality disorder was the third most common treason for referral (9%).

Nationally a large proportion of the in reach case load is taken up with people with a personality disorder with antisocial personality most commonly diagnosed. There is currently no formal provision of services for this disorder in prison and no coherent national approach agreed between health and the criminal justice system. The current availability of personality disorder appropriate services within mainstream community or specialist mental health services is also limited.

However changes to the Mental Health Act have established personality disorder as a condition that requires equal and appropriate assessment and treatment. There has also been National Institute for Health and Clinical Excellence (NICE) guidance on borderline and antisocial disorders. These two factors should improve community services for the condition and in turn those in prison.

Other referrals included dual diagnosis (0.9%), post traumatic stress disorder (PTSD) (2.4%), obsessive compulsive disorder (OCD) (0.7%) and learning disability (0.8%).

Recent national evaluations of the mental health in reach service provides comparator data. The most prevalent disorders were psychosis (22%) and major depression (20%) with rates very similar to HMP High Down. 60 % of the caseload did not have a diagnosis of current severe mental illness and of these 41% had a personality disorder and 70% had substance misuse problems. The study also indicated that only 23 % of prisoners with a current serious mental illness were assessed by in reach teams.

The evaluation recognised that in reach teams are no longer able to focus on the severely mentally ill and have had to accept prisoners who are not receiving appropriate treatment from other services. There has also been a rapid increase in the prison population and therefore the level of health need.

The Care Programme Approach (CPA)
Within the wider community the care programme approach has been developed as a process for ensuring co-ordination and continuity of care for people with mental health problems. As with other mainstream mental health management CPA should be integral to the treatment of the offender population. The in reach team undertake regular CPA audit.

The Bradley Report recommends that current mental health services need to shift away from a reliance on the provision of inpatient care towards the development of primary mental health services. These services should be supported by other activities such as education and training.

Recommendations

- Serious mental illness should be considered one of the conditions which requires a chronic disease register and management of this condition should comply with the formal approach to managing long term conditions in prison.

- Due to the high prevalence of mental health disorders within prison, the Health Promotion Action Group should ensure that self help information and activities which promote good mental health are provided and promoted, such as physical exercise, healthy diet.

- NICE guidance is available for the main mental health problems prevalent in prisoners; compliance with these guidelines should be audited and reported through the contract meeting.

- Compliance with CPA requirements should be audited and results should be monitored through contract monitoring.

- Referrers to Mental Health (MH) services should ensure they record the prisoner's ethnicity. Compliance with this should be monitored through the contract meeting.

  MH services should raise awareness of the MH needs of those from BME prisoners with prison officers and healthcare staff, proactively encouraging referrals for assessment and support.

- MH services should consider their referral process to identify what barriers there might be which may be preventing BME groups from accessing services. To measure effectiveness of this process, activity data should be broken down to include ethnicity and monitored through the contract meeting.

5.15 Suicide and self harm

Prisoners are an extremely high risk group for both suicide and self harm. The prison suicide rate in 2007 was 114 per 100,000 prisoners compared to 8.3 per 100,000 in the general population and it is estimated that 30% of offenders have engaged in some form of self harm during their custody. One in five suicides takes place in the healthcare or segregation units. Young people are the group of prisoners with the highest risk of attempting or committing suicide. Prisoners in the first seven days of custody and those newly released are also high risk groups.

Although the last Her Majesty's Inspectorate of Prisons report described suicide and self harm prevention arrangements as satisfactory there were 5 deaths in custody between December 2007 and November 2008. Three of these were young offender prisoners. One death was from natural causes.

At reception screening 3% of those questioned had self harmed in prison and 9% had self harmed in the community. 3% had thoughts of self harm at reception. It was not possible to analyse the overlap between these groups.

All deaths in custody are reported to the coroner and are considered Serious Untoward Incidents (SUIs).

Recommendations

- Positive responses to questions about previous self harm and/or suicide attempts at reception should always prompt appropriate referral or intervention.
- Training should be provided for prison and healthcare staff regarding risk factors and signs that a prisoner may be at risk of self injury.

5.16 Learning disabilities (LD)

Very little data is available on the prevalence of learning disabilities within the prison population. A recent study by the Prison Reform Trust -"No One Knows"[37] estimates that 20-30% of offenders have learning disabilities or learning difficulties that interfere with their ability to cope with the criminal justice system. It is estimated that 8% of the general population have learning disabilities or difficulties. There is no precise information on the prevalence of either condition in BME groups. Translating the prevalence estimates to HMP High Down there could be between 213 and 320 inmates with these problems within the jail.

Prisoners with LD are not routinely identified prior to arriving in prison and may be unable to access routine prison information. In particular, their exclusion from offending behaviour programmes makes it less likely their offending will be addressed and more likely that they will return to prison repeatedly.

Recommendations

- Prisoners with learning disabilities should be proactively identified during reception and by house block nurses.
- Prisoners with learning disabilities should be included on a health register.
- Health action plans should be developed for individuals with Learning Disabilities and information regarding key relevant health issues should be provided in an easy read format.

5.17 Integrated Drug Treatment System (IDTS)

Surveys of morbidity among prisoners have shown that:

- 10% of male remand and 11% of male sentenced prisoners reported moderate drug dependence
- 40% of male remand and 32% of male sentenced prisoners reported severe drug dependence
- 17% of male remand and 13% of male sentenced prisoners reported injecting drugs in the month prior to entering prison. Of these the majority injected daily (82% of male remand and 73% of male sentenced).

- The most commonly used drugs in the year prior to entering prison were cannabis (60%), followed by amphetamines (26%), heroin (25%), crack (21%) and cocaine powder (20.5%)

If prevalence figures from the survey were applied to the current HMP High Down prison population, the estimated numbers of prisoners with substance misuse problems would be as demonstrated in Table 5.5.

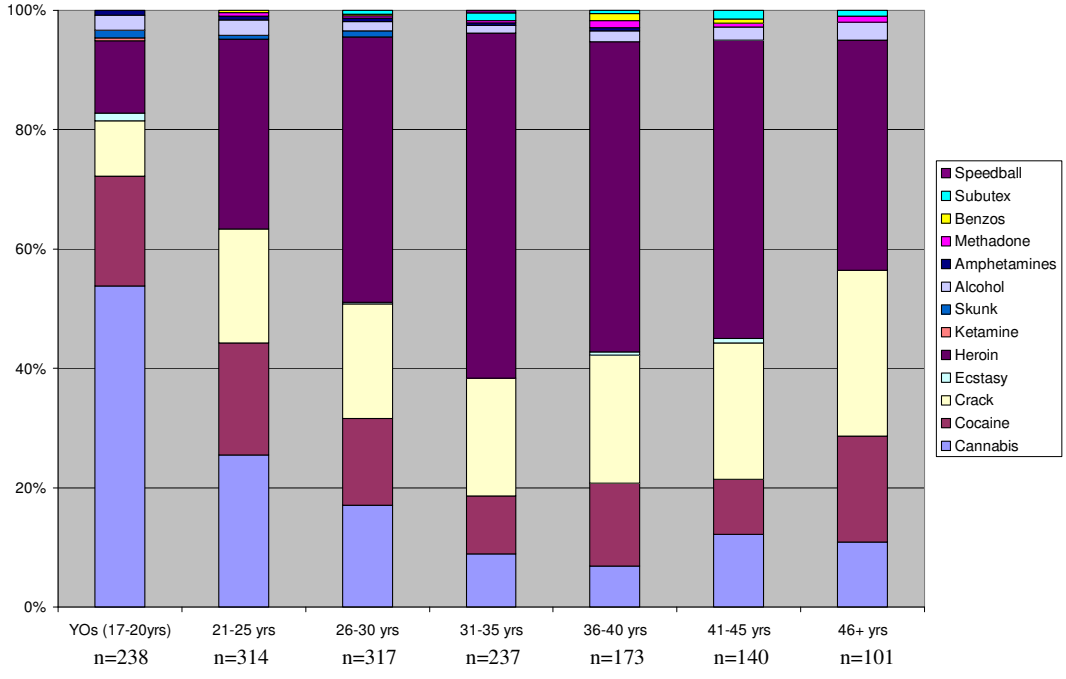
Table 5.5 Estimated prevalence of substance misuse in HMP High Down

TOTAL NUMBER OF PRISONERS	TYPE OF SUBSTANCE MISUSE	PREVALENCE	ESTIMATED NUMBER
1066	Moderate Drug Dependence	10.5%	111
1066	Severe Drug Dependence	36%	384

At reception over a six month period (Nov 08 – May 09) 41% of prisoners reported using drugs in the month preceding their entry to HMP High Down. 6% reported intravenous drug use. 7% had a positive urine test for heroin and 6% had a positive urine test for benzodiazepines.

Type of drug used by age
Figure 5.3 shows data on prisoners at HMP High Down by age and type of drug used during Jan-Dec 2008 and indicates that for young offenders, cannabis is the main drug used with just over half (53.78%) reporting using this drug. Heroin use increases dramatically with age from 12.18% in young offenders to a high of 57.81% in those aged 31-35 years. Heroin use amongst those aged 31-35, 36-40 and 41-45 years is at or above 50%. The main drugs used by all age groups are cannabis, cocaine, crack and heroin.

Figure 5.3 Percentage of prisoners using drugs by type of drug and age group



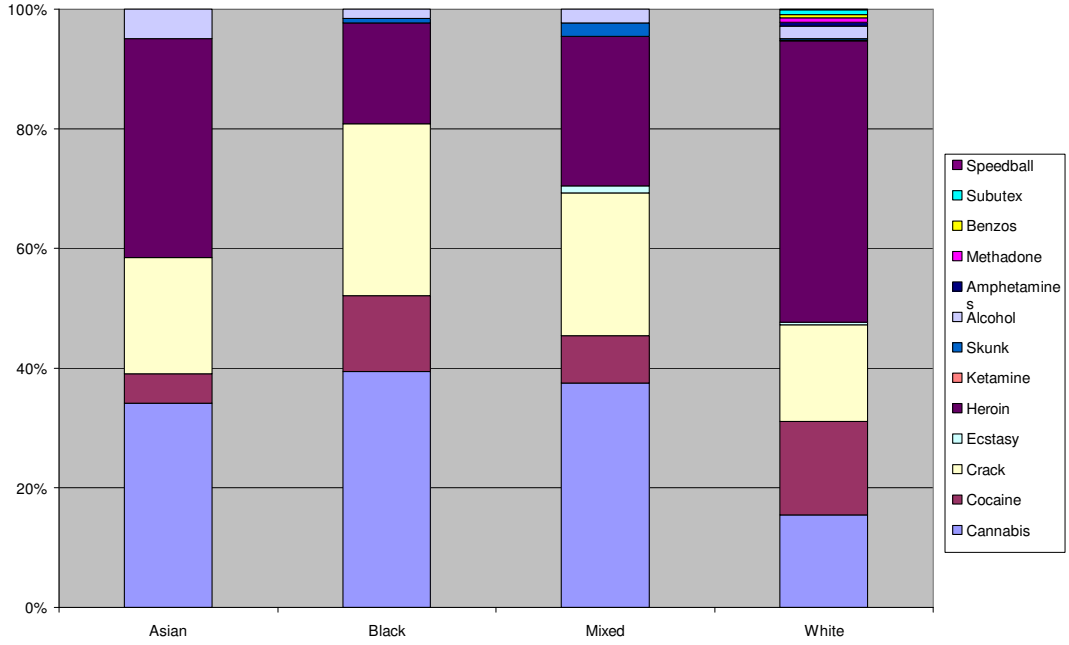
Source: RAPt database

A report by the Home Office[38] on the substance misuse treatment needs of minority prisoner groups indicated that the young offenders they interviewed most frequently cited cannabis as a drug they used (94%), which supports the data outlined above. The report also stated that whilst cannabis use was most commonly used, crack and heroin were the drugs young offenders were most likely to be dependent on.

Type of drug used by ethnicity
Figure 5.4 shows data on prisoners by ethnicity and drug used during Jan-Dec 2008 and indicates that those within the Black ethnic group were the most likely to report using cannabis and crack compared to other groups. Those prisoners from White backgrounds were the most likely to report using heroin compared to other groups.

The Home Office report also indicated that there were differences in the type of drug that Black and Asian prisoners were most likely to be dependent on or use compared to those from White backgrounds. The men they interviewed (80% of whom were Black and 20% of whom were Asian) indicated that they were more likely to use (85%) and be dependent on (68%) crack compared to prisoners from White backgrounds where the main drug was heroin. The data from HMP High Down is similar with 28.74% of Black prisoners reporting using crack compared to 16.22% of White prisoners and 47.01% of White prisoners reporting using heroin compared to 16.86% of Black prisoners.

Figure 5.4 Percentage of prisoners using drugs by type of drug and ethnicity



Recommendations

- An IDTS specific needs assessment should be conducted annually and feed into the IDTS treatment plan.
- IDTS staff should be aware of the differences in type of drug use between different ethnic groups and how this would be applicable to the high proportion of prisoners from BME groups at HMP High Down.

5.18 Alcohol misuse

Surveys of psychiatric morbidity in prisoners have suggested that 58% of male remand and 63% of male sentenced prisoners reported hazardous drinking and that 30% of all male prisoners had Alcohol Use Disorder Identification Test (AUDIT) scores indicating severe alcohol problems. Results from the HMP High Down Independent Monitoring Board (IMB) report concur with these estimates suggesting that 66% of prisoners entering the prison have issues with alcohol misuse.

Analysis of the reception database contained 489 responses on the use of alcohol. Of these 135 men (28%) stated that they drank at dangerous levels (50+ units per week), 50 (10%) stated they drank at hazardous levels and 58 (12%) drank at a safe level. An assessment could not be made on 246 prisoners as their database entries (e.g. social drinker) could not be quantified.

Applying the research figures to HMP High Down gives an estimate of 645 hazardous drinkers and 320 inmates with severe alcohol problems. The numbers of inmates with severe alcohol problems has been increasing steadily as shown in Table 5.6.

Table 5.6 Number of inmates with severe alcohol problems per year at HMP High Down

	2003-04	2005-06	2008
AUDIT score >32	180	250	320

In the last prisoners survey 25% of participating prisoners stated that they needed help with alcohol related issues. The last HMIP report survey suggested that 18% of inmates (192) would have an alcohol problem on release. This is comparison to 13% at other local prisons.

Recommendations

- To enable more appropriate assessment of need and provision of services, reception health care staff should be trained to be able to calculate units of alcohol consumed per week from information provided by prisoners.
- As expected by the prison performance quality indicators screening of alcohol should be conducted using an evidence based tool and when indicated brief intervention should be provided.

5.19 Dual diagnosis

The issue of dual diagnosis (mental health problems combined with drug and/or alcohol problems) is a major challenge. One study showed that 75% of users of drug services and 85.5% of users of alcohol services experienced mental health problems. It also showed that 44% of mental health service users reported drug use and/or were assessed to have used alcohol at hazardous or harmful levels in the past year. Despite the recognised high prevalence of dual diagnosis there is currently an imbalance between resource provision for the treatment of alcohol and illicit drug use, with greater provision being made for the latter.

Recommendation

- Management of dual diagnosis should comply with national guidance ensuring that interventions are integrated and provide staged interventions with a social support aspect that are matched to individual need. A long term perspective on the management of these conditions should be expected.

5.20 Disabilities

HM Chief Inspector of prisons has described the response of prisons to the needs of disabled inmates as reactive rather than proactive. Disabled prisoners are more likely to feel unsafe, are less involved in activities and reported receiving less help than other prisoners. PSI 31/2008: Allocation of prisoners with disabilities amends two existing PSOs to comply with the requirements of the Disability Discrimination Act. The prevalence of disability in England is estimated at 18%, increasing with age. If these figures were applied to the population of HMP High Down there would be 192 inmates with a degree of disability.

Analysis of the reception database showed that 13 prisoners identified themselves as disabled or having problems with mobility. Of these 2 required a walking aid, 6 were unable to transfer independently, 2 reported loss of a limb and 3 described themselves as blind.

5.21 Pharmacy

The top ten items prescribed by volume were:

11) Methadone
12) Suboxone
13) Fluoxetine
14) Mirtazapine
15) Citalopram
16) Diclofenac
17) Ibuprofen
18) Loratadine
19) Omeprazole
20) Salbutamol

The drugs prescribed reflect the high prevalence of substance misuse and mental health problems within the prison.

At reception 21% of prisoners reported that they were receiving medication.

A study across 5 prisons in one region demonstrated significant variation in the average annual prescribing cost per annum per person. In a local prison the spend was £273, but in a Category C prison it was only £78. This will reflect the differing needs of the populations of the establishments. The average annual prescribing cost per annum in primary care NHS is £110 per person – an average of 11 prescription items per year.

5.22 Use of healthcare in prison

One study has demonstrated that male prisoners consult their GP on average 6 times more a year compared to a demographically equivalent community. This may be due to better access, increased morbidity and the culture of the institution. Prison limits the ability of the individual to self care and therefore the GP may be accessed for more trivial complaints. Medical opinions are also sought more often before legal proceedings which may alter the perceived threshold for accessing care.

Prisoner admissions to NHS beds are lower than that expected in a demographically equivalent community but admissions to prison beds are high. Admissions to prison beds are 0.7 episodes per prisoner year which equates to a ten times higher rate than an equivalent population.

Recommendations

- The provision of a comprehensive health promoting service could reduce inappropriate GP attendance.
- The extension of the role of pharmacists as health educators should be considered.

5.23 Health promotion

5.23.1 Smoking cessation services

Smoking is widespread among prisoners with one study stating that 85% of male remand and 78% of male sentenced prisoners were current smokers compared to the UK smoking prevalence of 24%. The estimated prevalence at HMP High Down is 75% which would translate into 800 smokers based on the current population of the establishment.

Despite the challenges of providing a smoking cessation service studies have demonstrated that substantial quit rates can be achieved in prison settings. A study of prisons in the North West region showed that, while the average quit rate (41%) was below the national average (57%), the rate was similar to levels achieved by some local community based services.

Using a range of support methods adapted to the prison, providing Nicotine Replacement Therapy (NRT) and gaining organisational support from the management have been identified as key drivers of success. These services, if successful, can help primary care trusts continue cessation and reduce health inequalities. They also help the prison in meeting PSO 3200 health promotion requirements and address occupational health issues around a smoke free workplace.

5.23.2 Exercise

Across the prison estate only 40% of prisoners participate in exercise and so can take advantage of its physical and psychological benefits. At HMP High Down this would mean that 640 prisoners may not be getting enough physical activity. The average number of hours spent exercising per week by a prisoner is 2.4 for adults and 3.5 for young people. Figures for the number of referrals made for remedial gym are unavailable.

5.23.3 Vaccination requirements

The cost and clinical effectiveness of Hepatitis B vaccination has been proven and prisons are monitored monthly on their coverage by the Health Protection Agency (HPA). In the first quarter of 2009 HMP High Down scored red on the rating system indicating a vaccine uptake of less than 50%. Taking an average of the first quarter of 2009 the vaccine uptake (which is monitored in the performance indicators) was 9% (37 vaccinations per month). On average there were 420 receptions per month of whom 3 were already vaccinated and 12 refused the vaccine. Therefore in order to meet the amber target 203 reception prisoners need to be vaccinated every month. To reach the green target (80%) this would have to increase to 324 per month.

Immunisation uptake in prisoners is likely to be lower than the general population due to their poor access to primary care and chaotic lifestyles in the community. Therefore their time in prison should be considered an opportunity to optimise their health. A study of young offenders in Canada found that 73% had an incomplete immunisation history. 49% were not fully immunised for diphtheria, whooping cough and tetanus, 33% for meningococcal vaccination, 37% for Hepatitis B and 2% measles, mumps and rubella (MMR). It is likely that MMR default rates will be higher in the UK due to the controversy around the MMR vaccine. A study of vaccination rates in adult prisoners in Australia found that 36% of eligible prisoners had incomplete influenza immunisation and 12% had incomplete pneumococcal vaccination.

Flu vaccination is required annually by all inmates aged over 65 and those with chronic diseases. Pneumococcal vaccination is required by the same groups but only once. Using the population data available in the needs assessment approximately 92 inmates would require these vaccinations (around 10 aged over 65, 38 with cardiovascular disease, 19 with diabetes, 25 with chronic obstructive pulmonary disease) annually or a one off. This figure is likely to be an underestimation as there are other chronic diseases that have not been considered in the needs assessment that are eligible for vaccination e.g. chronic renal disease.

Hepatitis A vaccination is also recommended to prevent potential outbreaks developing. The two target groups are intravenous drug users and men who have sex with men. The latter group is very difficult to identify. The former would be at least 64 prisoners based on self reported intravenous drug use at reception.

5.23.4 Screening

Four main screening programmes are applicable to the inmates are HMP High Down – abdominal aortic aneurysm (AAA), diabetic retinopathy, bowel cancer screening and vascular checks.

AAA screening is targeted at men aged over 65 and therefore will apply to approximately 10 inmates at HMP High Down. Retinopathy screening should be

undertaken annually on all patients with diabetes aged over 12. There should be at least 19 prisoners eligible for this screening. Bowel cancer screening is targeted at the 60-69 year old age band and this will involve approximately 8 inmates.

The vascular check programme is being rolled out from 2009/10 with full implementation by 2012/13. Adults aged over 40 are eligible and need to be recalled every 5 years. This is an important future development for the prison as it will involve 17% of the current prison population.

Recommendation

- Healthcare should be aware of the relevant screening programmes and take proactive steps to identify the relevant individuals and investigate if screening has occurred from the Inmate Medical/GP records. If screening has not taken place within the designated time period arrangements should be made to undertake it with prompt follow up of results and recording/forwarding these on as appropriate. This process should be audited.

5.24 Epidemiological Recommendations

Health Assessment at Reception

- Screening of new prisoners should be comprehensive and not restricted to being conducted only at reception. House block based nurses should be responsible for ensuring that all prisoners on their block have a comprehensive health assessment, that health promoting information and intervention has been provided and referrals and access to appropriate services have been made. The health service provider should develop an auditable process to measure compliance with this requirement and regularly report compliance through contract monitoring meeting.

- Review and update of information provided to prisoners on release in order to ensure that they have sufficient information to contact and register with a local GP.

- Education department to review all discharge information to ensure that it is suitable for literacy levels within the prison.

- Education department to run courses on basic form completion with all prisoners prior to release.

Asthma

- Asthma should be considered one of the conditions which requires a chronic disease register and management of this condition should comply with the formal approach to managing Long term conditions in prison.

- A report of asthma at reception should lead onto a clinical assessment, confirmation of diagnosis and prescription of appropriate treatment. Compliance with this should be regularly audited.

- A review of asthma prescribing and a programme seeking and identifying those prisoners with unmet need should be undertaken.

- Smoking cessation should be proactively promoted to all those with asthma and prisoner response recorded.

- Exposure to environmental tobacco smoke should be reduced, especially in reception.

Chronic Obstructive Pulmonary Disease

- COPD should be considered one of the conditions which requires a chronic disease register and management of this condition should comply with the formal approach to managing long term conditions in prison.

- Smoking cessation should be proactively promoted to all those with COPD and prisoner response recorded.

- Exposure to environmental tobacco smoke should be reduced, especially in reception.

Epilepsy

- Epilepsy should be considered one of the conditions which requires a chronic disease register and management of this condition should comply with the formal approach to managing Long term conditions in prison.

- A report of epilepsy at reception should lead onto a clinical assessment, confirmation of diagnosis and prescription of appropriate treatment. Compliance with this should be regularly audited.

Diabetes

- Diabetes should be considered one of the conditions which requires a chronic disease register and management of this condition should comply with the formal approach to managing long term conditions in prison. The register should ensure that the age and ethnicity of the prisoner is recorded. These variables should be included in any activity reporting.

- Given the high proportion of BME prisoners in HMP High Down and higher prevalence estimates from previous assessments, the low estimated prevalence of diabetes could indicate undiagnosed/untreated diabetics. This unmet need should be addressed by proactive screening and identification of prisoners who may have undiagnosed or diet controlled diabetes and appropriate intervention provided.

- Health care providers should raise awareness of the signs and symptoms of diabetes amongst prisoners and prison staff.

Coronary Heart Disease

- Coronary Heart Disease should be considered one of the conditions which requires a chronic disease register and management of this condition should comply with the formal approach to managing Long term conditions in prison.

- Given the higher prevalence estimates from previous assessments and the low estimated prevalence of CHD currently, this could indicate undiagnosed/untreated CHD. This unmet need should be addressed by proactive screening and identification of prisoners who may have undiagnosed CHD and appropriate intervention provided.

- Healthcare staff should be made aware of the potentially increased risk of hypertension associated with imprisonment.

Sexually transmitted infections (STIs)

- Due to the high prevalence rates within prisons and the known benefits to the wider community by effectively intervening with this group, screening and treating prisoners for STIs should be a priority.

- Due to the high numbers of young men in this prison the Chlamydia screening programme should be formally introduced and compliance monitored.

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. Screening for TB should be a priority and proactive measures should be taken to identify cases - such as asking specific questions related to TB symptoms at reception.

Accidents and self-harm incidents

- Ensure appropriate prescribing and efficient observation when patients take their medication.
- Audit of F213 and F213SH against accident register.
- Further questions about previous self harm and/or suicidal attempts should be asked at reception.

Oral Health

- Access to a dentist is the main cause of complaint by prisoners in HMP High Down and in response to this a dental health needs assessment has been commissioned.
- A dental triage system led by a dental nurse should be developed and implemented. Those most in need should be prioritised. Self care alternatives to seeing a dentist should be considered in all routine cases and appointments for non-urgent needs should be effectively managed. NHS Surrey should monitor dental waiting times to measure effectiveness of this.

Other physical health problems

- Due to the high proportion of BME prisoners in HMP High Down, any reporting of sickle cell disease or trait at reception should be proactively followed up and appropriate intervention offered.

Mental Health

- Serious mental illness should be considered one of the conditions which requires a chronic disease register and management of this condition should comply with the formal approach to managing long term conditions in prison.
- Due to the high prevalence of mental health disorders within prison, the Health Promotion Action Group should ensure that self help information and activities which promote good mental health are provided and promoted, such as physical exercise, healthy diet.
- NICE guidance is available for the main mental health problems prevalent in prisoners; compliance with these guidelines should be audited and reported through the contract meeting.

- Compliance with CPA requirements should be audited and results should be monitored through contract monitoring.

- Referrers to Mental Health (MH) services should ensure they record the prisoner's ethnicity. Compliance with this should be monitored through the contract meeting.

  MH services should raise awareness of the MH needs of those from BME prisoners with prison officers and healthcare staff, proactively encouraging referrals for assessment and support.

- MH services should consider their referral process to identify what barriers there might be which may be preventing BME groups from accessing services. To measure effectiveness of this process, activity data should be broken down to include ethnicity and monitored through the contract meeting.

Suicide and self-harm

- Positive responses to questions about previous self harm and/or suicide attempts at reception should always prompt appropriate referral or intervention.

- Training should be provided for prison and healthcare staff regarding risk factors and signs that a prisoner may be at risk of self injury.

Learning disabilities

- Prisoners with learning disabilities should be proactively identified during reception and by house block nurses.

- Prisoners with learning disabilities should be included on a health register.

- Health action plans should be developed for individuals with Learning Disabilities and information regarding key relevant health issues should be provided in an easy read format.

Integrated Drug Treatment Service (IDTS)

- An IDTS specific needs assessment should be conducted annually and feed into the IDTS treatment plan.

- IDTS staff should be aware of the differences in type of drug use between different ethnic groups and how this would be applicable to the high proportion of prisoners from BME groups at HMP High Down.

Alcohol Misuse

- To enable more appropriate assessment of need and provision of services, reception health care staff should be trained to be able to calculate units of alcohol consumed per week from information provided by prisoners.

- As expected by the prison performance quality indicators screening of alcohol should be conducted using an evidence based tool and when indicated brief intervention should be provided.

Dual Diagnosis

- Management of dual diagnosis should comply with national guidance ensuring that interventions are integrated and provide staged interventions with a social support aspect that are matched to individual need. A long term perspective on the management of these conditions should be expected.

Use of healthcare in prison

- The provision of a comprehensive health promoting service could reduce inappropriate GP attendance.

- The extension of the role of pharmacists as health educators should be considered.

Health Promotion

- Healthcare should be aware of the relevant screening programmes and take proactive steps to identify the relevant individuals and investigate if screening has occurred from the Inmate Medical/GP records. If screening has not taken place within the designated time period arrangements should be made to undertake it with prompt follow up of results and recording/forwarding these on as appropriate. This process should be audited.

6 Service mapping

6.1 Quality of services

Her Majesty's Inspectorate of Prisons inspects against the expected outcome that prisoners should be cared for by a health service that assesses and meets their health needs while in prison and promotes continuity of care on release. The standard of care should be equivalent to that which prisoners would expect to receive in the community[11].

If mental and physical health problems are inadequately treated in prison it can become more difficult for prisoners to make best use of other opportunities, such as education and retraining, which can help reduce re-offending [3].

The Social Exclusion Unit[39] has identified nine key factors that influence re-offending:

- education
- employment
- drug and alcohol misuse
- mental and physical health
- attitudes and self-control
- institutionalisation and life-skills
- housing
- financial support and debt
- family networks.

Health has a crucial role to play in addressing several of these complex and often interlinked needs.

6.2 Healthcare funding

Primary care trusts now have responsibility for the healthcare provided in prison and the NHS has been providing services at HMP High Down since 2005. The latest Independent Monitoring Board report describes the transfer as mainly 'advantageous' but describes some difficulties in communication, decision making and some areas of the budget [5].

NHS Surrey commissions Surrey Community Health (SCH) to provide the majority of general healthcare within the prison. SCH has prioritised mental health, substance misuse and communicable diseases in its Provider Service Plan 2007-09[40]. Services for mental health have been commissioned from Surrey and Borders Partnership NHS Foundation Trust since 2005.

GP services are commissioned from Secure Care who took over from Sussex Forensic Medical Services on 1st May 2009. Harmoni provides out of hours cover. GUM services are commissioned from Ashford & St Peter's NHS Trust

6.3 Information and data sources

HMP High Down is currently using a paper records system in healthcare whilst awaiting the installation of a computerised patient data system. Therefore, a combination of information and data sources have been used to estimate the activity levels of services:

1. Local Inmate Database system (LIDS)
2. Healthcare activity sheets e.g. waiting lists
3. Referrals to psychiatric services
4. Referrals to secondary care
5. Appointment applications for minor illness/injuries
6. Collated attendance figures from specific departments e.g. sexual health
7. Reception database

6.4 Healthcare organisational structure

Within the prison Governor Ian Rodger and Senior Officer Danny Craft have a designated interest in healthcare. The head of healthcare is also the lead for all four prisons and is an 8c post.

The organisational diagram for the staff is included in Appendix D.

6.5 Healthcare structures

HMP High Down provides 24 hour access to healthcare for prisoners. Healthcare is located in a purpose built facility near reception. Out patients is located on the upper floor and inpatients on the lower floor. There are 23 inpatient cells each of which can accommodate a disabled prisoner. There is one shower on the unit.

Healthcare provision is comprised of the following services:

- Primary care including GP sessions, nurse-led out patients clinics, nurse-led wing-based clinics
- In patient unit
- Step down unit
- Mental health in-reach
- Integrated Drug Treatment Service
- Dental service
- Podiatry
- Optometry
- Genito-urinary medicine (GUM) service
- Pharmacy
- Reception health screening.

6.6 Staff induction & training

All staff have a two week induction shared between Surrey Community Health and the prison. There is clinical supervision for nursing staff and appraisal. Staff are expected to have completed personal development plans that link their personal objectives into those of the organisation.

Nursing cover is provided by bank staff. Agency nurses are used mainly to cover sickness and special watches. The 2008 Independent Monitoring Board report [5] highlighted that due to recruitment problems and delays, the prison had to rely on a high number of agency staff and that, at times, this had resulted in a lack of continuity of care. Annual staff turnover is 15% [36].

6.7 Reception

It is vital that the prison has all the relevant information about an offender's health needs when they come into reception. Although the current reception health screen

is an improvement on previous versions concerns have been raised nationally that it is not being properly implemented[41]. Ideally prison reception should not be the first point at which a health need is identified; it should be the point where the prisoner enters the criminal justice system. Information should then be added as the prisoner proceeds through the system.

6.7.1 Process
During the health needs assessment the reception screening process was being modified. With a turnover of approximately 115 new prisoners per week, the time pressure to provide a comprehensive initial health screen poses a significant challenge to the nurses working in the reception department, particularly as no secondary screen is undertaken.

All prisoners are screened by a Registered General Nurse (RGN) using the 'First reception health screen questionnaire' developed by the Department of Health & Her Majesty's Prison Service. This records basic data on:

- demographics
- disability
- sentencing status
- medication
- physical injury
- past & present medical history
- alcohol and drug use
- mental health
- suicidal ideation.

If the reception nurse has any medical concerns the prisoner can be transferred to healthcare for overnight assessment and where necessary an Assessment, Care in Custody and Teamwork (ACCT) document opened. If a prisoner does not require admission but needs to see a doctor a note is placed in the front of their IMR and this is followed up the next day. Prisoners are given an induction pack which includes information on accessing healthcare services.

The introduction of a Healthcare support worker (HCSW) was piloted in 2008 and has been rolled out. The HCSW's role was supportive enabling the Registered General Nurse (RGN) to focus on the consultation. The HCSW managed the throughput of prisoners as well as carrying out some screening procedures such as urine testing, blood pressure recordings etc.

An Integrated Drug Treatment Service (IDTS) doctor and nurse are also present at reception. Any prisoners with substance misuse issues are directly referred to the team for assessment and interventions if required. Those prisoners who require either detoxification programmes or methadone maintenance are placed on House block 6, where the IDTS service is based. If not referred to healthcare or House Block 6, reception prisoners go to House Block 3. A telephone interpreting service is available in reception and is used regularly by healthcare staff.

6.7.2 Throughput
Between November 2008 and May 2009 995 reception health screens were undertaken. Of these 721 prisoners (73%) were deemed fit for normal location in the prison.

168 patients (17%) were referred to the doctor and 14% were referred to other non specified healthcare professionals. Of those referred to the doctor 35% were for physical illness and a small number were self referrals (6%).

21% of those seen in reception were recognised as having substance misuse issues but only 4% of those seen at reception were recorded as being referred to the appropriate detoxification services. 4% of those seen in reception were referred for a mental health assessment. During the same time period 19 Assessment, Care in Custody and Teamwork (ACCT) documents were opened. Only 2 inmates were recorded as receiving any health promotion leaflets.

Recommendations

- As only 4% of those seen at reception were recorded as being referred to the appropriate IDTS service a comprehensive review of this process must be undertaken.
- Reception must be used as an opportunity to provide comprehensive health promotion information in an accessible format and signposting to other services.

6.7.3 Reception database
The in-house database (which has been piloted since November 2008) has been specifically designed to capture the details of all initial health screens. This information will be used to inform future service development.

A data entry post was introduced in November 2008 to record demographic and health information into the database thus freeing up more of the RGN's time. The validity of the information on the database will be reliant on the completeness and quality of the information recorded for each prisoner and the accuracy with which this is entered into the system.

6.7.4 Environment
The reception wing was being refurbished during the health needs assessment. The building work negatively impacted on the attempts at streamlining the prisoners' journey. Nurses were concerned about providing appropriate and consistent levels of confidentiality within the reception environment. To overcome this they were using a second room in addition to the doctor's room. However this room did not have appropriate hand washing facilities.

There was also exposure of staff and prisoners to significant levels of environmental tobacco smoke, as one of the 'holding' rooms was designated for smoking.

6.8 Accessing healthcare

Prisoners requesting healthcare services complete an application form (available from the wing office) and place this in a dedicated box on the House Block. This box is emptied every day by the House Block nurse who then triages all prisoners wishing to see the doctor. If appropriate they are given an appointment. Internal appointment slips are delivered to cells the night before the appointment in individual brown envelopes. The clinics are called non specific non identifiable names. The House Block nurse also arranges all other healthcare appointments within the prison. Prisoners can also ask to attend the wing based clinic. The hatch itself operates an 'open access' policy.

Prisoners in the Separation and Reintegration unit are seen daily by a nurse and medicines administered as required. The nurse also attends all reviews. The doctor attends the unit three days a week and can be called for special visits if necessary.

6.9 Inpatients (including house block 6 Step Down Unit)

6.9.1 Staff structure

- 1 x Band 7
- 2 x Band 6
- 2 x Band 5
- 2 x Band 3
- 13 x Discipline officers (1 x senior officer, 12 others)

Two nurses are nurse prescribers – one for minor ailments/injuries and one for psychiatry. Several healthcare officers are working towards a Level 3 NVQ qualification in Health & Social Care.

8 administrative staff cover the entire healthcare centre including the main unit, mental health and IDTS. Their banding is PA to the Head of Healthcare, 1x Band 4, 1x Band 3 and 5x Band 2.

Clinical governance is a Band 7 post supported by one Band 3 administration officer.

At present there are no agency staff covering vacancies.

6.9.2 Capacity

The inpatient facility currently provides 23 single cell beds offering care for acute mental and physical healthcare needs. Other internal departments such as chaplaincy and education can visit inpatients. Patients are allowed personal or official visitors in the visiting hall but visits to healthcare are only allowed in exceptional circumstances such as legal visits. The psychiatrist, community psychiatric nurse and GP visit inpatients. However for the latter there are no set times for visits. Each patient has a named nurse and officer and patient management is discussed at daily handover meetings.

6.9.3 Reasons for admission

The 8 month period April – Nov 2008 was sampled. During this time there were 455 inpatient admissions. These figures were extrapolated to give an estimate of 780 admissions for the year. In the months sampled 64% of admissions were for mental health issues, 22% for physical health, 11% for substance abuse, 3% for lodging, and in 6% of cases the reason for admission was not stated. 51% of admissions were from reception, 47% from house blocks, and 3% are from other prisons/hospital. Data is unavailable on the number of patients that received medication under restraint but it is anecdotally estimated that numbers are low.

Recommendation

- Medication received under restraint should be considered an auditable intervention and therefore should be formally audited on the small number of occasions when it occurs.

6.9.4 Length of stay
Mental health patients had a mean length of stay of 6.5 days (median 3 days), while physical health and substance abuse patients had a mean length of stay of 3.5 days (median length of stay 1 day for both these sets of patients). The average bed occupancy was 87%, reaching a maximum of 96% in September and a minimum of 62% in April.

Recommendation

- A formal review of bed occupancy should be undertaken to identify if the audit period findings that maximum bed occupancy was 87% are consistent. This review should then consider if the prison requires 23 in-patient beds.

6.9.5 Patient profile
The mean ages at admission for physical health and substance abuse patients were 34 and 37 respectively. The mean age for mental health was significantly lower at 28. Accurate ethnicity statistics are not available. The limited data available indicates the majority of in patients define themselves as 'white British'.

6.9.6 Discharges
Record keeping on discharges was poor with approximately 50% not stating whether the discharge was successful or not. 4% of discharges were known to have failed but in half of those cases the reason for failed discharge was not stated. 78% of discharges were to house blocks, 4% to other prisons/hospital, and 18% to court.

Recommendation

- Record keeping of discharges needs to be improved. This should be audited and reported through the contract meeting.

6.10 Step down unit

The step down unit is a new development. Patients who are no longer acutely unwell but who may still not be sufficiently independent to cope on the residential wings can convalesce in the step down unit. Rehabilitation can also be undertaken. There is liaison between the inpatient healthcare department, the step down unit and the discipline officers that promotes a smooth transition from healthcare back to the wings.

6.10.1 Turnover
The unit consists of 12 cells which are usually full, with reviews being carried out daily. There are normally 2-3 inmates on the waiting list for the unit. At the time of data collection there were no statistics available on turnover. It was estimated that the average stay was 24 – 48 hours. The conditions treated included hypertension, diabetes and respiratory problems.

6.10.2 Staffing
The unit is staffed by one dual qualified Registered Mental Health Nurse (RMN)/Registered General Nurse (RGN) and 1 RMN with 1 HCSW at night. There is currently a vacancy for a further RGN.

6.11 Daffodil day care centre

A range of therapies are offered to both inpatients and outpatients via the day care facility which is housed within the inpatient unit. Activities include dance and movement, self help groups, relaxation and art psychotherapy. The service is designed to provide support to vulnerable patients particularly those being discharged back onto the wing by providing them with tools to assist in relapse prevention. Her Majesty's Inspectorate for Prisons praised the centre for providing 'meaningful and therapeutic care and activity' [9].

6.12 GP Service

GP sessions are held three times a day at 8.30am, 10am and 2pm and each session is held on a different house block. The current schedule for the week is :

Monday	8.30 am HB6, 10am HB2, 2pm HB1
Tuesday	8.30 am HB5, 10am HB4, 2pm HB3
Wednesday	8.30 am HB6, 10am HB2, 2pm HB1
Thursday	8.30 am HB5, 10am HB4, 2pm HB3
Friday	4 sessions HB6, HB5, HB1 & HB2

If a prisoner cannot see the GP when he visits the house block he can be seen in out patients usually that afternoon. The GP also visits the Separation and Reintegration Unit on Wednesday and Friday. The current wait for the GP service is one week with emergencies seen on the same day.

The GP service was provided by Sussex Forensic Medical Services until 1st May this year when it was taken over by Secure Care. Concerns had been raised by staff members that the high turnover of GP locums has led to inconsistencies in prescribing particularly for sleeping tablets and opiate based analgesics. The IMB also highlighted that the service provided was not consistent or timely [5]. There is currently no GP IT system in place. Harmoni provides weekend cover and an on-call over night service.

6.13 Out of hours provision

At present the only information available on the demand for and use of out of hours primary care services is based on the period 7/5/09 to 20/6/09. During this time period there were 7 calls for out of hours primary care. Two of these were for respiratory issues, 2 for pain and one each for self harm, medication and triage. In all cases only advice was given.

The Hotel 1 team is based in in-patients and acts as a back up to the Hotel 2 team. There is also a Band 5 nurse (IDTS), one healthcare assistant and one officer all based on inpatients. The HMIP raised concerns that after 5pm the staff on duty find it challenging to deal with emergencies across all the house blocks [9].

6.14 Wing based clinics

The wing based clinics provide a mechanism for triaging patients to other healthcare professionals. The clinic room has a hatch that opens out on to a main thoroughfare on the wing. This can pose challenges for the nurses around confidentiality. Medications are dispensed by the nurses from the hatch twice a day (morning and afternoon) but controlled drugs are dispensed from the nurses station in outpatients

and house block 6 (substance misuse wing) . Emergency nurse practitioner clinics are held twice weekly on house block 3.

The current waiting time to see a house block nurse is 2 days with emergencies seen the same day.

A sample of the conditions seen and/or triaged by the nurse on one day are described in Table 6.1. In total 19 patients were sampled, some of whom presented with more than 1 condition. The average experience of pain was 5 on a visual analogue scale.

Table 6.1 Conditions presented to the wing based clinic

Condition	Number presenting
In grown toe nail	11
Discharge	1
Injury	1
Other nail problems	2
Skin problems	4
Foot problems	1
Diabetes	3
Fungal infection	3
Verruca	1

In 2006 the three most common presenting symptoms in a single day snapshot were headache, musculoskeletal pain and skin problems. These accounted for 74% of consultations [9].

6.15 Out patients clinics

6.15.1 Staff structure

- 1 x Band 7
- 2 x Band 6
- 1 x Band 5
- 1 x Band 3

6.15.2 Service provision

Phlebotomy clinic	weekly
Hepatitis B immunisation	daily
Podiatry	2 x clinics per week
Dental	10 x sessions per week
Smoking cessation	2 x clinics a week
Asthma	2 x clinics a week
Diabetes	Bi-weekly
X-ray	2 x clinics a week
Sexual health	1 x clinic a week
Wellman	Weekly (includes dental health screening)
Flu vaccinations	annually between Oct – Nov
Physiotherapy	3 x clinics per week
Optometry	4 sessions per month (average)

The majority of these clinics are nurse led and overseen by the primary care lead nurse. As detailed for individual clinics 'did not attend' (DNA) rates are high and this has not improved since the last inspection in 2006 when the rate was 10% [5].

Occupational therapy sessions are not formally provided but this service can be accessed for individuals from Central Surrey Health.

6.16 Hepatitis B vaccination clinic

6.16.1 Structure
The average number of available appointments per week is 55, with on average 14 injections administered per week. Each clinic is normally managed by a nurse and a HCSW.

Recommendation

- A service review should be undertaken, to identify what activity occurs during the 55 appointments available per week and what proactive approaches are taken to improve Hepatitis B vaccination uptake and recording.

6.16.2 Patient profile
117 of the patients receiving the vaccine were aged 19-25 years, 105 were aged 26 to 35 years and 109 were aged between 35 and 60 years.

Ethnicity data was not complete but suggested that the majority of those vaccinated were White British (56%) followed by Black African (15%) and Black Caribbean (12%) ethnic minority groups.

756 new IDTS clients assessed were offered Hep B vaccination during 2007. Of those offered 7.5% (57) went on to be vaccinated.

6.17 Genito-urinary medicine (GUM) clinic

6.17.1 Service provision
One clinic is provided per week in the health care centre by the GUM consultant from Ashford & St Peter's NHS Trust. The clinic offers a full sexual health service. All patients attending are offered Chlamydia testing (this does not constitute screening). They can also access testing for other STIs and blood borne viruses. Prisoners access the clinic using the standard referral procedures. On average 7 patients are seen per clinic with 2 DNAs. There are currently 55 people on the waiting list.

6.17.2 Other sexual health services
Barrier protection and lubricants are available from the nurses on the house block and these services are advertised using artwork designed by the prisoners. There is currently no sexual health and relationships education available within the prison. Discussions are underway on the feasibility of introducing more formalised Chlamydia screening to the prison.

6.18 Optometry

Service provision

On average there are 4 optometry clinics a month, but this can vary. An average of 9.5 appointments are available per clinic. On average 6.5 of these are attended and 3 are DNAs. The current waiting list is 5 weeks and there are 30 inmates on the list at present.

Recommendation

- A third of all appointments are not attended, reasons for this need to be clarified and approaches to improve this DNA rate should be adopted. Effectiveness of this should be monitored through the contract meeting.

6.19 Smoking Cessation

Smoking is widespread among prisoners with one study stating that 85% of male remand and 78% of male sentenced prisoners were current smokers [42]. Estimates at HMP High Down suggest that 75% of the population smoke. This would translate into 800 smokers based on the current population of HMP High Down. HMP High Down is a non smoking prison. Prisoners are allocated smoking cells with other smokers. Staff are not allowed to bring cigarettes into the prison and cannot smoke on the premises.

6.19.1 Service provision
A weekly smoking cessation service operates at the prison with waiting times of between 4 and 10 weeks depending on the numbers completing the course. The service is run by a Band 5 pharmacy technician and two Band 2 pharmacy assistants. The service provides advice on techniques to achieve smoking cessation and prisoners are given one cessation aid (e.g. patch or inhaler). The service is run only for offenders and not for staff. The smoking cessation advisors are trained by the NHS Surrey and submit their returns to them. Staff can access smoking cessation services via the occupational health service.

6.19.2 Throughput
Approximately 21 prisoners are seen a week and a total of 1050 per year. Although success rates at 4 weeks are 95% these drop to 55% at 10 weeks.

Recommendation

- 4 week quit rates are successful, therefore consideration should be given to increasing the number of smoking cessation clinics available to prisoners to reduce the waiting times and to support the programme of care being promoted for the management of chronic disease.

6.20 Dental Service

The dental service is provided in the healthcare centre at HMP High Down for two sites – HMP High Down and HMP Downview. The service has been developed and extended considerably since 2007. There is close working between the dental department and the healthcare staff, with the dentist and dental nurse attending the lunchtime hand over meetings in healthcare. Here specific concerns can be raised and resolved and DNAs can be followed up daily.

6.20.1 Service provision
5 hours of dentistry is provided per day. Each new patient session is 20 minutes long so 15 new patients can be seen per day. There are currently 100 prisoners on the urgent waiting list with a waiting time of 4 weeks. There are 70 prisoners on the routine waiting list with a 6 week wait. Due to the rapid turnover some prisoners leave HMP High Down before their appointment.

6.20.2 Triage
A triage system is operated on a daily basis by the house block nurses. The nurse submits the assessment to the dental department, prescribes analgesia, refers to the GP or can refer to the emergency out of hours dental access centre run in the community. It is estimated that 75 requests are triaged per week. Appointments are allocated according to urgency of problem and length of wait.

Recommendation

- A review of triaging dental pain should be conducted and consideration should be given to when it is appropriate for a dental nurse to triage and when a house block nurse should triage. This could free up considerable amounts of time for house block nurses to focus on other health needs.

6.20.3 Out of hours
Protocols for antibiotics and analgesia have been developed to enable medication to be prescribed out of hours for toothache or dental infection. SCH provide an emergency community service out of hours at dental access clinics. The house block nurse can access this service via the Surgery Dental Help Line. Out of hours dental care can also be accessed via healthcare. At present there are no records available of how many prisoners accessed the service.

6.20.4 Imaging
Digital radiography scanners for intraoral x-rays are on site. This has eliminated the need for patients to attend hospital for x-rays and reduced the oral surgery referral rate as more complex oral surgery and treatment can be carried out in house. The x-rays can now be uploaded to Kodak R4 software so x-rays and notes can be accessed at any prison dental clinic as well as the community clinics in Surrey thus maintaining continuity of care.

6.20.5 Attendance
399 appointments were made between January 08 – Nov 08. Of these 273 were attended (68%) but 19% of these appointments started late. There were 126 (32%) cancellations or ‘did not attend’. The main problem appears to be patients not being aware they had an appointment as they had not received their ‘movement’ slips. An audit of non attendance was carried out with the cooperation of prison officers. This highlighted the extent of the problem and since then rates have improved although the Senior Dental Officer reports on-going problems with poor attendance. All DNAs are followed up by letter. There remain problems around late start times for the dental surgery due to prisoners being released from their house blocks late and there being no healthcare officers available resulting in prisoners not being able to be seen by the dental team for security reasons.

A range of patient information leaflets have been devised for HMP High Down with information on health promotion information, how to access an appointment and the process for cancellations and non attenders.

Recommendation

- A third of all appointments are not attended, reasons for this need to be clarified and approaches to improve this DNA rate should be adopted. Effectiveness of this should be monitored through the contract meeting.

6.21 Referrals to other agencies/secondary care

Table 6.2 shows the hospital specialty referred to over an 11 month period. The figure in brackets extrapolates these figures to 12 months. Most referrals were to orthopaedics. It was not possible to elicit monthly data as a large proportion of the referral letters were undated.

Occasionally prisoners can be put on medical hold which prevents them being moved to another prison while they are waiting for an important NHS appointment. Over a 6 month period 6% of prisoners coming through reception had outstanding appointments with healthcare professionals.

In the first six months of 2009 the DNA rate for referrals to other agencies was 34%. No data was available on how many referrals were new or follow up.

Recommendations

- A third of all external appointments are not attended, reasons for this need to be clarified and approaches to improve this DNA rate should be adopted. Effectiveness of this should be monitored through the contract meeting.

- All healthcare staff must ensure that all their notes, letters and other documentation meets NHS Surrey information governance standards.

Table 6.2 Referrals to secondary care over 11 months

Specialty	Total (estimated number for a year)	Percentage
Dermatology	9 (10)	8.7%
ENT	13 (14)	12.5%
Audiology	1 (1)	1.0%
Orthopaedic	20 (22)	19.2%
Urology	5 (6)	4.8%
Surgery	10 (11)	9.6%
Neurology	8 (9)	7.7%
Hand Surgery	1 (1)	1.0%
Liver Specialist	1 (1)	1.0%
Cardiology	8 (9)	7.7%
Maxillo Facial	2 (2)	1.9%
Chest Clinic	1 (1)	1.0%
Gastroenterology	8 (9)	7.7%
Misc. Clinic	5 (6)	4.8%
Spinal Injury	1 (1)	1.0%
Eye Clinic	6 (7)	5.8%
Radiology	1 (1)	1.0%
Fracture Clinic	2 (2)	1.9%
Total	102	

In 2006 there were 325 referrals. The majority of these were described as general medical (14%), radiology (9%) and general surgery (7%). There may have been a reduction in referrals to some services in 2008 as they are now provided in house or quality of provision is better. GU medicine, diabetes care, occupational therapy, physiotherapy, chiropody, dental and rehabilitation referrals account for 7% of referrals in 2006 and as no referrals were made to them in 2008 services may have been developed or improved. A number of referrals in 2006 were cancer related (4%) and will reflect the needs of a specific population group within the establishment at that time.

6.22 Mental Health

6.22.1 Staff structure and whole-time equivalent

- 0.5 x Consultant psychiatrist
- 0.7 x Specialist Registrar (SpR) in psychiatry
- 5 x Band 6 nurses (includes 0.4 WTE mental health social worker)
- 1.2 x Admin support
- 1 x Band 8a manager (covers all 4 prisons and is included in the HMP Down View budget allocation)
- 1 x Band 7 senior nurse
- 1 x Band 3 Support, Time and Recovery worker

Sessional staff

- 0.2 x Psychotherapist
- 0.2 x Movement psychotherapist
- 0.1 x Clinical psychologist
- 0.2 x Counsellor

There is currently one Band 6 nurse vacancy.

As the psychiatry services were originally run jointly between HMP High Down and HMP Downview there are some outstanding issues around the allocation of budgets and the employment status of some staff who are still employed by NHS Surrey.

Historically there has been a shift towards increased provision of psychological support from acute nursing provision. This shift has been risk managed and funded in part by additional one off grants from the Department of Health.

6.22.2 Provision

The Mental Health In Reach Team are commissioned by NHS Surrey from Surrey and Borders Partnership NHS Foundation Trust. The team are based in the prison and provide both primary and secondary mental health services. The service is a mixture of outpatient clinics, visiting prisoners on normal location and close liaison with the inpatient unit.

The consultant psychiatrist provides 4 sessions per week, the SpR in psychiatry provides 5 and the nurse prescriber one session.

There are 6 nurse outpatient clinics per week which are predominantly new patient and joint multi-disciplinary team reviews. Most one to one sessions are held on normal location.

There are also clinics in movement psychotherapy (1 session group, 1 session individual), psychotherapy (1 session individual, 1 session group), psychology (0.5 session) and counselling (1 session). There is also 1 Capoeira session per week. Eye movement desensitization and reprocessing (EMDR) therapy is available if clinically indicated.

Care programme approach (CPA) is well established and is initiated or maintained according to need. CPA is also transferred on discharge and community teams are invited to CPA reviews to maintain continuity of care. There are also regular team meetings with healthcare, substance misuse and house block officers and team members attend Assessment, Care in Custody and Teamwork (ACCT), safer custody and Multi-Agency Public Protection Arrangements (MAPPA) meetings. Care plans are regularly updated including house block files.

It is estimated that between them the mental health team will have between 140-160 contacts with patients per week. Some of these will include multiple contacts with the same individual and group contacts which account for 18% of contacts. Generally the inreach team has 100-120 cases open at any one time.

6.22.3 Number of referrals
The total number of referrals received by the mental health in reach team between February 2008 and February 2009 was 1108. The rate of referrals increased markedly from October 2008 in line with the increase in the prison population. Referrals are screened by a CPN each day. Of the 1108 referrals 822 (74%) were not accepted. Some referrals were refused due to lack of information. Others were referred on to other healthcare professionals (e.g. GP, house block nurse) for initial assessment or support.

A needs assessment undertaken in 2006 looked at referrals for one month (March). If the number of referrals is scaled up there were approximately 648 referrals received by the mental health team in 2006 – 62% less than the number referred in 2009 [43]. Of these referrals approximately 132 (20%) were refused.

Recommendation

- 74% of referrals were not accepted reasons for this should be clarified and methods of addressing this should be formally reported.

6.22.4 Source of referrals
47% of referrals came from other healthcare professionals within the prison (16% house block nurses, 7% GPs, 24% healthcare centre). Officers made 20% of referrals and the majority of these were from normal locations. 4% of prisoners referred themselves and other referrals came from CARATs (6%) and Probation (6%). Courts (7%) and solicitors (3%) made the largest number of referrals from outside the prison.

6.22.5 Assessment waiting times
The aim of the team is to assess all accepted referrals within 10 working days. Emergencies were seen within one working day and Court reports were not subject to the target as they required more complex assessment. 17% (49) of referrals were seen within 1 working day. 12% of referrals were not seen within 10 days

6.22.6 Community Development Workers
HMP High Down now has two mental health Community Development Workers (CDW). This 3 year project is commissioned by Surrey and Borders Partnership NHS Foundation Trust. The workers, who work across two prison sites, carry out training for staff around mental health and cultural awareness. They also provide additional screening for new receptions and referral to the mental health in reach team where appropriate. The CDWs work with BME groups, foreign nationals and gypsies and travellers within the prison and out in the community. Also within their remit is the training of listeners and diversity representatives for mental health and cultural awareness.

6.22.7 Referrals
In 2008 there were 27 people transferred to medium or high security settings. An additional 38 were identified as requiring transfer but were not moved either due to an improvement in their condition or because they were released.

6.22.8 Care Programme Approach
On average there are 35 people on enhanced CPA at any one time in HMP High Down although this number can vary. The inreach team are trying to make links with the eCPA system used in the community in order to keep better records on exact

numbers. Many prisoners are managed on statements of care and are rescreened and moved to enhanced CPA prior to release.

6.22.9 Service development
The priorities for the next year will be developing an early intervention in psychosis service, improving primary care services (particularly cognitive behavioural therapy (CBT) for depression and anxiety) and improving links with Safer Custody.

6.23 Learning Disability Provision

The in reach team has two qualified learning disability nurses. Extra specialist input from a psychologist in the Community Learning Disability Team is accessed as required.

6.24 Suicide Prevention

HMP High Down has a Suicide Prevention Policy that has been adapted from national guidelines. The policy outlines how staff can work with prisoners of concern in a compassionate, supportive and empowering way whilst maintaining cooperation and communication between agencies. There is also a Food/Fluid refusal policy about to be published.

Healthcare and Safer Custody have implemented an Emergency Response system for incidents and increased the number of emergency self-harm intervention kits around the prison. The monthly Safer Custody meeting is regularly attended by mental health but not healthcare. A representative from healthcare or mental health attends the Risk Management Meeting.

If there is suspected risk of self harm any member of staff can open an Assessment, Care in Custody and Teamwork (ACCT) document which is then passed to the prisoner's Senior Officer to develop an action plan. A member of mental health or healthcare staff should contribute to ACCT reviews either in person or send in their comments.

All incidents of self harm are recorded on a F213SH form. Copies of the form are sent to healthcare, Safer Custody and kept on the prisoner's file.

6.25 Addiction Services

6.25.1 Staffing & facilities

- GP with a Special Interest (GPwSI)
- 1 x Band 7
- 2 x Band 6
- 1 x Band 5
- 1 x Band 3
- 1 x Band 2

The Integrated Drug Treatment Service provision at HMP High Down comprises of 120 beds on house block 3 with house block 4 taking the overflow. The team had several vacancies in nursing, healthcare workers and admin. Healthcare workers expressed concern that they were unable to engage in extra-therapeutic activities with patients. Additional funding has been allocated to HMP High Down for the IDTS service for the coming financial year.

6.25.2 The programmes
The IDTS programme in HMP High Down has 4 stages:

- Entry into prison - all new receptions have a healthcare screen. Those with substance misuse problems are identified and are seen by a doctor. They are put on the stabilisation unit and provided with an IDTS welcome pack.
- Clinical interventions - a clinical substance misuse assessment determines whether the individual needs to commence detoxification or stabilisation/ maintenance. Those identified as injecting drug users are offered screening for blood borne viruses. Referral to Counselling, Advice, Referral, Assessment and Throughcare (CARAT) team for 28 day psychosocial intervention
- Psychosocial interventions - group and 1:1 support
- Continuity of care - joint care plans and lead the planning around continuity of care upon release from prison

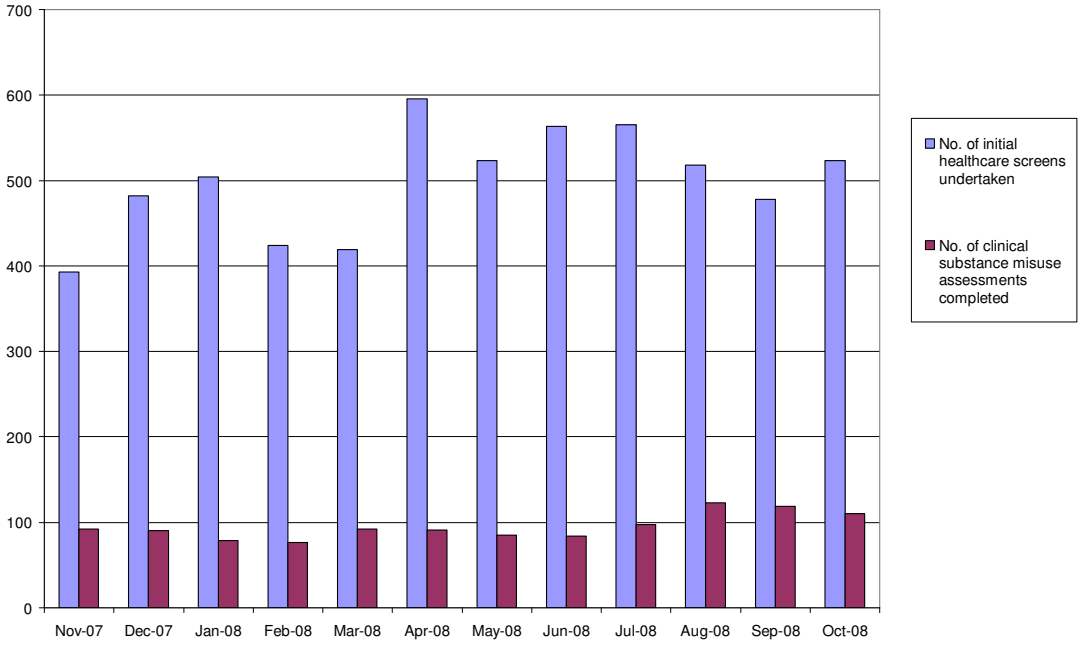
A needs assessment of IDTS is carried out annually.

6.25.3 IDTS Activity

Stage 1 & 2 – Entry into prison/clinical interventions
Data for the period November 2007-October 2008 indicates that the number of initial healthcare screens undertaken varies by month, with an average of 499 new healthcare screens being carried out each month. The number of initial healthcare screens peaked at almost 600 in April 2008 and apart from September has remained above 500 since that time (Figure 6.1).

On average 95 clinical substance misuse assessments have been completed each month over the same period. The number of assessments completed peaked in August 2008 and has not gone below 100 since then (figure 5). 19% (1138/5988) of those initially screened also had a clinical substance misuse assessment.

Figure 6.1 Number of new healthcare screens and clinical substance misuse assessments undertaken at HMP High Down prison between November 2007 and October 2008



Source: Monthly IDTS Healthcare Activity Reports

A comparison of two quarters in 2007 with the same two quarters in 2008 indicates that the numbers of prisoners entering HMP High Down and requiring initial healthcare screens and clinical substance misuse assessments (CSMA) has increased in 2008 compared to 2007.

In 2008 (January-October) the numbers of people referred and starting detoxification dropped to single figures in June 2008 and have continued to remain low since that point (Table 6.3) The reasons behind this sudden drop off requires further investigation.

Table 6.3 IDTS activity January 2008-October 2008

Month	No. referred & starting detox	Total number receiving medication	Total number failing to complete detox	No. referred / starting maintenance	No. on continued	No. released on maintenance
Jan-08	67	223	32	48	158	21
Feb-08	65	221	27	46	144	14
Mar-08	132	243	27	47	119	39
Apr-08	66	231	25	36	127	30
May-08	63	243	34	48	120	30
Jun-08	5	245	0	47	145	46
Jul-08	7	240	38	63	101	36
Aug-08	9	276	60	64	134	51
Sep-08	5	303	40	68	103	36
Oct-08	4	277	32	70	145	30
Totals	**423**	**2502**	**315**	**537**	**1296**	**333**

Source: IDTS monthly returns

Whilst the number of new referrals and those starting detoxification have reduced over the periods compared, all other elements of the service have increased. This may imply that because the numbers on maintenance / continuation have increased significantly there is less capacity to deal with new IDTS clients requiring detoxification

The increase in the numbers failing to complete detoxification in 2008 is mainly due to an increase in discharge and transfers (Table 6.4). Given the increasing turnover of prisoners and the relatively short period of time many prisoners actually spend at HMP High Down, this figure may increase further in the coming year.

Figure 6.4 Comparison of data from April-Oct 2007 to the same period in 2008

	April-Oct 07	April-Oct 08	% Change
No. referred & starting detox	397	159	-60%
Total no. receiving medication	1149	1815	+37%
Total no. failing to complete detox	145	229	+37%
No. referred / starting maintenance	178	396	+55%
No. on continued	582	875	+33%
No. released on maintenance	89	259	+67%

Source: IDTS monthly returns

6.26 Counselling, Advice, Referral, Assessment and Throughcare Team (CARAT)

6.26.1 Activity
During the period January-October 2008 the CARAT team saw on average 178 clients per month. The majority were aged under 30 (60%). Most were White British (67%). The second largest group were Black British (11%). All these figures showed no significant change from 2007 and reflect the nature of the prison population.

There has been a 13% increase in the number of CSMAs conducted by the CARAT team within 15 days during the period April-October 2007 and April-October 2008. The monthly average of CSMAs conducted has increased from 75 per month during April-October 2007 to 86 per month during the same period in 2008.The number of clients referred to Drug Intervention Programmes (DIPs) by CARAT workers has increased by 42% during the period April-October 2007 and April-October 2008. The monthly average of referrals to DIPs has increased from 90 per month during April-October 2007 to 155 per month during the same period in 2008.These increases may again reflect the increase in the prison population generally and the high turnover over prisoners.

6.26.2 Staff
There are currently 15 CARAT workers who work 8.30-5pm Monday-Friday. There is no out of hours service. The team currently has 2 officer and 2 civilian vacancies.

6.27 Alcohol detoxification

An alcohol detoxification programme is available and there are weekly AA meetings held at the prison. The CARAT team provides 1:1 counselling for multi-drug users. 313 patients were referred for alcohol detoxification in 2008 and all participants completed the programme.

6.28 Pharmacy

6.28. Staff structure
- Band 8c x 1
- Band 7 x 1
- Band 6 x 2
- Technicians band 5
- Pharmacy assistants band 2

6.28.2 Service provision
Pharmacy runs the asthma and smoking cessation clinics. Medication is administered from the house blocks except for controlled drugs which are dispensed from out patients. Charts must be physically taken from the house blocks to the pharmacy and then returned to the house block in order for drugs to be dispensed. Every morning the house block nurse checks if any controlled drugs are required and puts a note on the pharmacy charts. As medication must be transferred to the house blocks with an escort there can be delays. Atypical medication may need to be brought in from outside the prison.

Medication is issued twice a day with any night time medications dispensed by the night nurse. Over 85% of medications are in possession (weekly or monthly) and prisoners with diabetes are allowed their insulin in possession. For prisoners with low literacy levels medication is colour coded. A number of over the counter (OTC) medications (e.g. ibuprofen) are available on the canteen list. The means of accessing OTC medication are the canteen, via pharmacy or homely remedies from the house block nurses.

If medication is changed the prisoner is provided with the medicine information leaflet contained with the new medication. An out of hours drug cupboard can be accessed if necessary and pharmacy can be opened in an emergency.

6.28.3 Governance
The pharmacy staff are linked in to the drugs and therapeutics committee of Surrey Community Health and NHS Surrey but the in possession policy has not been signed off by the NHS Surrey.

6.29 Podiatry

At present there are 27 people on the waiting list for podiatry. The 'did not attend' (DNA) rate is approximately 10%.

6.30 Physiotherapy

There are 10 people on the physiotherapy waiting list and the DNA rate is approximately 10%.

6.31 Communicable disease

At present there is a named prison lead within the local Health Protection Unit that liaises with prisons over relevant issues. Infection control training for staff is provided by NHS Surrey. The prison has a communicable disease policy that includes a section on pandemic flu and HMP High Down hosted and participated in a multiagency table top pandemic flu exercise in October 2008. There is currently no communicable disease steering group to oversee strategy development and implementation.
Flu immunisation was administered on house block 3. All prisoners were targeted and there was optimum uptake. There are currently no figures available on the number of vaccinations administered and the number declined.

6.33 Prisoners with disabilities

At the last Her Majesty's Inspectorate for Prisons inspection it was noted that two disabled men were housed in health care as they were wheelchair bound and there were no disabled facilities in the rest of the prison. National standards state that healthcare should not be the default setting to house disabled prisoners. House blocks 5 and 6 include 2 disabled cells each.

6.34 Health promotion

There is currently no prison Health Promotion Action Group in place and no prison health promotion strategy.

6.35 Exercise Referral Schemes

Figures for the number of referrals for remedial gym and the underlying causes are unavailable. Referrals are made by the GP and the emergency nurse practitioner for a number of indications including back pain and minor injuries.

6.36 Medical emergencies

Emergency resuscitation equipment (including a defibrillator) is stored in the treatment room in healthcare. Oxygen and defibrillators are on all house blocks. The Hotel 2 team is on duty for emergencies and has the role of administering treatment to patients safely, effectively and efficiently. The team consists of a Band 5 and a Band 6 nurse who are on call 24 hours a day. Referrals are given a RAG (red/ amber/green) rating for severity and the team try to reach them as soon as possible. The Hotel 2 cannot run to emergencies and there is no maximum time limit within which they must respond. They also liaise with discipline staff and arrange for transport to hospital following standard protocols.

Prison staff have a number of trained staff who can administer first aid and offer practical skills such as cut down before Hotel 2 arrives.

6.37 Complaints

Although feedback mechanisms are in place, with each complaint receiving a written response, there is no formal procedure to ensure that user's views inform service provision. PALS are involved with the prison and complaints are recorded on the DATIX system but very few prisoners have knowledge of the scheme. Future developments could be a PALS drop in session and the development of a DVD to help prisoners better understand how to make a complaint. There were 31 complaints and 24 red dots (external correspondence that needs to be actioned within a set time frame which is assessed in HMP Key Performance Indicators) in April – May 2009. All of these were resolved locally. The complaints tend to be around the areas of medication and access to the dentist. Mental health received 4 complaints over the same period. One has been passed on to Surrey Community Health as it concerns one of their employees.

6.38 Release information

On release prisoners are provided with a card with NHS Direct contact details, a list of local GPs (Surrey, Sutton, Merton & Croydon only) and a form for free medication. HMPS provides information on other agencies e.g. Citizen's Advice Bureau.

Recommendations

- Both prison and healthcare staff to have regular updates on the availability of the smoking cessation service in order to facilitate referral to the service
- Prison and healthcare staff to have training in basic smoking cessation techniques in order to provide appropriate opportunistic advice to prisoners
- Clarification of the roles of Hotel 2 and prison staff in emergency situations in order to ensure that assistance is provided as soon as possible
- First aid trained prison staff to be distributed across all house blocks on all shifts
- Negotiate with prison staff whether new prisoners can be allowed into reception first on transfer
- Consider the development of easy read versions of medication information leaflet for common generic drugs
- Healthcare to access GP lists from local NHS organisations for main areas to which prisoners are released
- Pharmacy should consider the establishment of a specific medication review clinic
- HMP High Down to review the canteen list to increase the number of healthy options and improve equity of pricing

APPENDIX A

MEMBERSHIP OF NEEDS ASSESSMENT STEERING GROUP

- Anna Raleigh, NHS Surrey
- Ayesha Ali, NHS Surrey
- Sue Davies, Head of Healthcare, HMP High Down & Prison Health, Surrey Community Health
- Emma Daniells, NHS Surrey
- Steve Norman, Department of Health South East
- Donna Goddard, HM Prison Service (South Central)
- Gary Crosskey, HM Prison Service (South Central)
- Mark Girvan, Surrey & Borders Partnership NHS Foundation Trust
- Brian Palmer, Surrey & Borders Partnership NHS Foundation Trust
- Nicky Croft, NHS Surrey
- Alison Moyce, NHS Surrey
- Linda Murray, Surrey Community Health

APPENDIX B

SUMMARY OF RECOMMENDATIONS

Staffing

To ensure continuity and high quality of care, each area of the prison should employ permanent healthcare staff. This will also support the development and consolidation of professional relationships with prisoners enabling them to fully address their health needs. Health service providers should ensure that staffing vacancies are recruited to in a timely manner and reliance is not placed on agency staffing on a long term basis. This recommendation is particularly important for house block nurses.

Risk Management

The NHS has a zero tolerance policy on abuse against healthcare staff and this should be supported within prison settings. Appropriate supervision of the hatch/ healthcare by prison staff should be standardised, to prevent abuse against healthcare staff. Any supervision process should ensure that it does not conflict with a prisoners' right for confidentiality when discussing health concerns.

The system for movement of charts needs to be improved so that charts are in the right place at the right time, and medication continuity can be ensured. The installation of a prison IT system would support this but should not be considered the only intervention which will improve this problem.

Ensure appropriate prescribing and efficient observation when patients take their medication.

Audit of F213 and F213SH against accident register should be conducted.

Prisoner engagement and satisfaction

Health service providers should formally seek the views of prisoners on a regular basis and be able to demonstrate that any concerns raised regarding standards of care and levels of respect served by healthcare staff towards prisoners are addressed. NHS Surrey should monitor the effectiveness of attempts to gain prisoners views and how widely information on how to make a complaint about healthcare is publicised. Prisoner complaints, compliments and Patient Advice and Liaison Service (PALS) feedback should be monitored through the contract meeting.

The application system should be completely confidential, so prison officers do not see applications (i.e. post box for applications picked up by medical staff). Prison staff must be reminded that they should not take applications from prisoners.

Negotiate with prison staff whether new prisoners can be allowed into reception first on transfer.

Improvement in clinical practice

The recent development of the medication review clinic should be mainstreamed and developed to ensure that:

- Communication around medication changes (e.g. when changed to generic drugs) is improved and prisoners have a clear understanding about why their medication has been changed

- Medication reviews are conducted regularly, linking into national performance indicators on increasing generic prescribing.
- Prisoners are aware of how to use their medications and any side effects to be aware of.
- There is regular audit of medication charts to ensure that prisoners are getting appropriate medication, in appropriate doses.
- Administration of medicines can be audited and any medication errors highlighted and formally reported through the health service providers' governance systems.

Health service providers should ensure that their triage system is clinically effective and provides confidence to prisoners that their health needs are going to be appropriately addressed. NHS Surrey should monitor this though prisoner feedback mechanisms and concerns should be raised and assurance sought that they are being addressed through the contract monitoring process.

A dental triage system led by a dental nurse needs to be developed and implemented. Those most in need should be prioritised. Self care alternatives to seeing a dentist should be considered in all routine cases and appointments for non-urgent needs should be effectively managed. NHS Surrey should monitor dental waiting times to measure effectiveness of this.

Healthcare staff should report any instances in reception where information could not be collected and processed due to time pressures and each of these collated, investigated and reported back to each Prison Health Partnership board.

Screening of new prisoners should be comprehensive and not restricted to being conducted only at reception. House block based nurses should be responsible for ensuring that all prisoners on their block have a comprehensive health assessment, that health promoting information and intervention has been provided and referrals and access to appropriate services have been made. The health service provider should develop an auditable process to measure compliance with this requirement and regularly report compliance through contract monitoring meeting.

The following conditions require a chronic disease register and management of these conditions should comply with the formal approach to managing Long term conditions in prison.
A report of these conditions at reception should lead onto a clinical assessment, confirmation of diagnosis and prescription of appropriate treatment. Compliance with this should be regularly audited.

Asthma
Epilepsy
Diabetes
COPD
Coronary Heart Disease
Serious Mental Illness

Due to the high prevalence rates within prisons and the known benefits to the wider community by effectively intervening with this group, screening and treating prisoners for STI's should be a priority.

Due to the high numbers of young men in this prison the Chlamydia screening programme should be formally introduced and compliance monitored.

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. Screening for TB should be a priority and proactive measures should be taken to identify cases, such as asking specific questions related to TB symptoms at reception.

A dental triage system led by a dental nurse should be developed and implemented. Those most in need should be prioritised. Self care alternatives to seeing a dentist should be considered in all routine cases and appointments for non-urgent needs should be effectively managed. The NHS Surrey should monitor dental waiting times to measure effectiveness of this

MH services should consider their referral process to identify what barriers there might be which may be preventing this group from accessing MH service. To measure effectiveness of this process, activity data should be broken down to include ethnicity and monitored through the contract meeting

Specific questions about previous self harm and/or suicidal attempts should be asked at reception and appropriate action should be taken.

Prisoners with learning disabilities should be included on a health register. Health action plans should be developed for individuals with LD and information regarding key relevant health issues should be provided in an easy read format.

As expected by the prison performance quality indicators screening of alcohol should be conducted using an evidence based tool and when indicated brief intervention should be provided.

Management of dual diagnosis should comply with national guidance ensuring that interventions are integrated, provide staged interventions with a social support aspect that are matched to individual need. A long term perspective on the management of these conditions should be expected.

Consider the development of easy read versions of medication information leaflet for common generic drugs.

Cost Effectiveness use of health resources

Prison officers and healthcare staff should develop a co-ordinated approach to communicating medical appointments and the progress of referrals to prisoners. This process should ensure security considerations are taken into account but should not prevent the prisoner from having timely access to this information which will enable them to plan their day. Prison and healthcare staff should also work collaboratively to ensure that prisoners legitimately missing work for healthcare appointments are not penalised and that when appointments are scheduled attempts are made to ensure that they do not conflict with work times as much as possible.
Did not attend (DNA) rates should be monitored by the NHS Surrey to monitor the effectiveness of this process.

The health service provider should review the effectiveness of the current immunisation and screening programme - in particular, addressing the poor uptake of

Hepatitis B vaccination. This should be formally monitored though the contract process.

As only 4% of those seen at reception were recorded as being referred to the appropriate service a comprehensive review of this process must be undertaken.

A formal review of bed occupancy should be undertaken to identify if the audit period findings that maximum bed occupancy was 87% are consistent. This review should then consider if the prison requires 23 in-patient beds.

A service review should be undertaken, to identify what activity occurs during the 55 appointments available per week and what proactive approaches are taken to improve Hepatitis B vaccination uptake and recording.

A third of all Hep B appointments are not attended, reasons for this need to be clarified and approaches to improve this DNA rate should be adopted. Effectiveness of this should be monitored through the contract meeting.

A review of triaging dental pain should be conducted and consideration should be given to when it is appropriate for a dental nurse to triage and when a house block nurse should triage. This could free up considerable amounts of time for house block nurses to focus on other health needs.

A third of all external appointments are not attended, reasons for this need to be clarified and approaches to improve this DNA rate should be adopted. Effectiveness of this should be monitored through the contract meeting.

74% of MH referrals are not accepted, reasons for this should be clarified and methods of addressing this should be formally reported.

Professional standards

NICE guidance is available for the main mental health problems prevalent in prisoners; compliance with these guidelines should be audited and reported through the contract meeting.

Compliance with CPA requirements should be audited and results should be monitored through contract monitoring.

Referrers to mental health services should ensure they record the prisoner's ethnicity. Compliance with this should be monitored through the contract meeting.

Medication received under restraint should be considered an auditable intervention and therefore should be formally audited on the small number of occasions when it occurs.

Record keeping of discharges from mental health services needs to be improved. This should be audited and reported through the contract meeting.

Health Promotion

In line with the Prison Health Quality Indicators a Health Promotion Action Group should be established, which is tasked with ensuring that each prisoner has access

to information on how to stay healthy in prison. Innovative delivery mechanisms for this information should be considered and developed, with input from prisoners. The provision of a comprehensive health promoting service/prison could reduce inappropriate GP attendance.

The Health Promotion Action Group should also report to the Prison Health Partnership Board on action taken and progress made against the following areas:

- A review of the use of the gym; including prisoner access (including access for those who work) and ensuring that prisoners are able to use the gym to maximum effect.

- A review of the use of Gym equipment within in the in-patient healthcare setting in order to improve access to physical activity for this group.

- Improving access to remedial gym, including for those with mental health problems and those trying to lose weight.

- Measure accessibility and the effectiveness of smoking cessation services within the Prison.

- A mental health promotion campaign which also informs prisoners on how to access support for mental health concerns.

- Improving the availability of healthy food and ensure that healthy alternatives are effectively highlighted.

The Health Action Group should seek feedback from prisoners on a regular basis to gain their views and evaluate the effectiveness of interventions.

Smoking cessation should be proactively promoted to all those with asthma, COPD and other respiratory conditions and prisoner response recorded.

Due to the high prevalence of mental health disorders within prison, the Health Promotion Action Group should ensure that self help information and activities which promote good mental health are provided and promoted, such as physical exercise, healthy diet.

The use of pharmacists as health educators should be considered.

4 week quit rates are successful, therefore consideration should be given to increasing the number of smoking cessation clinics available to prisoners to reduce the waiting times and to support the programme of care being promoted for the management of chronic disease.

HMP High Down to review the canteen list to increase the number of healthy options and improve equity of pricing.

Training

With the aim of increasing understanding of Healthcare and Prison staff roles and responsibilities and the promotion of more productive working relationships, the following interventions should be implemented or improved:

- The security induction of healthcare staff should be reviewed in order to ensure that there is sufficient input on what it means to work within the prison system and how best to maintain security. Any healthcare staff found to be beaching security protocols should attend refresher training.

- All prison staff should be educated on the professional standards expected of those working in healthcare, the importance of prisoners receiving effective healthcare and the importance of confidentiality in the health care setting. Updates should be made available for all staff when appropriate.

- A formal process should be developed which monitors conflicts between the two roles which prevents effective healthcare or poses security risks. Problems raised and action taken to address such problems should be reported to the Prison Health Partnership Board.

- More joint training should be undertaken between health and prison staff.

- Internal information sharing policies should clearly outline what information can and should be shared between agencies and in what circumstances. This may include using joint incident log books and having joint briefings.

- Ensure that all prison staff have up to date Safeguarding training appropriate to their position within the organisation. NHS Surrey should receive an annual update on this training.

Health care providers should raise awareness of the signs and symptoms of diabetes amongst prisoners and prison staff

Healthcare staff should be made aware of the increased risk associated with imprisonment and hypertension

Training should be provided for prison and healthcare staff regarding risk factors and signs that a prisoner may be at risk of self injury.

Prisons, healthcare and IDTS staff should be aware of the differences in type of drug use between different ethnic groups and how this would be applicable to the high proportion of prisoners from BME groups at HMP High Down**.**

To enable more appropriate assessment of need and provision of services, reception health care staff should be trained to be able to calculate units of alcohol consumed per week from information provided by prisoners.

Both prison and healthcare staff to have regular updates on the availability of the smoking cessation service in order to facilitate referral to the service

Prison and healthcare staff to have training in basic smoking cessation techniques in order to provide appropriate opportunistic advice to prisoners

Clarification of the roles of Hotel 2 and prison staff in emergency situations in order to ensure that assistance is provided as soon as possible

First aid trained prison staff to be distributed across all house blocks on all shifts.

Environment

Healthcare providers and the prison should actively consider how improvements can be made across all areas where healthcare is delivered, especially during the reception process, which ensures that prisoner confidentiality in relation to health concerns can be maintained.

Exposure to environmental tobacco smoke should be reduced, especially in reception.

Proactive case finding

A review of asthma prescribing and a programme seeking and identifying those prisoners with unmet need should be undertaken.

Given the high proportion of BME prisoners in HMP High Down and higher prevalence estimates from previous assessments, the low estimated prevalence of diabetes would indicate undiagnosed/untreated diabetics. This unmet need should be addressed by proactive screening and identification of prisoners who may have undiagnosed or diet controlled diabetes and appropriate intervention provided.

Given the higher prevalence estimates from previous assessments and the low estimated prevalence of CHD currently, this would indicate undiagnosed/untreated CHD. This unmet need should be addressed by proactive screening and identification of prisoners who may have undiagnosed CHD and appropriate intervention provided.

Specific questions about previous self harm and/or suicidal attempts should be asked at reception

Due to the high proportion of BME prisoners in HMP High Down, any reporting of sickle cell disease or trait at reception should be proactively followed up and appropriate intervention offered.

MH services should raise awareness of the MH needs of those from BME prisoners with prison officers and healthcare staff, proactively encouraging referrals for assessment and support.

Prisoners with learning disabilities should be proactively identified during reception and by house block nurses.

Healthcare should be aware of the relevant screening programmes and take proactive steps to identify the relevant individuals and investigate if screening has occurred from the Inmate Medical/GP records. If screening has not taken place within the designated time period arrangements should be made to undertake it with prompt follow up of results and recording/forwarding these on as appropriate. This process should be audited.

Effective Discharge

Review and update of information provided to prisoners on release in order to ensure that they have sufficient information to contact and register with a local GP.

Healthcare to access GP lists from local NHS organisations for main areas to which prisoners are released

Education department to review all discharge information to ensure that it is suitable for literacy levels within the prison

Education department to run courses on basic form completion with all prisoners prior to release

Further needs assessment

A refresh of the prison health needs assessment should be conducted annually.

Access to a dentist is the main cause of complaint by prisoners in HMP High Down and in response to this a dental health needs assessment has been commissioned.

An IDTS specific needs assessment should be conducted annually and feed into the IDTS treatment plan.

APPENDIX C

FOCUS GROUP SCHEDULE

Introduction

- Introduce facilitators
- We are looking at how we can help men at High Down be healthier and what you think of the health services you get while you are here.
- Welcome and thanks for taking part.
- Ground rules: 1 hour session, may move you along if we need to. Please can we agree to let everyone have a chance to speak; agree to listen to each other; agree to respect each others views.
- All information provided is confidential. Exceptions may be made if a child protection, security or self-harm issue is raised. Discussion should also be confidential among people here- ok?
- You can refuse to answer any questions you wish and you can ask any questions you wish.
- No right or wrong answers, hoping for a range of views.

- Introduce yourselves- Give us one piece of health advice you know about

_____

Being Healthy/ Healthy Lifestyle

1. What does 'being healthy' mean to you?

2. Are people generally healthy in High Down?

3. How do you try and stay healthy? What stops you doing this?

4. Do you feel you can access the following things at High Down?

> *Jabs/immunisations, Exercise, Good/healthy food, Advice on being healthy, Advice on safe sex, alcohol and drugs*

[PROMPT FOR FEEDBACK]

Health Problems

5. If you had a problem with your health, who would you go to first?

> *PROMPTS*
> *Wing officer, Mate/friend, Doctor, Casework, Teacher, Healthcare nurse, Mental health, Family*

6. What type of health problems do you think are a problem in High Down?

> *PROMPTS*
> *Drugs, Alcohol, Sexually transmitted infections, Depression/low mood, Other mental health problems, Pain*

[PROMPT FOR FEEDBACK]

Accessing Healthcare

7. How do you get to see the doctor at High Down? How long does it take?
8. What about other services such as the dentist or optician?

9. Have you been to Healthcare at High Down? What did you think of it? What was good? What was bad?

10. Have you ever been to a GP or practice nurse outside High Down? How did it compare?

11. Can you see someone about your mental health while you are at High Down?

[PROMPT FOR FEEDBACK]

12. If you could change one thing to make health better at High Down, what would it be?

Summary

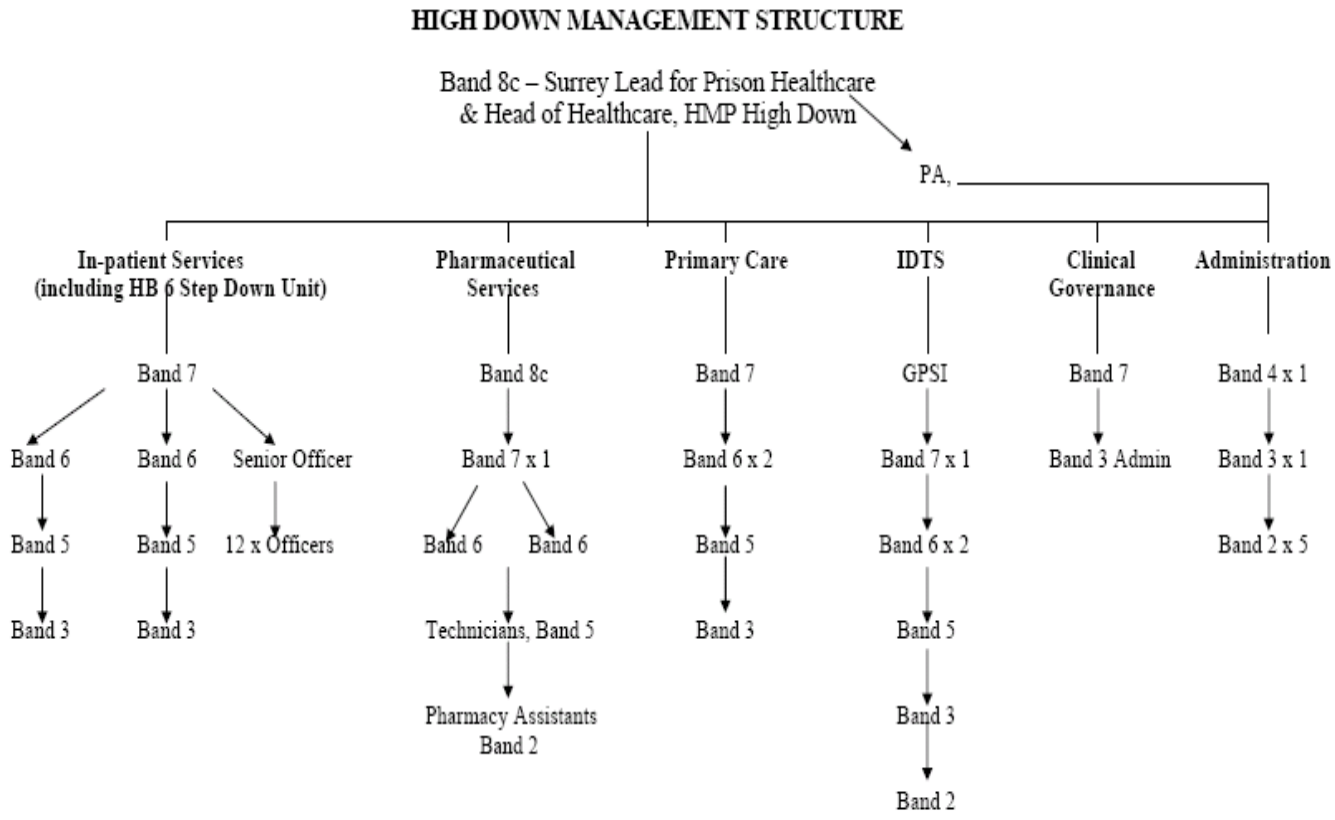
- Summarise main points

13. Any other comments?
14. Anything important we haven't covered?

- Thank you and close

APPENDIX D

HEALTHCARE ORGANISATIONAL STRUCTURE



APPENDIX E

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