HMP Downview
Health Needs Assessment Refresh 2012

NHS Surrey Public Health Team

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Executive Summary

Background

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

HMP Downview

HMP Downview is a closed female prison with accommodation for up to 358 prisoners including a 16 bed juvenile unit (The Josephine Butler Unit) which has a separate HNA. There was a 16% increase in the number of prisoners entering the prison in 2011- there were 418 new receptions.

Prisoners at HMP Downview are mostly between 22-50 years old and 8% are over 50 years old. There is a high proportion of Black and Minority Ethnic prisoners (58%) and the number of foreign nationals has increased to 24%.

Methods

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

Areas of Recommendation

Long term conditions

It was clear that many improvements had been made in the detection and management of long term conditions since the 2010 HNA. The production of Quality Outcome Framework scores provides a source of performance management that should be utilised more to ensure each patient is receiving the appropriate care for their condition.

Communicable Diseases

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

Oral Health

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

Mental Health

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

Learning Disabilities

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

Health Improvement

The Health Promotion Action Group should be improved and the action plan renewed. Smoking remains a problem with no data being submitted to the Surrey Stop Smoking Service. This should be a priority. More data on physical activity should be collected, and the new physical activity guidelines should be promoted. Some problems with screening are ongoing, with bowel and breast screening coverage low. NHS Health Checks have been implemented successfully, and it is recommended that this programme continue.

1 Introduction

1.1 Background

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

1.2 Health Needs Assessment

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

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

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

1.3 Methods and Structure of this Paper

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

2. Prison Profile

There have been no significant changes to the number of prisoners (or capacity) in HMP Downview since 2010. In May 2012 the population of HMP Downview was 336, which is similar to the last HNA (337) and lower than the certified normal accommodation (358), but this is likely due to normal fluctuations in population numbers.

There were 418 new receptions into HMP Downview in 2011, which is a 16% increase on the 360 estimated in the 2010 HNA, indicating a slightly less stable population.

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

Age

The age groups are different between 2010 and 2012, but there appears to be no major differences in the age profile. The table below shows the age categories used in the last HNA and the standardised age categories used in all prison HNAs this year.

Table 1: Prisoners per age group in 2012, and compared to 2010

Previous Age Groups	2010	2012 New Age Groups	2012 New Age Groups
18-21	14% (n=48)	18-21	13% (n=43)
22-24	14% (n=46)	22-30	31% (n= 100)
25-34	31% (n=104)	31-40	27% (n= 87)
35-44	23% (n=76)	41-50	22% (n= 70)
45-54	13% (n=45)	51-60	5% (n= 16)
55-64	5% (n=16)	61-70	2% (n= 6)
64+	0.6%	70+	0

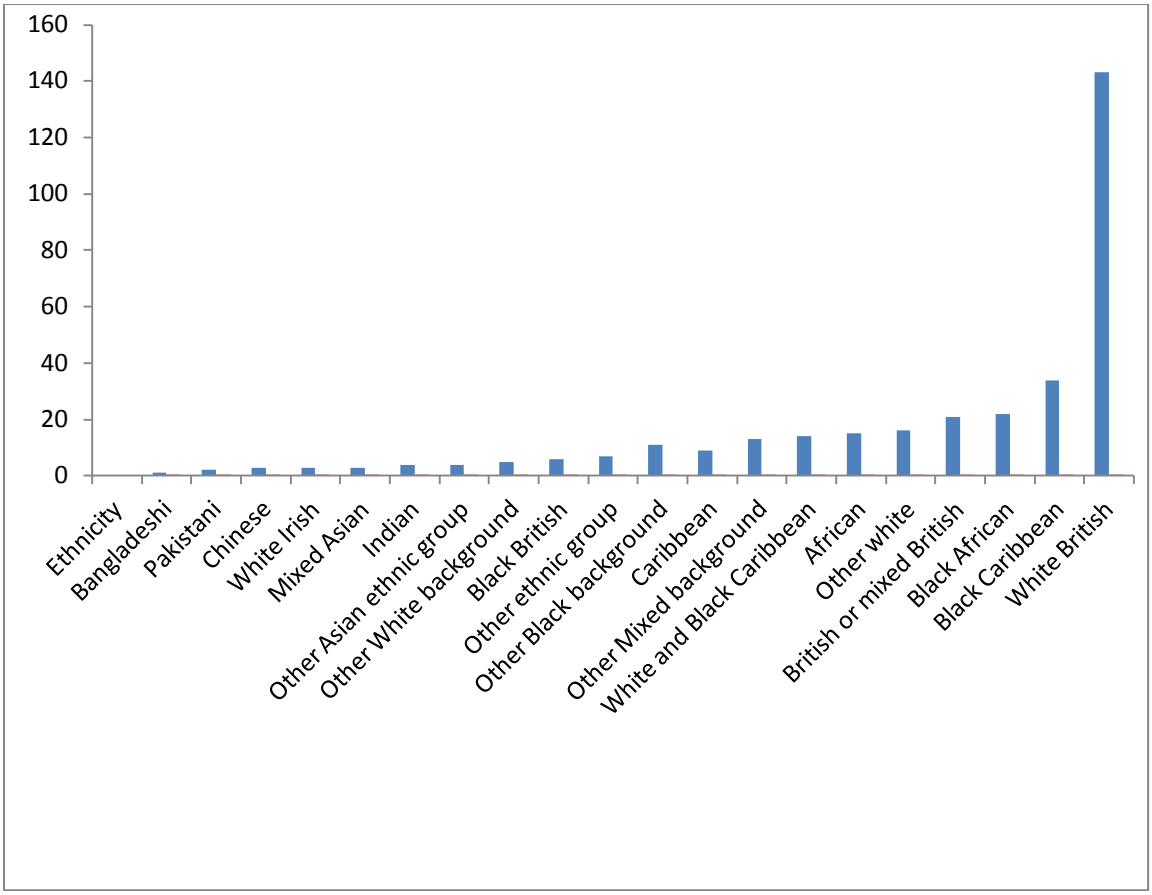
Source: SystmOne (information provided for 322 prisoners)

Ethnicity

HMP Downview has a Black and Minority Ethnic population of 58%, which is higher than the 56% recorded in 2009. 10% of the prison population defined their ethnicity as Black Caribbean- this is the largest ethnic minority group. 2% of the prison population defined their ethnicity as Black British and 3% as other black - in 2009 this group recorded combined represented 36.1% of the prison population.

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

Figure 1: Prison population by ethnicity (number of prisoners)



Source: SystmOne

Foreign Nationals

The most recent data available from the Ministry of Justice from December 2011, indicates a small increase in the percentage of foreign national prisoners from 22% (80/358) in 2010 to 24% (70/291), although the overall number has decreased.

Religion

No information was provided on religion.

Disability

2% of prisoners declared a disability. The number of reported disabilities is too low to report. However they included mental health disorder, reduced mobility, learning disability, impaired vision and hearing impairment. Although in 2010 there was no clear data on disabilities, 4% had personal emergency evacuation plans which included only some women with a disability.

Sexuality

No information was provided on sexuality.

Sentence Length

No information was provided on sentence length.

Recommendations

1. All recording of ethnicity should use the standards set out in the 2011 Census.
2. Data on religion, sexuality and sentence length should be collected and collated in order to inform service planning and ensure health needs are met.

3. Physical Health Needs

3.1 Long term conditions

Table 2: Observed and expected prevalence for physical conditions in 2012, compared to 2010

	2010							2012			
	Expected		Observed					Expected		Actual	
Disease	**Overall prevalence**	**Expected no.**	**Chronic Disease Register (C wing)**	**IMR Reception audit**	**Systm1**	**Pharmacy data**	**Observed no. (range)**	**Overall prevalence**	**Expected no.**	**QOF/336 (19/03/2012)**	**Self-reported on reception/ 418 (2011 new receptions)**
Treated asthma (BTK)[1]	5-8%	23	56/183 (30.6%)	13/67 (19.4%)	110/337 (32.6%)	35/338 (10.4%)	37-117	6%	19 (5.7%)	71 (21.1%)	95 (22.7%)
COPD (UK)[2]	0.3-3.6%	2	2/183 (1.1%)	0 (0%)	-	-	4	1.6%	0.9% (3)	4 (1.2%)	2 (0.5%)
Epilepsy (BTK)	3%	11	8/183 (4.4%)	1/67 (1.5%)	14/337 (4.2%)	5/338 (1.5%)	5-16	-	0.6% (2)	9 (2.7%)	8 (1.9%)
Diabetes (UK)[3]	0.3-4%	4	4/183 (2.2%)	0 (0%)	11/337 (3.3%)	15/338 (4.4%)	0-16	5.3%	4.5% (15)	3.6% (12)	1.9% (8)
Hypertension (UK)[4]	1-18%	33-64	10/183 (5.5%)	3/67 (4.5%)	23/337 (6.8%)	21/338 (6.2%)	16-24	29.0%	12.5% (42)	24 (7.1%)	15 (3.6%)
Ischaemic heart disease (BTK)	0.1-5.9%	2	3/183 (1.6%)	5/67 (7.5%)	-	13/338 (3.8%)	6-27	-	0.9% (3)	2 (0.6%)	2 (0.5%)
Pregnancy (BTK)	3%	11	-	0 (0%)	-	-	0	3.0%	10	-	-
Hepatitis B (BTK)	12%	43	-	0 (0%)	-	-	0	12.0%	39	-	-
Hepatitis C (BTK) *	11%	39	9/358 (2.6%)	-	-	-	9	11.0%	35	-	19 (4.5%)
HIV (BTK) *	1.2%	4	-	Number withheld	-	-	16	1.2%	4	-	4 (1.0%)

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

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

[1] Marshal, T., Simpson, S. and Stevens, A. (2000). *Toolkit for healthcare needs assessment in prisons*. University of Birmingham.

[2] Public Health Intelligence Unit. *Model for Estimating the Prevalence of Chronic Obstructive Pulmonary Disease (COPD).* http://www.doncasterhealth.co.uk/PHIU/pdfs/QOF/COPDModel.pdf [Accessed July 2012]

[3] Diabetes UK. (2011). Diabetes in the UK 2011/12: Key statistics on diabetes. http://www.diabetes.org.uk/Documents/Reports/Diabetes-in-the-UK-2011-12.pdf [Accessed 07/2012]

[4] The Information Centre. (2010). *Health Survey for England.* http://www.ic.nhs.uk/hse [Accessed July 2012]

Methodology

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

In 2010, the observed prevalence of diseases was taken from manually created and maintained paper registers (although at HMP Downview some early SystmOne data was available). The 2012 prevalence of diseases is taken directly from SystmOne through QOF.

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

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

Asthma

2010 Expected	**2010 Observed** ***Asthma Register***	**2012 Expected**	**2012 Observed**	
			Asthma Register QOF	***2011 receptions***
5-8% (23/338)	30.6% (56/183)	5.7% (19/336)	21.1% (71/336)	22.7% (95/418)

Of the new receptions in 2011, 22.7% reported asthma as a current problem when they arrived at the prison. This is a similar prevalence to those on the QOF asthma register, which includes only those prescribed medication for asthma in the last 12 months. This is a much higher number than we would expect for this group of prisoners.

Self-reported asthma on reception was similar in the previous HNA (19.4%) to the 2011 receptions (22.2%), however the observed prevalence from the manually maintained asthma register (30.6%) was higher than the current QOF asthma register (21.1%).

Data from SystmOne indicates that 57% (37/65) of those diagnosed with asthma have had an asthma review in the preceding 15 months, and that 24% (11/45) were diagnosed and had measures of variability or reversibility. Both these figures should be improved.

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

Chronic Obstructive Pulmonary Disorder (COPD)

2010 Expected	2010 Observed *COPD Register*	2012 Expected	2012 Observed	
			COPD Register QOF	*2011 receptions*
0.3-3.6% (2/338)	1.1% (2/183)	0.9% (3/336)	1.2% (4/336)	0.5% (2/418)

Of the new receptions in 2011, 0.5% reported COPD as a current problem when they arrived at the prison. This is a lower prevalence to the COPD register (1.2%), which may indicate prisoners do not report they have the condition or that they are diagnosed whilst in the prison. The number on the QOF COPD register is similar to the expected number. The prevalence is similar to the previous HNA.

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

66% (2/3) of patients with COPD had received a flu vaccination in the preceding flu season (September-March) which is a good result, but this should be increased to 100%.

Epilepsy

2010 Expected	2010 Observed *Epilepsy Register*	2012 Expected	2012 Observed	
			Epilepsy Register QOF	*2011 receptions*
3% (11/338)	4.4% (8/183)	0.6% (2/336)	2.7% (9/336)	1.9% (8/418)

Of the new receptions in 2011, 1.9% reported epilepsy as a current problem when they arrived at the prison. This is a lower prevalence than the QOF epilepsy register (2.7%), which may indicate prisoners not declaring their diagnosis or being diagnosed while in prison. The number on the epilepsy register is higher than the expected number, although lower than the previous HNA.

Data from SystmOne indicates that 80% (4/5) patients on the epilepsy register have a record of their seizure frequency taken in the last 15 months. Only 40% (2/5) were recorded as seizure free for 12 months, which may indicate that the management of medication could be improved although it is recognised that seizure control is often under the influence of factors outside medical control. 60% (3/5) patients had had advice about contraception, conception and pregnancy.

Diabetes

2010 Expected	2010 Observed *Diabetes Register*	2012 Expected	2012 Observed	
			Diabetes Register QOF	*2011 receptions*
3% (11/338)	4.4% (8/183)	4.5% (15/336)	3.6% (12/336)	1.9% (8/418)

Of the new receptions in 2011, 1.9% (8/428) reported diabetes as a current problem when they arrived at the prison. This is a lower prevalence to the QOF diabetes register (3.6%), which is likely to indicate that diabetes is being diagnosed in the prison. This is similar to the expected prevalence, which is very positive and shows patients are being screened for diabetes appropriately.

The expected number in this HNA is now based on the age-adjusted prevalence for England[5]. The Birmingham Toolkit is based on community data for 1996, and the prevalence of diabetes has increased greatly since then; for example from 3% in 2004 to 5.5% in 2011.

Also among women, diabetes is more than five times as likely among Pakistani women, at least three times as likely in Bangladeshi and Black Caribbean women, and two-and-a-half times as likely in Indian women, compared with women in the general population. We may expect the prevalence to therefore be higher given the high BME population at HMP Downview; at least 11% (37/336) of prisoners at HMP Downview are of an ethnicity with a higher risk of diabetes.

Of the 13 diabetes indicators for QOF on SystmOne, 11/13 had scores above 70% which is excellent. For the percentage of patients with diabetes who have a record of micro-albuminuria testing in the preceding 15 months (exception reporting for patients with proteinuria) only 60% (6/10) were recorded as receiving this. This is a recommendation of the NICE clinical guideline 87[6].

Only 50% (5/10) had a record of a foot examination and risk classification. Patients with diabetes are at high risk of foot complications. Evaluation of skin, soft tissue, musculoskeletal, vascular and neurological condition on an annual basis is important for the detection of feet at raised risk of ulceration.

Cardiovascular Disease

Hypertension

2010 Expected	**2010 Observed** *Hypertension Register*	**2012 Expected**	**2012 Observed**	
			Hypertension Register- QOF	***2011 receptions***
1-18% (33-64/338)	5.5% (10/183)	12.5% (42/336)	7.1% (24/336)	3.6% (15/418)

Of the new receptions in 2011, 3.6% (15/418) reported hypertension as a current problem when they arrived at the prison. This is a lower prevalence to the hypertension register (7.1%), which may indicate prisoners are being diagnosed with the condition in the prison. This is much lower than the expected prevalence (12.5%), meaning there could be up to 18 patients with undiagnosed hypertension in the prison. However, this has increased since the last HNA indicating an improvement in detection levels.

100% (24/24) patients on the register had had their blood pressure taken in the preceding 9 months and 86% (19/22) had a last blood pressure reading of 150/90 or less. This indicates excellent management of patients with hypertension.

[5] Diabetes UK. (2011). Diabetes in the UK 2011/12: Key statistics on diabetes. http://www.diabetes.org.uk/Documents/Reports/Diabetes-in-the-UK-2011-12.pdf [Accessed 07/2012]
[6] NICE clinical guideline 87 (2010). Type 2 Diabetes: The management of Type 2 diabetes. http://guidance.nice.org.uk/CG87

Heart Disease

2010 Expected	2010 Observed ***Heart Disease Register***	2012 Expected	2012 Observed	
			Heart Disease Register- QOF	***2011 receptions***
0.1-5.9% (2/338)	1.6% (3/183)	0.9% (3/336)	0.6% (2/336)	0.5% (2/418)

Of the new receptions in 2011, 0.5% (2/418) reported heart disease as a current problem when they arrived at the prison. This is similar to the heart disease register (0.6%), the expected prevalence (0.6%) and prevalence in the last HNA (0.9%).

Of the five coronary heart disease indicators for QOF on SystmOne, 4/5 had scores of 100%. 50% (1/2) of patients on the register had had a flu vaccine in the previous flu season. This indicates excellent management of patients with heart disease in the prison.

CVD Primary Prevention

Data from SystmOne indicated 14 patients were on the Cardiovascular Disease Primary Prevention register (recorded a new diagnosis of hypertension, excluding those with pre-existing CHD, diabetes, stroke and/or TIA). SystmOne showed that 25% (2/8) of patients on the register had received a face to face cardiovascular risk assessment at the outset of diagnosis and 54% (7/13) had received lifestyle advice.

Stroke, TIA and Atrial Fibrillation

Two patients were recorded as having a stroke or TIA at HMP Downview, and no patients had a diagnosis of atrial fibrillation. Of the five Stroke/TIA indicators for QOF on SystmOne, 4/5 had scores of 100%.

Other conditions

Table 3: The prevalence of other conditions

Condition	Prevalence (Number)
Dementia	None
Heart failure	None
Hypothryroidism - Prevalence of 1.9% in women in community	1.8% (6/336) *100% with thyroid function tests recorded in the preceding 15 months*
Sickle cell*	0.6% (2/336)
Cancer	0.3% (1/336)
Renal Impairment*	None
Chronic Kidney Disease	None

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

Recommendations

3. Audit of clinical records to examine diagnoses of asthma patients against SIGN guideline 101[7].
4. Increase the percentage of patients who have a diagnosis with measures of variability or reversibility.
5. Audit of asthma reviews to ensure they cover the factors outlined in SIGN guideline 101.
6. Audit of asthma patients to ensure they all have an up to date asthma action plan in place.
7. Audit of all patients with COPD to ensure they have received a diagnosis confirmed by post bronchodilator spirometry, and a review of their condition including FEV1 and inhaler technique in the last 15 months.
8. Medication review of all patients with epilepsy on the register, to ensure the chances of patients being seizure free are maximised.
9. Audit of all patients with diabetes to ensure they have had micro-albuminuria testing in the preceding 15 months. This is a recommendation of the NICE clinical guideline 87 (2010)[8].
10. Audit of all patients with diabetes to ensure they have had a foot examination and risk classification.
11. Audit of those on the CVD register to ensure they have received a cardiovascular risk assessment.

[7] British Thoracic Society and the Scottish Intercollegiate Guidelines Network (2008, revised January 2012). British guideline on the management of asthma (101): a national clinical guideline.
[8] NICE clinical guideline 87 (2010). Type 2 Diabetes: The management of Type 2 diabetes. http://guidance.nice.org.uk/CG87

3.2 Communicable Diseases

Hepatitis B

No prisoners entered HMP Downview with a diagnosis of Hepatitis B in 2011, and no new diagnoses were made. We would expect 39 patients to have a diagnosis of Hepatitis B at HMP Downview.

Hepatitis B Vaccination

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

In the previous HNA, it was reported that for 2009/10-Q4 Downview achieved 60% coverage. The table and graphs below show excellent improvements in coverage since the last HNA and over 170 prisoners have been vaccinated in the last year. HMP Downview should however continue to focus on Hepatitis B to ensure that the coverage reaches 80% every quarter. Detailed below is also the percentage of prisoners who decline the vaccine, and the number who have not been offered the vaccine.

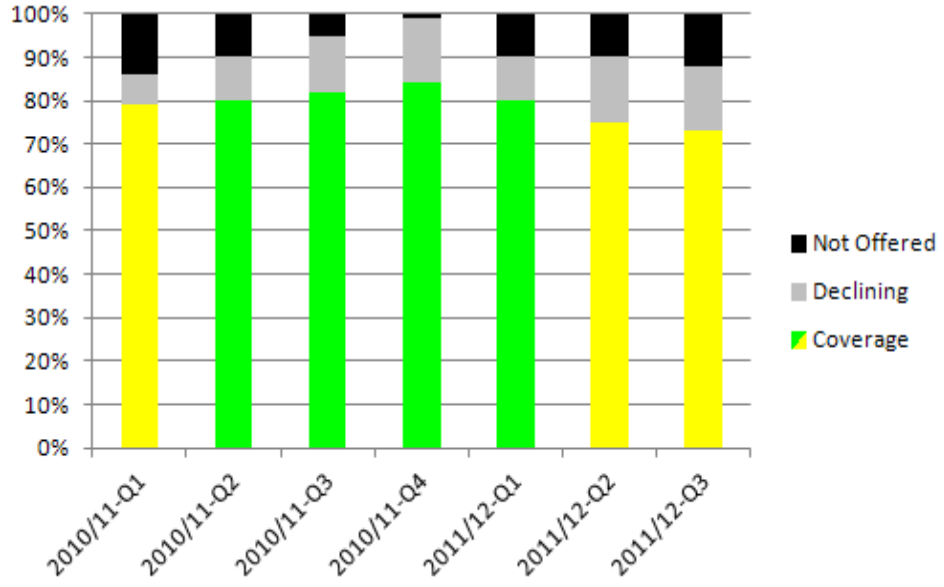
Table 4: Rating, coverage, declining and not offered for Hepatitis B vaccinations

Year and Quarter	Rating and Coverage	Declining	Not offered
2010/11-Q1	*Amber* 79%	7%	14%
2010/11-Q2	*Green* 80%	10%	10%
2010/11-Q3	*Green* 82%	13%	5%
2010/11-Q4	*Green* 84%	15%	1%
2011/12-Q1	*Green* 80%	10%	10%
2011/12-Q2	*Amber* 75%	15%	10%
2011/12-Q3	*Amber* 73%	14%	11%

Source: PHPQI Website

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

Figure 2: Coverage, declining and not offered Hepatitis B vaccinations



Source: PHPQI website

Hepatitis C

Of the new receptions in 2011, 4.5% (19/418) reported a diagnosis of Hepatitis C. No information was available on the current number of prisoners with Hepatitis C, although 3 were diagnosed while in the prison in 2011. We would expect to see 35 prisoners (11%) with a diagnosis of Hepatitis C. The data below indicates 67% (282/418) of new receptions did not know their Hepatitis C status.

Hepatitis C Tests

Hepatitis C testing is now reported on quarterly as part of the Prison Health and Performance Quality Indicators (PHPQI 3.2). The graph below shows the percentage of new receptions who were tested for Hepatitis C in 2011; 280 prisoners were tested over the year which is around 67% of new receptions- this is an excellent result. This data was not available in the previous HNA, although a recommendation was made for more testing to be carried out.

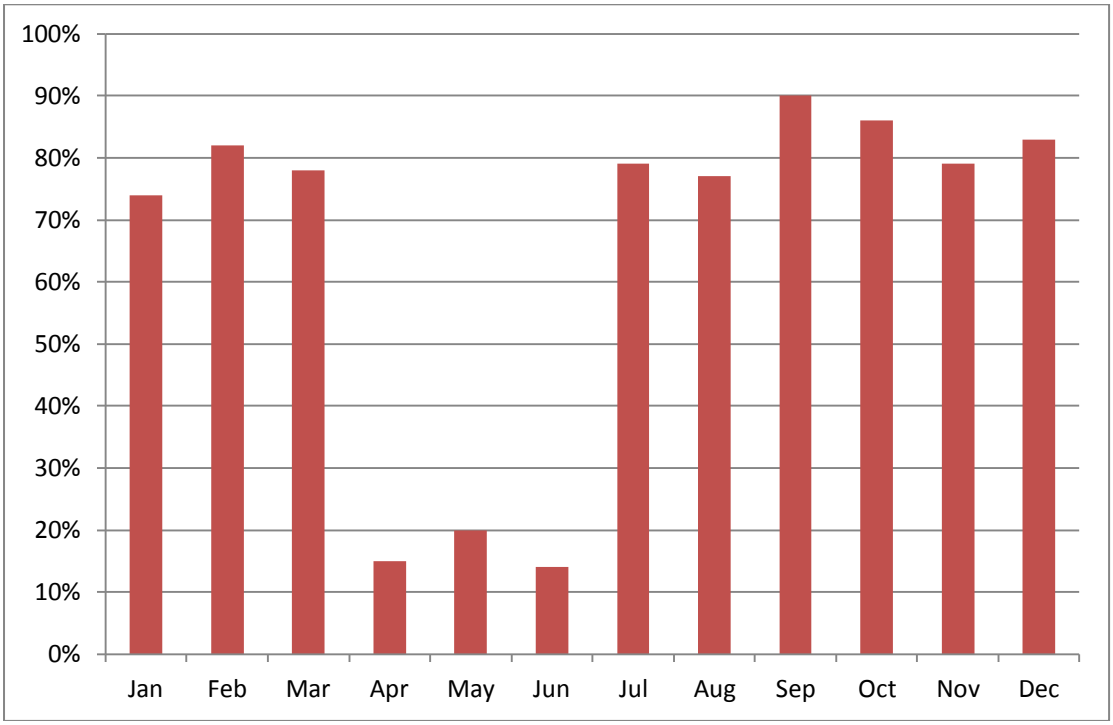
Table 5: Hep C tests offered, already taken, declined or tested in HMP Downview

Receptions	Declined	Already tested +ive	Already tested -ive	Tested	Uptake %	Declined %	Already tested %	Coverage %
418	54	19	127	280	-	-	-	-

Source: PHPQI website

Calculations could not be made on these figures, as the number offered testing plus already tested equalled more than the total new receptions. This could be due to duplication or patients being offered the test more than once in 31 days. It is recommended that this data process is checked to ensure it is accurate in the future.

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



Source: PHPQI website

HIV

Of the new receptions in 2011, 1.0% of patients (4/418) reported a diagnosis of HIV- this is slightly lower than the expected value of 1.2% (6/418).

No information was available on the current number of prisoners with HIV, and no prisoners were diagnosed while in the prison in 2011. Data from SystmOne indicated 86 patients accepted an offer of a HIV test on reception and 80 declined an offer of testing. 127 patients reported they had received a negative test result. Data from SystmOne indicates 69% (287/418) of new receptions were unaware of their HIV status.

Tuberculosis

Of the new receptions in 2011, 14 reported they had had possible contact with someone with TB, 50 were screened and no cases were detected.

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

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

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

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

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

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

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

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

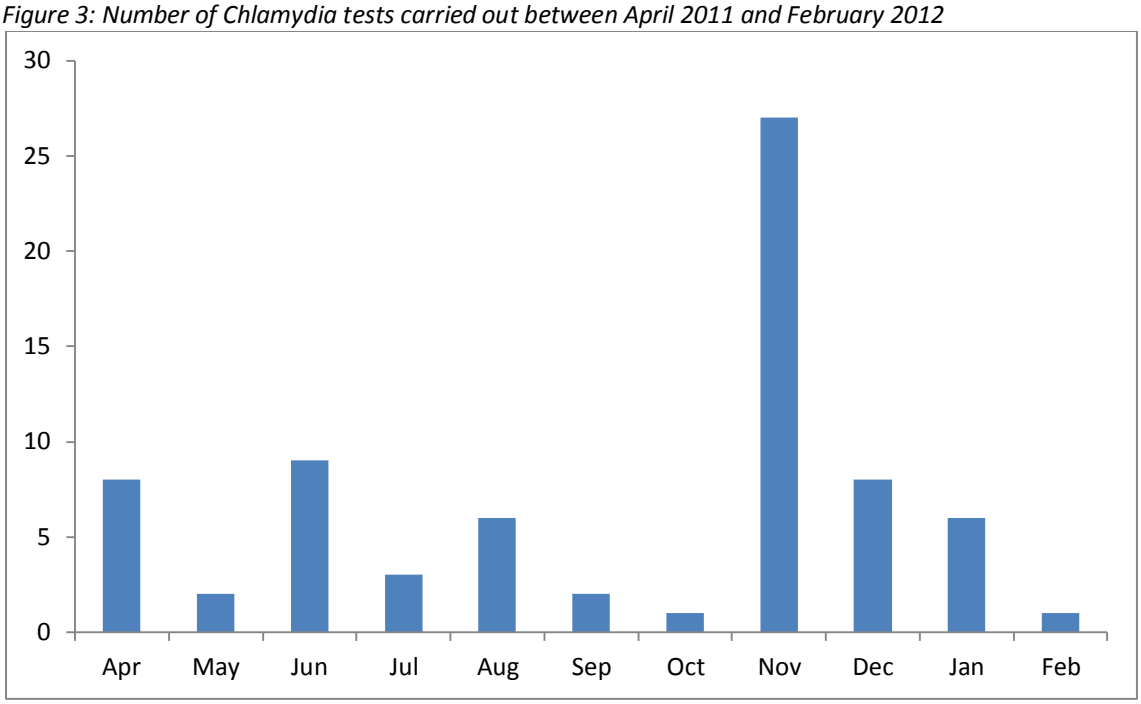
12. Processes should be put in place to ensure that 100% of new receptions are offered the Hepatitis B vaccination within 31 days of reception, and the coverage is 80% every quarter.
13. An audit should be carried out on the Hepatitis C testing data, and processes put in place to ensure its accuracy before submission to the PHPQI website.

3.3 Sexual Health

Chlamydia Testing

Chlamydia is the most commonly diagnosed sexually transmitted infection (STI) in the UK, affecting both men and women. The National Chlamydia Testing Programme offers testing to all under 25s. Data from the Surrey Chlamydia Testing Programme showed that in 11 months a total of 73 tests were carried out- this is an excellent result. HMP Downview has averaged 35 new receptions a month, so with the age profile outlined in the demographic section we would expect 7-8 tests to be offered a month. The data is consistent with this, with the spike in November likely due to testing of those already resident in the prison.

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



Source: Surrey Chlamydia Screening Programme

Compared to the data in the previous HNA, the number of tests offered has increased.

Table 6: Comparative number of Chlamydia tests carried out in two time periods

Time period	Number of Chlamydia Tests
April 2009– March 2010	44
April 2011– February 2012	73

Source: Surrey Chlamydia Screening Programme

Improvements have been made on the number of prisoners being tested for Chlamydia, and it would be of benefit to maintain this improvement and further increase the number being tested. There is

also a high positivity for Chlamydia in this population which indicates the programme is of value within the prisons.

Using data from April to November 2011, a target was estimated which would encourage improvement; for Downview the target for 2012/13 is 108 tests.

3.4 Oral Health

The *Strategy for Modernising Dental Services for Prisoners in England (2003)* and later the *Reforming Prison Dental Services in England Guidance (2005)*[9] focuses on improving the quality of dental care provided in prisons while raising awareness of the need for good oral health. A number of key good practice recommendations are made and include undertaking an oral health needs assessment, oral health promotion, improving access to treatment and improving quality of care.

Three key access standards to prison dentistry have been identified:

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

Dental Health Provision

NHS Surrey monitors prison dentistry through the PHPQI and commissioning plans.

Table 7: Information on dental appointments June 2011- December 2011

	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	**Total**
Number of patients referred (emergency)	0	0	0	0	0	0	0	**0**
Number seen same day in hospital (emergency)	0	0	0	0	0	0	0	**0**
Number of patients referred (urgent)	7	4	6	5	10	22	6	**60**
Number of patients seen within 24 hours (urgent)	7	4	6	5	10	22	6	**60**
Number of patients referred (routine)	10	10	7	12	11	28	8	**86**
Number of patients seen within 6 weeks (routine)	10	0	0	2	1	6	3	**22**

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

Data was not available on dental health service activity for April and May 2011 but capacity in June appears to have been able to cope with the demand. This situation has significantly deteriorated from that point with only 26% of patients being seen within an acceptable timeframe. Recent verbal information shows that at one point there were 165 patients waiting to be seen with a waiting time of 50 weeks in November 2011. This has recently dropped to 64 patients waiting to be seen in February. Formal contract monitoring data has not yet been submitted for the remainder of the year but a significant effort needs to be made to deal with the backlog of prisoners waiting for routine treatment.

- No patients were referred for emergency treatment
- 100% of patients referred for urgent treatment were seen within 24 hours
- 26% of patients referred for routine treatment were seen within 6 weeks

Recommendation

14. A dental improvement plan should be put in place to improve waiting times, and ensure that the access targets are met. This should be regularly monitored. Major service changes should be undertaken if the recommended waiting times cannot be met.

4. Mental Health and Learning Disabilities

4.1 Prevalence of Mental Health

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

Table 8: Questions regarding mental health asked in the first reception screen

Question Asked	% Answering yes
Prisoner has received treatment from a psychiatrist outside prison	23.29
Prisoner has stayed in a psychiatric hospital	19.25
Prisoner has had a psychiatric nurse or care worker in the community	16.15
Prisoner has received medication for mental health problems	38.82
Prisoner has tried to harm themselves (within prison)	14.60
Prisoner has tried to harm themselves (outside prison)	23.29
Prisoner feels like self-harming or Suicide	3.11

Source: SystmOne

Over a third of new receptions reported receiving medication for mental health problems. This is low in comparison to national estimates that an estimated 70% of female sentenced prisoners have at least one mental disorder[10]. This could be due to underreporting by prisoners or untreated mental health within the community.

4.2 Mental Health Provision

Staffing

- Service Manager 0.25 Whole Time Equivalent
- Community Psychiatric Nurse 2.0 Whole Time Equivalent
- Support, time and recovery (STR) worker 1.0 Whole Time Equivalent
- Counsellor 0.2 Whole Time Equivalent
- Movement Psychotherapy 0.3 Whole Time Equivalent
- Associate Specialist Psychiatrist 0.2 Whole Time Equivalent
- Consultant Psychotherapist 0.2 Whole Time Equivalent
- Administrator 0.2 Whole Time Equivalent

Number of Services a Week

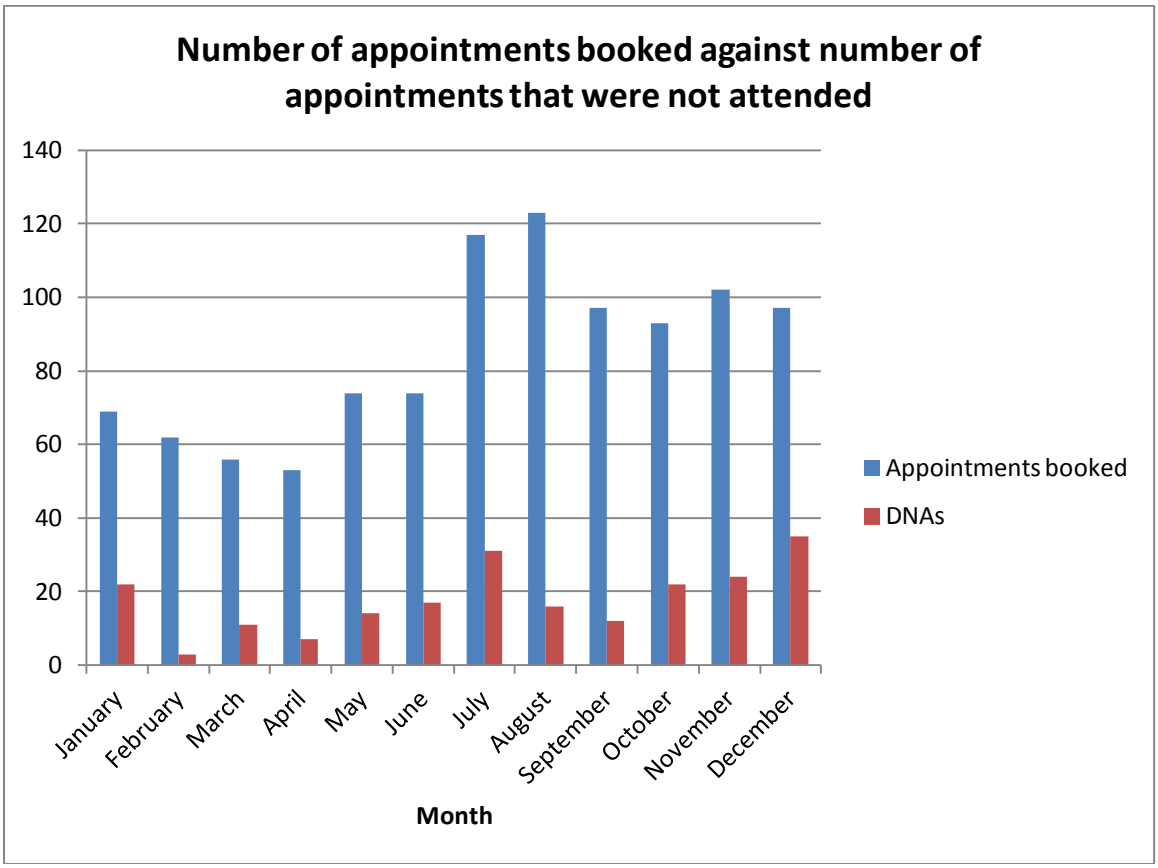
- 2 sessions of Movement Psychotherapy
- 2 sessions of Psychotherapy
- 5 sessions of counselling (3 by volunteer counsellors).
- Eye Movement Desensitization and Reprocessing therapy is available.

There is a small waiting list for each service- data was unavailable on the length of waiting time.

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

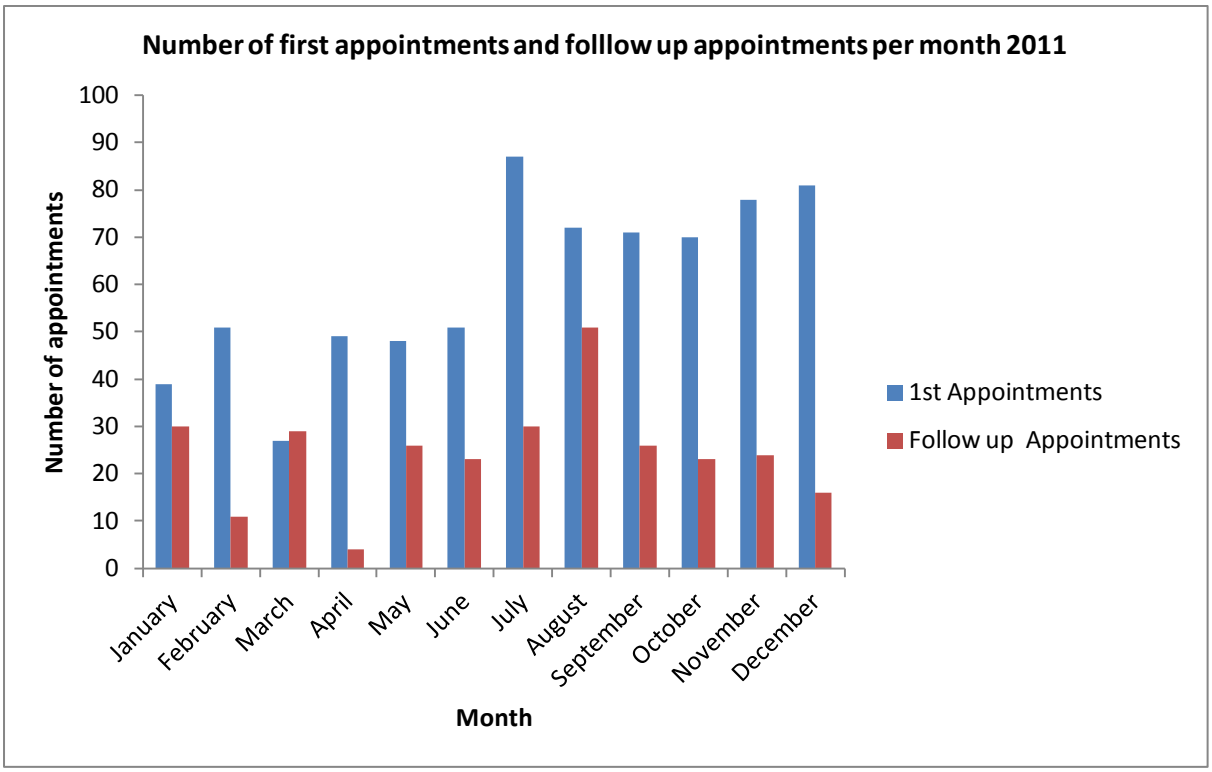
Number of Appointments

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



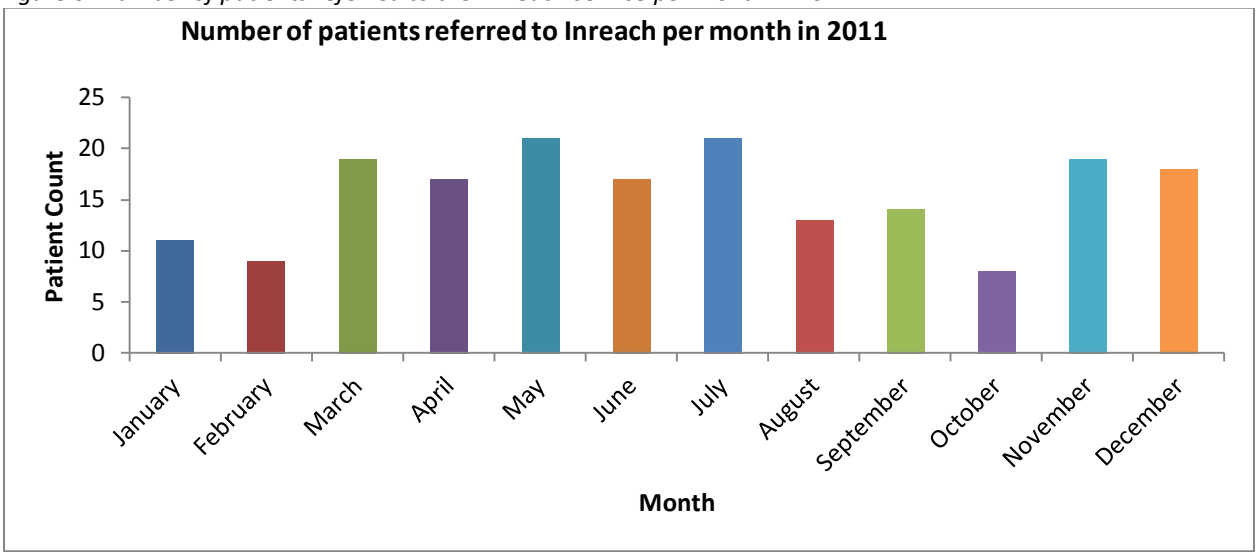
During 2011, on average 20.55% of allocated appointments were lost through 'Did not attend' (DNA). The highest number of DNAs was in December (36.1%). The lowest DNA rate was in February (4.84%).

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



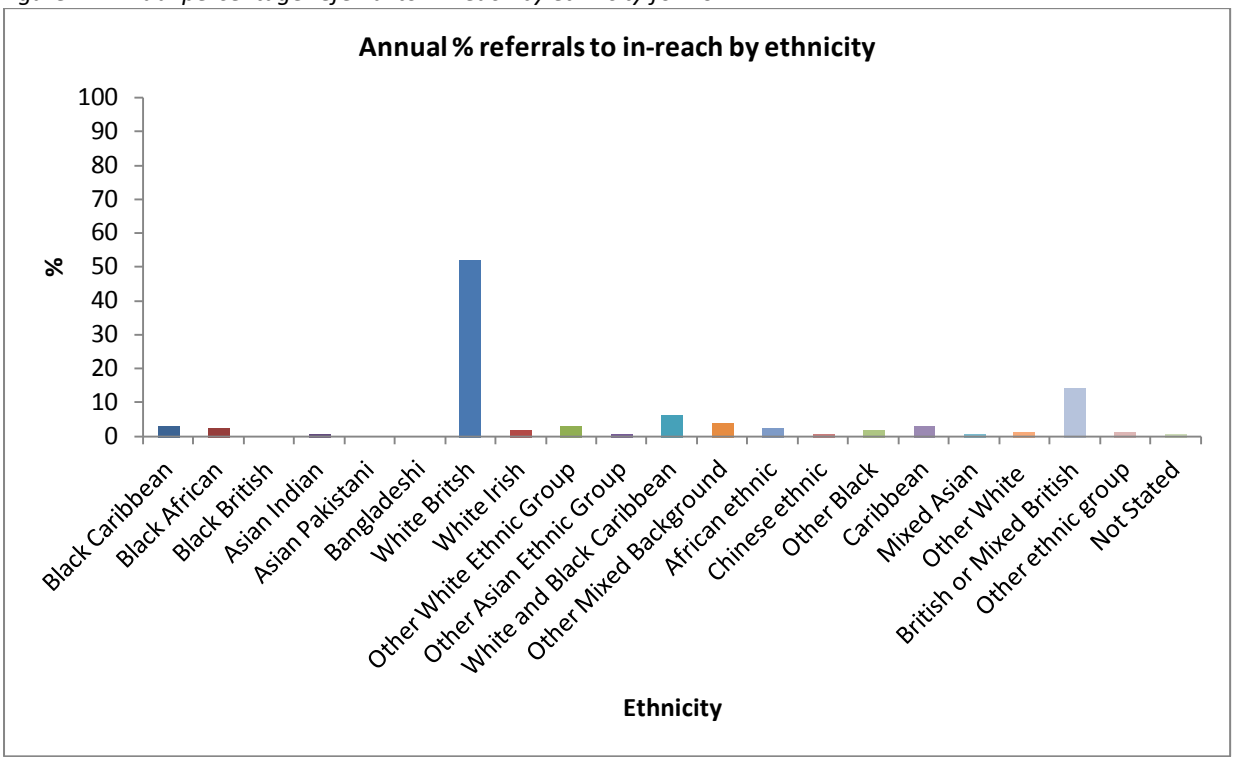
Referrals to the Service

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



On average 15.6 patients were referred to the in-reach service per month in 2011. The highest number of referrals were received in May and July (21). The lowest number of referrals were received in October.

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

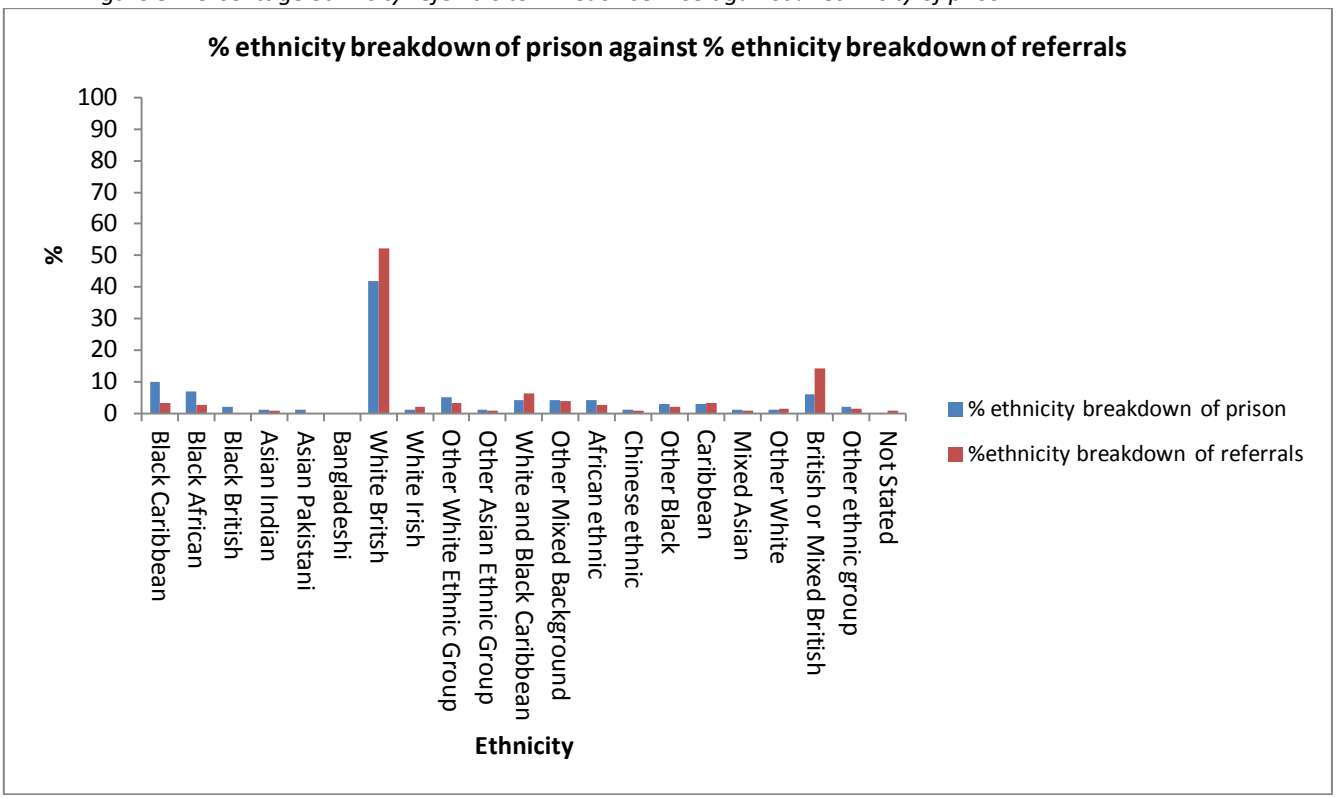


The five most common ethnic groups to be referred to in-reach in order were:

- White British (52.17%)
- British or Mixed British (14.29%)
- White and Black Caribbean (6.21%)
- Other Mixed Background (3.73%)
- Black Caribbean, Other White and Caribbean (3.11%)

There were no referrals from prisoners from the Bangladeshi, Black British and Asian Pakistani ethnic groups.

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



There is an overrepresentation of referrals to in-reach from the following groups (More than 50% of this group are referred relative to their proportion in the prison):

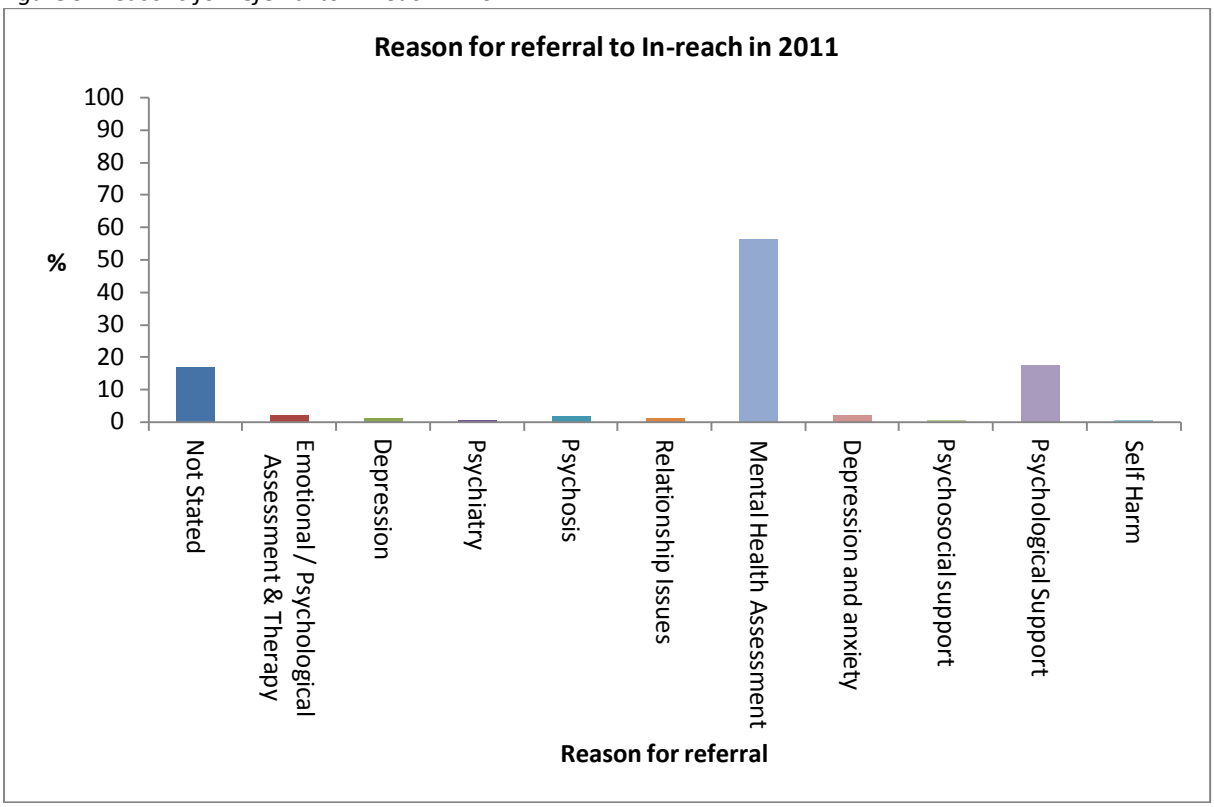
- White and Black Caribbean
- White Irish
- British or Mixed British

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

- Black Caribbean
- Black African

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

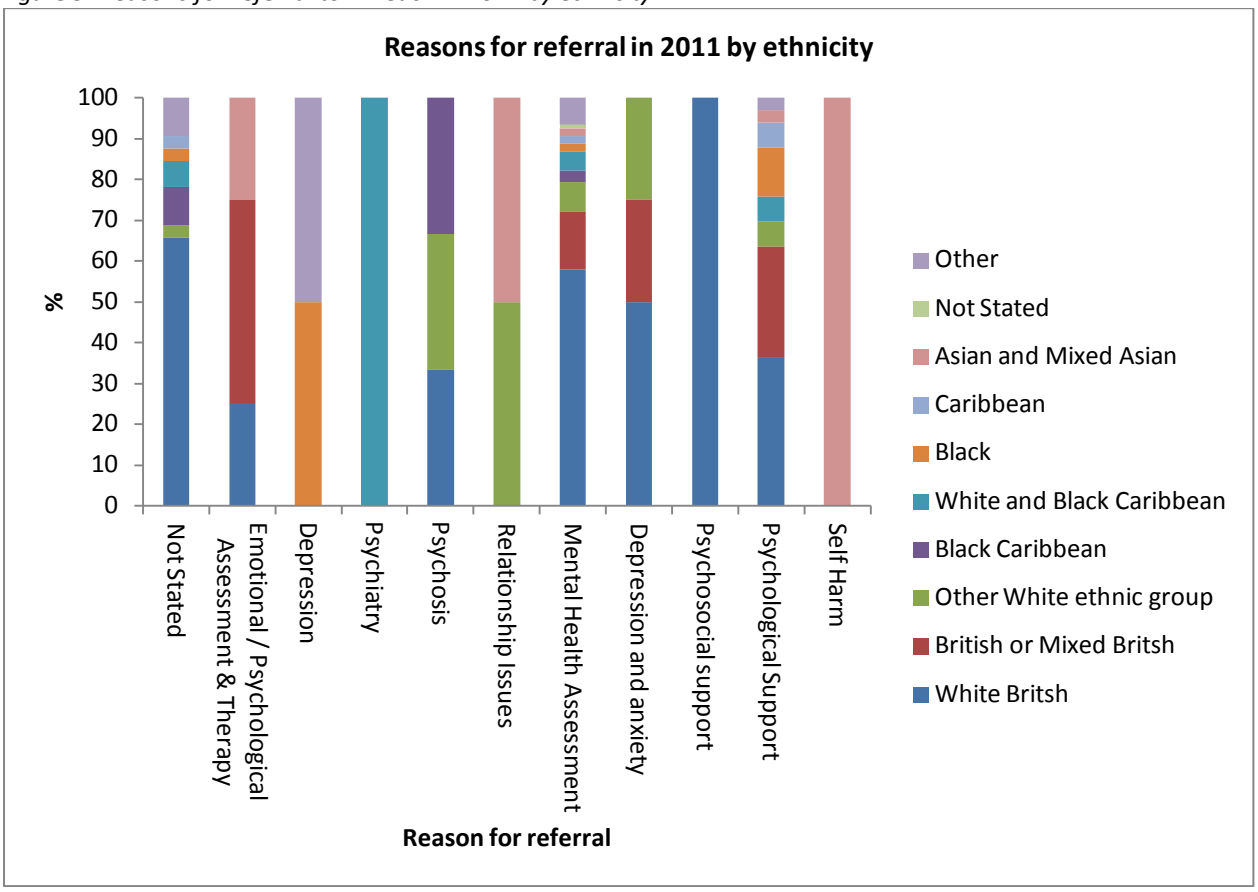
Figure 9: Reasons for referral to in-reach in 2011



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

- Mental Health Assessment (56.32%)
- Psychological Support (17.37%)
- Not Stated (16.84%)
- Emotional/Psychological Assessment and Therapy (2.12%)
- Depression and Anxiety (2.12%)

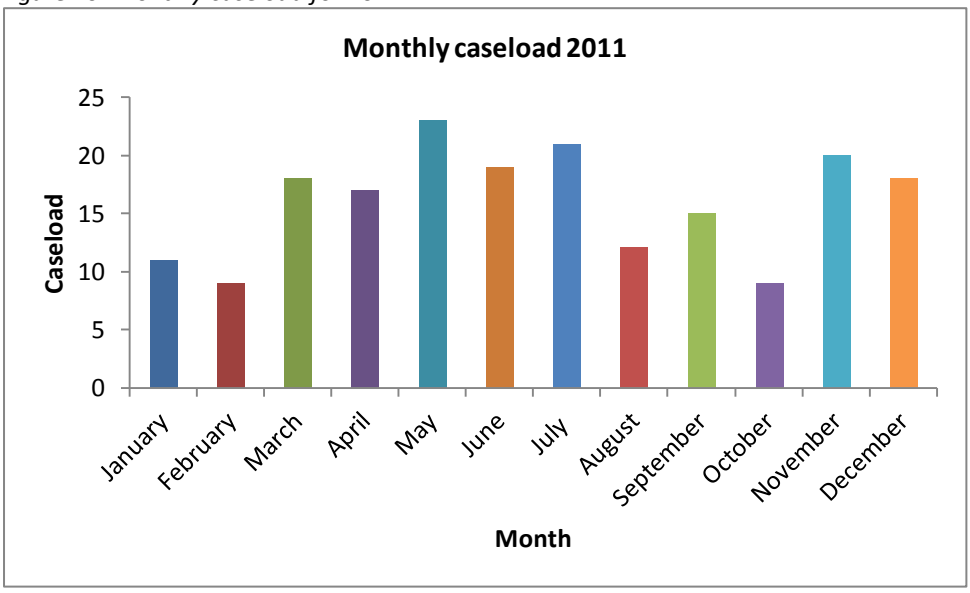
Figure 9: Reasons for referral to in-reach in 2011 by ethnicity



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

In-reach caseload

Figure 10: Monthly caseload for 2011



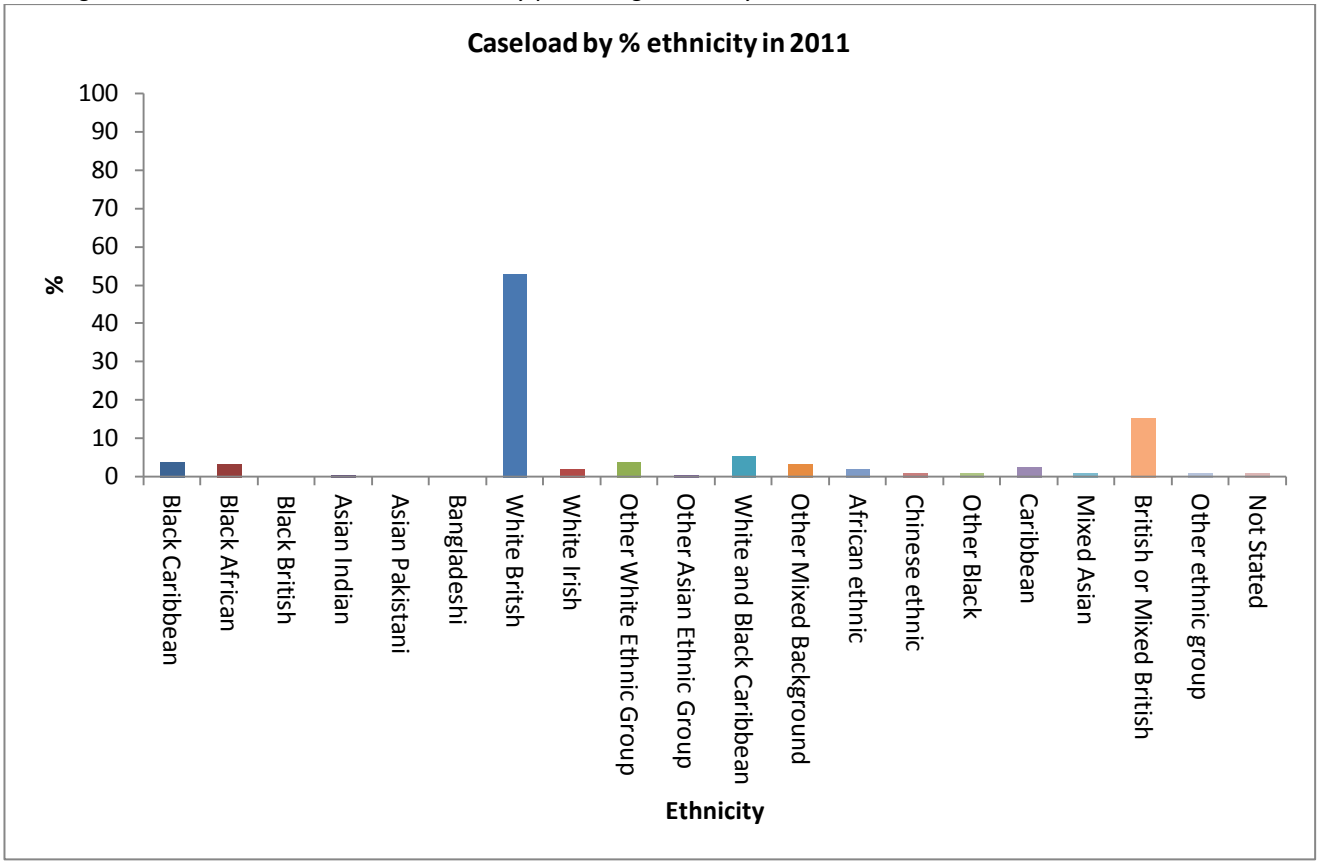
During 2011 on average in-reach had a monthly caseload of 16 service users. During March the caseload was highest in May (23) and lowest in February and October (9). This correlates with the relative number of referrals for those months

Table 9: Breakdown of caseload in 2011

Service	Annual caseload by % in 2011
Keyworker	69.79%
Counselling	6.25%
Drop in clinic	17.71%
Healthcare Liaison	6.25%

The majority (69.79%) of the in-reach caseload was seen by keyworkers. The Counselling and Healthcare Liaison had the smallest caseload.

Figure 11: Annual caseload broken down by percentage ethnicity



The five most common ethnic groups on the in-reach caseload in 2011 were:

- White Britsh (52.88%)
- British or Mixed British (15.18%)
- White and Black Caribbean (5.24%)
- Other White Ethinic Group (3.66%)
- Black Caribben (3.66%)

4.3 Self Harm

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

An Assessment, Care in Custody, and Teamwork (ACCT)[11] is used to help identify and care for prisoners at risk of suicide or self-harm. It is designed to provide more flexible multi-disciplinary support to prisoners at-risk of harming themselves. The plan encourages staff to work together to provide individual care to prisoners in distress, to help defuse a potentially suicidal crisis or to help individuals with long-term needs (such as those with a pattern of repetitive self-injury) to better manage and reduce their distress.

The number of prisoners that reported a history of self harm or feelings of self harm is very low (3.11%). This could be because self harm questions were not mandatory until 21st October 2011. The 2007 Corston Report[12] estimated that 37% of female prisoners self-harmed. At HMP Downview this is an estimated 130 prisoners.

Recommendations

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

4.4 Learning Disabilities

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

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

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

[11] Her Majesties Prison Service (2007) *The ACCT Approach: Caring for people at risk in prison* http://www.hmprisonservice.gov.uk/assets/documents/10000C1BACCTStaffGuide.pdf
[12] Corston, J. (2007) The Corston Report, London: Home Office.

HMP Downview was rated RED on this indicator in 2010 and 2011. A new Prison Learning Disabilities Nurse was appointed in May 2011, for the Surrey Prisons by SABPFT, to implement the standards of the indicator and GREEN was achieved in 2012.The Prison Learning Disabilities Nurse has rolled out a learning disability screening toolkit. The screening tool currently used is the Learning Disability Screening Questionnaire (LDSQ) developed by Karen Mckenzie and Donna Paxton. The screening is undertaken by the Primary Health Care team in each prison.

Between September 2011 and May 2012, 316 prisoners in HMP Downview were screened for learning disability. Of these, 312 completed the screening and 16 prisoners refused the screening.

Taking into consideration the churn, the total number of prisoners offered the screening equates to over 50% of the prison population.

Only one prisoner was identified as probably having a learning disability, however this was an incorrect diagnosis. Due to the lack of prisoners identified, no Health Action Plans or Health Passports have been used as yet.

Concerns about the screening tool have arisen due to a difference between the predicted numbers of prisoners with a learning disability (7%) and the actual numbers that have been identified (2%). There have also been some prisoners who have not been identified by the screening tool who at a later date have been found to be known to learning disability services in the community.

Awareness training has been delivered to eight members of the healthcare team and is available to all departments in the prison.

The Information and Resource Pack contains sections on:

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

Recommendations

17. Each prison to have a named nurse who has a special interest in people who have a learning disability. The named nurse responsibility to include liaising with the LD nurse specialist and disability officer.
18. Health action plans and health passports to be jointly developed with prison and health care for each identified individual according to need.
19. A review of the present screening tool, to assess its accuracy, as number of prisoners being identified is lower than anticipated.
20. Screening to be offered to whole prison population.

5. Substance Misuse

In October 2011 a joint substance misuse needs assessment was completed by Surrey Drug and Alcohol Action Team. The most prevalent drug of choice was heroin, followed by crack, cannabis, crack and cocaine. When tested for drugs the highest number of positive test was for cannabis followed by opiates. Data from healthcare showed that 49% of current prisoners reported a history of substance misuse at the first reception screen.

6. Alcohol

Prisoners' exhibit extremely high rates of both alcohol and substance misuse. The Office for National Statistics[13] reported a large proportion of both female and male prisoners were found to be drinking above lower risk levels as defined by the Alcohol Use Disorder Identification Test (AUDIT) in the year before entering prison.

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

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

Since the 2009 HNA, Alcohol Use Disorders Identification Test (AUDIT) has become one widely used alcohol screening tool. Developed by the World Health Organisation it used around the globe to help identify drinking behaviours that may cause damage to health. The AUDIT tool is routinely used as part of the reception screening. AUDIT scores were available for 74% (264) of HMP Downview prison population.

Table 10: A snap shot of AUDIT outcomes for 2011

AUDIT Score	Category	Count	%
0-7	**Sensible drinking / Low Risk**	227	63%
8- 15	**Hazardous Drinking / Increased risk**	11	3%
16- 19	**Harmful Drinking / High Risk**	8	2%
20+	**Dependent drinking**	28	8%

Research by MacAskill etal [14] found that 73% of prisoner AUDIT scores indicate an alcohol use of over 8. In HMP Downview only 13% of the population that undertook the AUDIT assessment had audit scores of over 8. AUDIT has its limitations as the assessment is based upon current drinking patterns and current perceptions of alcohol use.

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

In February 2011, the Surrey Drug and Alcohol Action team (DAAT) sent questionnaires to all the Surrey HMP establishments to identify what alcohol services they were delivering.

[13] Office of National Statistics (1999) Health Statistics Quarterly - No. 3, Autumn 1999.
[14] MacAskill et al. (2011). Assessment of alcohol problems using AUDIT in a prison setting: more than an 'aye or no' question. BMC Public Health. http://www.biomedcentral.com/content/pdf/1471-2458-11-865.pdf [Accessed July 2012]

Table 11: Alcohol intervention provision in HMP Downview

Alcohol Intervention	Delivery in HMP Downview
AUDIT-C (as part of health assessment on arrival	As part of the reception screening prisoners are asked about alcohol use. They are assessed using the AUDIT-C tool.
DETOXIFICATION	Through Healthcare
CARAT	The CARAT team accept referral from • Class A, B or C problematic drug users • There needs to be a link substance misuse and offence and prisoners should have a dependency on substances

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

Recommendation

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

7. Health Improvement

7.1 Smoking

Around 21% of the adult population in England are smokers[15]. In comparison the smoking prevalence in HMP Downview is double this. At the first reception screen 46% of prisoners reported a smoking status. Of those that reported a smoking status, 22% received smoking cessation advice in reception.

In 2011, 26.5% of prisoners with a smoking status were referred to smoking cessation clinic. No data has been provided on the number of prisoners that set a quit date and successfully stopped smoking, and no data is reported to the Surrey Stop Smoking Service.

Recommendations

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

7.2 Obesity

Data from SystmOne indicated that 26% (n=87) of women were on the QOF obesity register, indicating that they have a Body Mass Index of over 30. This is equal to the national average for women in the United Kingdom[16]. Data from the 2010 HNA indicated that around 23% of prisoners at HMP Downview were obese. This increase is either due to an increase in data collection, or an increase in obesity in this population.

There was no information provided on the number of prisoners who were overweight or underweight.

7.3 Physical Activity

New UK-wide physical activity guidelines were released by the Department of Health in July 2011[17]. To stay healthy, it is recommended that adults aged 19-64 should try to be active daily and should do:

- At least 150 minutes (2 hours and 30 minutes) of moderate-intensity aerobic activity such as cycling or fast walking every week and

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

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

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

- muscle-strengthening activities on 2 or more days a week that work all major muscle groups (legs, hips, back, abdomen, chest, shoulders and arms).

OR

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

OR

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

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

Recommendations

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

7.4 Health Promotion Action Group (HPAG)

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

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

A health promotion action group was set up in 2010. The group was chaired by a senior manager at HMP Downview. Representation on the group included healthcare, gym, kitchens and Public Health (NHS Surrey). Progress towards the action plan for the work was monitored by the group and progress is reported bi-monthly to the Partnership committee.

In 2011 the group was not meeting on a quarterly basis and the action plan was not up to date. There was no consistent representation from mental health and substance misuse. It is important that health promotion campaigns and interventions are measured for effectiveness. There is no evidence of any analysis of health promotion campaigns.

HMP Downview were therefore rated AMBER in the 2012 PHPQIs.

Recommendation

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

7.5 Screening

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

Table 11: Screening data

Bowel Screening	Number of Eligible Patients	7
	Number offered Screening	1
	Number of completed screenings	0
	Number refusing Screening	0
	% Coverage	0%
Breast Screening	Number of Eligible Patients	13
	Number offered Screening	13
	Number of completed screenings	0
	Number refusing Screening	0
	% Offered	100%
	% Coverage	0%
Diabetic ROP Screening	Number of Eligible Patients	4
	Number offered Screening	4
	Number of completed screenings	0
	Number refusing Screening	0
	% Offered	100%
	% Coverage	0%
Cervical Screening	Number of Eligible Patients	73
	Number offered Screening	73
	Number of completed screenings	5
	Number refusing Screening	22
	% Coverage	7%

Of the 7 prisoners of bowel screening age, none had received screening. It is vital that prisoners have access to this screening programme.

The breast screening coverage rate should be increased to 70%.

Data taken from SystmOne on the 19th March 2012 indicated that 89% (8/9) of patients with diabetes had received retinopathy screening, which is an improvement on the previous figures above.

The data above on cervical screening does not appear to give an accurate picture as data taken from SystmOne on the 19th March 2012 indicated that 87% (199/229) of patients had had cervical screening in the previous 5 years.

Recommendations

29. All prisoners eligible for bowel screening should be offered it, and the coverage rate should be increased to 60%.

30. The breast screening coverage rate should be increased to 70%.

7.6 Health Checks

The aim of an NHS Health Check[18] is to help lower the risk of the four common but often preventable diseases: heart disease, stroke, diabetes and kidney disease through early interventions and detection. People aged 40- 74 are eligible for a check.

Based on the current prison population, 93 prisoners are eligible and in 2011/12 HMP Downview carried out 115 health checks.

Recommendation

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

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

8. Full List of Recommendations

Prison Profile (demographic changes)

1. All recording of ethnicity should use the standards set out in the 2011 Census.
2. Data on religion, sexuality and sentence length should be collected and collated in order to inform service planning and ensure health needs are met.

Long term conditions

3. Audit of clinical records to examine diagnoses of asthma patients against SIGN guideline 101[19].
4. Increase the percentage of patients who have a diagnosis with measures of variability or reversibility.
5. Audit of asthma reviews to ensure they cover the factors outlined in SIGN guideline 101.
6. Audit of asthma patients to ensure they all have an up to date asthma action plan in place.
7. Audit of all patients with COPD to ensure they have received a diagnosis confirmed by post bronchodilator spirometry, and a review of their condition including FEV1 and inhaler technique in the last 15 months.
8. Medication review of all patients with epilepsy on the register, to ensure the chances of patients being seizure free are maximised.
9. Audit of all patients with diabetes to ensure they have had micro-albuminuria testing in the preceding 15 months. This is a recommendation of the NICE clinical guideline 87 (2010)[20].
10. Audit of all patients with diabetes to ensure they have had a foot examination and risk classification.
11. Audit of those on the CVD register to ensure they have received a cardiovascular risk assessment.

Communicable Diseases

12. Processes should be put in place to ensure that 100% of new receptions are offered the Hepatitis B vaccination within 31 days of reception, and the coverage is 80% every quarter.
13. An audit should be carried out on the Hepatitis C testing data, and processes put in place to ensure its accuracy before submission to the PHPQI website.

Oral Health

14. A dental improvement plan should be put in place to improve waiting times, and ensure that the access targets are met. This should be regularly monitored. Major service changes should be undertaken if the recommended waiting times cannot be met.

Mental Health

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

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

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

Learning Disabilities

17. Each prison to have a named nurse who has a special interest in people who have a learning disability. The named nurse responsibility to include liaising with the LD nurse specialist and disability officer.
18. Health action plans and health passports to be jointly developed with prison and health care for each identified individual according to need.
19. A review of the present screening tool, to assess its accuracy, as number of prisoners being identified is lower than anticipated.
20. Screening to be offered to whole prison population.

Alcohol

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

Smoking Cessation

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

Physical Activity

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

Health Promotion Action Group

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

Screening

29. All prisoners eligible for bowel screening should be offered it, and the coverage rate should be increased to 60%.
30. The breast screening coverage rate should be increased to 70%.

Health Checks

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