NHS Surrey

HMP Coldingley

Health Needs Assessment

January 2010

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Executive summary

Introduction

NHS Surrey's Public Health Directorate are undertaking a rolling programme of needs assessments that will be taking place across the five Surrey prisons to inform the commissioning process. This full needs assessment focuses on identifying the health needs of offenders in HMP Coldingley.

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 Coldingley has undergone major modification with the construction of a new wing. 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.

Demography

Prison receptions by age

Due to the turnover of inmates any demographic information can only provide a 'snapshot' of the population. An audit of new receptions for the period June to August (inclusive) 2009 shows that during that time period the majority of new receptions were aged 25-29 (23%), with 20-24 year olds (20%) and 30-34 year olds (16%) making up the next largest groups. There were a total of 167 new receptions in that period – an average of 56 receptions per month. During the 12 month period to June 2009 there were on average 65 new receptions per month (range 44 to 99)[1].

Prison population by age

The snap shot of the prison population in September 2009 broadly mirrored the receptions into the establishment over the preceding months. The majority of the population were aged 25-29 years (23%), with those aged 30-34 years (19%) and 20-24 years (16%) the next largest groups. 39% of the population were under the age of 30. The number of prisoners in each age band over 30 gradually decreases. Only 7% of the population were aged over 50 . In common with other similar areas of the prison estate and partly as a result of overcrowding and current sentencing practice churn data suggests a trend towards younger and shorter term prisoners at the establishment.
The 2008 HMIP report found that 56% of prisoners had children under the age of 18.

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 Coldingley has a higher BME population (43%) than the national average of 25%. In September 2009, the majority of prisoners in the establishment were White British (57%), followed by Black Caribbean (18%) and Other Black (7%). The South East region offender needs analysis [6] shows that the offender population in the South East is overwhelmingly white, male (91%) and aged 25-40. However in the South

East region as a whole, offenders from a BME background made up 34% of the survey participants.

Foreign nationals

Foreign nationals make up 4% 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 30 June 2009 were Jamaican nationals [2].
The 2007-08 IMB report states that 10% of prisoners were due for deportation on completion of their sentence[3]. The most recent national ethnicity available from June 2009 stated that 20 of the prisoners in Coldingley were foreign nationals and 486 were UK nationals.

Population by sentence length

HMP Coldingley has a relatively stable population with an average length of stay of 14 months. In September 2009 the majority of the population (42%) had a sentence of greater than 4 years or more (excluding indeterminate sentences). A significant proportion had sentences of 12 months to less than 4 years (15%) or indeterminate sentences (including life) (12%) . Most prisoners have more than six months left to serve on their sentence and the majority had been in at least two other prisons prior to coming to HMP Coldingley. 68% of those surveyed in 2008 had been in prison at least twice before. Data from the South East region offender needs analysis[4] undertaken in September 2009 indicated a proportionately higher number of previous convictions in prisoners in the region compared to the national sample. The proportion with no previous convictions was similar between the survey group and the national profile. Nationally, 47% of adults in prison are reconvicted within one year of being released.
The 2008 HMIP report stated that for the majority of prisoners their main offence was violence against the person (33%) [1]. In the South East region as a whole violence against the person was also the largest offence category (27.2%).

Discharge records for individuals being released into the community show that there were on average 14 discharges per month between January and October 2009. The majority of those stated their discharge area as London (32%) reflecting the fact that many prisoners originate from the Greater London area. 15% of discharge areas were stated as Surrey and 20% as the rest of the South East Coast SHA area. 6% of prisoners were discharged to no fixed abode. In the South East region as a whole 42% of prisoners described themselves as coming from the area and 33% from London.

Comparative needs assessment

All three comparator prisons had similar staffing structures to HMP Coldingley. No prison had inpatient facilities but outpatient provision was variable with some prisons not providing the in house GUM, physiotherapy or pharmacy services present in HMP Coldingley. Dental provision was at recommended levels in three of the four prisons but all experienced problems with long waiting lists. Substance misuse services addressed drug addiction but there was limited availability to support alcohol dependency. Mental health services were in crisis at HMP Dartmoor but in other prisons there was provision that was under pressure due to demand. Health promotion provision was variable with good smoking cessation services and gym provision but little overarching health strategy. Communicable disease control was

generally poor. There appeared to be limited consultation with prisoners despite high levels of need and low levels of satisfaction with healthcare.

Service mapping

Primary care trusts now have responsibility for the healthcare provided in prison. 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[5].
Services for mental health have been commissioned from Surrey and Borders Partnership NHS Foundation Trust since 2005.
GP services are commissioned from Harmoni who took over from Wayside on 1st November 2009. Their contract expires in March 2010. Thamesdoc provides out of hours cover.
GUM services are commissioned from Ashford & St Peter's NHS Trust

Referrals to other agencies/secondary care

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. No data was available on how many referrals were new or follow up.

During the period May to September 2009 124 external appointments were kept by prisoners at hospitals. Only 10 of these were recorded as follow up appointments and several appointments were made by individual prisoners receiving a course of treatment. Of the appointments the majority were maxillofacial (20%), ophthalmology (15%) and imaging (10%).

Between September and December 2009 there were 52 scheduled or outstanding hospital appointments that prisoners were due to attend. Many of the outpatient appointments breach the 18 week target due to delays in accessing notes, transferring appointments to local hospitals and security arrangements that need to be put into place.

Mental Health

Mental health clinics are held twice a week. In the month of August 2009 25 patients were seen. During August the psychologist saw 26 patients.
There were 141 referrals of which 93% were accepted for screening or assessment. Reasons for refusal of a referral included not enough time to see the individual before transfer/discharge, recommendation that care would be better on the wing or a case that was already open and known to Mental Health In Reach Team (MHIR).
The majority of referrals were from healthcare, Offender Management Unit, CARATs and staff on the wings. Only 2.8% of referrals were made by prisoners themselves.
The majority of referrals were for issues around self esteem/relationships (18%) and deliberate self harm (11%). Diagnosed mental illness (depression, SMI, anxiety, PTSD, OCD) accounted for an additional 25% of referrals with depression and SMI the largest contributors to that sub group.
Of the 16 prisoners referred for deliberate self harm (DSH) 6 (38%) had current thoughts of DSH, 7 (43%) had a history of DSH and 3 (19%) had harmed themselves in the prison.
All of the prisoners who were referred due to bereavement were referred to CRUSE.
The majority of referrals were screened by MHIR (28%) or referred for counselling (26%). 10% of referrals required more information.

CPA is available for those prisoners already subject to it and can be started for those requiring it. All prisoners should either be on enhanced CPA or enhanced care. A CPA audit is undertaken every two months, there are approximately 8- 12 prisoners on CPA at the moment.

Addiction Services

In the majority of cases the main clinical interventions will have been started or completed in the local prison where the prisoner first enters custody. It is unlikely that a prisoner will present for detox in a training prison but this may occur if a new transfer cannot sustain an illicit dependency in the new prison. Where opiate dependency is a new presentation in the prison the current practice is to try and manage the prisoner within HMP Coldingley unless a higher level of care (and therefore transfer) is required.
Most aspects of IDTS are up and running although not in their final form. In August 2009 IDTS had 34 patient appointments.

"A" wing will be the IDTS wing. "A" wing holds 93 prisoners and it is planned that eventually 40-50 of these at any one time will be IDTS prisoners receiving medication. "A" wing staff are all IDTS trained. It has been agreed that 6 maintained IDTS prisoners per week are transferred from HMP High Down to HMP Coldingley in order to relieve their backlog. It is likely that capacity will be reached at HMP Coldingley within two months.

A needs assessment of IDTS undertaken in August 2009 made the following key recommendations:
- IDTS commissioning partnership to agree strategy for managing IDTS treatment demand safely and effectively within available resources, specifically by agreeing guidelines for maintenance, preferably in conjunction with HMP High Down
- PCT to ensure Coldingley IDTS nurse staffing adequate to meet the increased demand when the establishment is at full capacity
- IDTS commissioning partnership to generate options for resourcing alcohol provision
- PCT to ensure clear and resourced arrangements re: leadership, coordination, accountability and day to day management of IDTS nursing staff

Pharmacy

Medication is issued twice a day (8.10am -9am and 4.30pm-5.15pm). In many other establishments medication is dispensed three times a day. Medication can be dispensed to individual prisoners more frequently but only in exceptional circumstances. A & E wings have their medications dispensed on the wing. All other prisoners must get their medication from the healthcare centre. The overall aim is for all dispending to be wing based.
Simple medications such as Gaviscon and paracetamol are available overnight. These medications are stored in a locked cupboard with the key available at the main gate and can be signed out by prison officers. If a prisoner needs any other medication overnight the out of hours GP service is called or an ambulance in an emergency. Thamesdoc has an emergency bag that contains key medications.
Around 80% of medications are in possession (weekly, monthly or night in possession) and prisoners with insulin dependent diabetes are allowed their insulin in possession. It is likely that there are more prisoners who are clinically eligible for in possession medication but do not receive it due to other factors e.g. security, self

harm risk etc. If an insulin dependent diabetic cannot stabilise their illness using in possession mediation they are moved to a prison with 24 hour healthcare.
There are no special arrangements for coding or labelling medications for prisoners with low literacy levels. The in possession assessment is focused on reducing the risk of self harm rather than assessing the individual's level of understanding about the drug they are taking.
No over the counter (OTC) medications (e.g. ibuprofen) are available on the canteen list. If a new medication is prescribed, a new box started or medication is changed the prisoner is provided with the medicine information leaflet contained with the product.

A clinic is run by the pharmacist that undertakes medication reviews, discuss the use of generic/changed medications and decrease analgesia consumption as well as other issues. In August 2009 the clinic saw 24 patients with a waiting list of 8. The majority of these appointments were to discuss medication (37%).

The pharmacy team are managed by the Head of Pharmaceutical Services and Development for the Prisons in Surrey. They in turn are managerially accountable to the Operational Manager for prison healthcare and professionally to the Chief Pharmacist of Surrey Community Health Services.
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 NHS Surrey.

Epidemiological needs assessment

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 (there are no men of this age in the establishment at the current time). 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 8 and 32 inmates in HMP Coldingley with the condition.

Prescribing data indicates from November 2009 indicated that 14 patients were being treated for asthma and 3 were being treated for COPD. The chronic disease register in September 2009 has 29 inmates on it who had asthma or other respiratory disease. The discrepancy in the figures may arise as the prisoners had left the prison by November, the register is inaccurate, prisoners may self report disease but not require medication or there may be under detection of the condition. Using these figures the prevalence of respiratory disease in the prison is between 3.3% and 5.6%.

Epilepsy

An academic paper auditing 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, only 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.

Prescribing data from November 2009 indicated that 5 patients were being treated for epilepsy. The chronic disease register in September 2009 has 1 inmate on it who had epilepsy. The discrepancy in the figures may arise as new prisoners with the condition had entered the prison by November, the register is inaccurate, or there may be under detection of the condition. Using these figures the prevalence of epilepsy in the prison could be between 0.2% and 1.0%.

Diabetes

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.

Prescribing data from November 2009 indicated that 8 patients were being treated for diabetes. The chronic disease register in September 2009 had 4 inmates on it who had diabetes. The discrepancy in the figures may arise as new prisoners with the condition had entered the prison by November, the register is inaccurate, individuals may self report the condition but not require medication for it or there may be under detection of the condition. Using these figures the prevalence of diabetes in the prison could be between 0.8% and 1.6%.

Coronary heart disease (CHD) and hypertension

The prevalence within the prison is 5.4% compared to that seen in the general population (3.7%) but differs significantly from prevalence rates seen in other prisons (14%). Prescribing data from November 2009 indicated that 27 patients were being treated for cardiovascular disease (including hypertension). The chronic disease register in September 2009 had 21 inmates on it being treated for hypertension, 9 being treated for hypercholesterolaemia and one for other cardiac disease. The discrepancy in the figures may arise as some prisoners may have more than one co-morbidity, prisoners with the condition may have left the prison by November, the register is inaccurate, or there may be under detection of the condition. Using these figures the prevalence of hypertension in the prison could be 4.1% and hypercholesterolaemia 1.8%.

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[6] 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 could be between 35 and 64 inmates with undiagnosed hypertension.

Corporate needs assessment

The feedback was transcribed and key themes were identified. A thematic approach was used to analyse the findings, which were then grouped and split into different categories.

Gym

- Prisoners were concerned that it was becoming increasingly difficult to make healthy choices as there were too many obstacles.
- An example described in all the focus groups was difficulty in using the gym as there were limited opportunities and trying to fit it into duties, prison regime and visits was challenging. Prisoners reported that the remedial gym was good when it worked, however access was difficult. The most common reason for this was that when prisoners got referred to the gym the officers refused to accept their form.

Motivation

- Many of the prisoners felt that they didn't have anyone encouraging them to improve their health through changing their lifestyle. As a result many prisoners reported that they had seen other prisoners *"give up through lack of motivation"*

Diet

- Prisoners felt that there were limited opportunities to eat healthy food; many described the food as lacking in nutrients.
- When asked about the purchase of healthy food options available through the canteen list, prisoners reported that they could not afford to buy them as they were too expensive. Prisoners reported that the weekly prison wage of £2.50 had remained consistent for some years; however the overall price of the canteen list had increased.
- A concern for some of the prisoners was their poor relationship with food. When asked for more information, two prisoners reported ordering biscuits and several Mars bars from the canteen and eating them all within a few hours. They felt that for a few hours it made them feel "happier", but this was followed by low moods. They reported witnessing :-

    - Binge eating
    - Comfort eating
    - Eating then making themselves sick (Bulimia)
    - General poor eating habits, e.g. consistently choosing food with high carbohydrate and fat content from the menu

Communication

- The lack of communication about Swine Flu was a major concern for prisoners. Many felt that the information received were limited and contained mixed messages

Mental health

- In all the focus groups, prisoners reported that they had on occasions experienced low moods and didn't feel that they could talk to an officer on the wing. When asked if they could access anyone else to speak with informally the most common response from prisoners was that they lacked knowledge of who to speak to. Prisoners felt uncomfortable accessing the listeners, and felt that there wasn't any information about mental health on the wings. Many felt that HMP Coldingley could do more to increase the awareness of mental health issues by providing accessible information on what to do if you feel low.

Healthcare

- A small number of prisoners reported that they had a good experience of healthcare; however a large number of prisoners felt that there were not enough healthcare staff and as a result they were always rushed and busy.

- Many prisoners reported that they choose to self- medicate for minor ailments as this was viewed as quicker than waiting to see healthcare. Some prisoners also felt that it was inappropriate to go to healthcare for complaints that they could manage themselves. An example of these complaints included headaches, vomiting and diarrhoea, general aches and pains.
- In all the focus groups prisoners reported experiencing a long wait to obtain treatment. When asked how long, prisoners reported that they could see a nurse within days but had to wait a few weeks to see the doctor. Many said that in that time their health complaint had either resolved or got worse. Some prisoners reporting witnessing other prisoners health complaints getting so bad that they had to go to hospital
- Prisoners reported feeling frustrated at the waiting times to see a doctor. Some prisoners had seen nurses being confronted by other inmates about this issue during wing visits.
- Several participants complained of waiting months for an external appointment and felt that when they asked healthcare staff they had no information on how long they would be waiting.
- Prisoners felt that there was no continuity of care; some felt that it was up to them to justify their existing health complaints.
- Prisoners reported that when they did receive healthcare appointment slips it was normally after the appointment so they ended up missing their slot.
- Prisoners felt that new comers weren't receiving the same health checks that they used to two years ago. They reported a "rushed" health check at reception. Some prisoners reported waiting in reception for health care staff.
- Prisoners reported concerns that health care refused to prescribe medication that had been prescribed to them before coming to Coldingley. Prisoners were aware of some of the reasons for this, but felt that better communication from healthcare would have relieved their concerns and anxieties.

Conclusion

This HNA report clearly demonstrates that any healthcare provision in HMP Coldingley needs to ensure it meets the needs of a young, male and ethnically diverse population that are likely to be in the prison for a prolonged period of time and whose health should be optimised to take advantage of the work opportunities in the establishment.

Current service delivery does not completely meet the population's health need 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, under the main areas of structure, process, diseases, and procedures (summarised in full in the appendices). The full HNA report identifies how these should inform the commissioning process and how these can be contractually performance managed.

1 Introduction

1.1 Background

NHS Surrey's Public Health Directorate are undertaking a rolling programme of needs assessments that will be taking place across the five Surrey prisons to inform the commissioning process. This full needs assessment focuses on identifying the health needs of offenders in HMP Coldingley.

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 Coldingley has undergone major modification with the construction of a new wing. 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 will determine prisoners' ability to benefit from healthcare. The need for health 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, 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 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. **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.

2. **Comparative approach –** Services are compared with those of other providers e.g. community services or those within other prisons.

3. **Epidemiological approach** – The main approach through which health care needs are determined by considering three areas:

    - Incidence and prevalence of a disease or condition
    - Effectiveness and cost effectiveness of services
    - Services available

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 (NHS) in the community.

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 ascertain a baseline of current services

There are five objectives of a health care 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 health needs assessment can stimulate the involvement and ownership of the various stakeholders in the process.

The health needs assessment has been conducted using the 'Toolkit for health care needs assessment in prisons' developed by the University of Birmingham. A Prison Health Needs Assessment Steering Group was responsible for the overview, planning and governance of the needs assessment. The membership of this group is listed in Appendix A.

2 HMP Coldingley Prison Profile

2.1 Category, logistics and prison function

HMP Coldingley opened in 1969 as a Category B industrial training prison. In 1993 it was redesignated as a Category C training prison. HMP Coldingley is focused on providing a framework to support the achievement of realistic resettlement goals for prisoners. Prisoners follow a standardised core day. The regime offers activities including full time workshop employment, vocational training and education. In its last Her Majesty's Inspectorate of Prisons (HMIP) report in 2008 HMP Coldingley was described as "one of the better training prisons in the country"[7].

HMP Coldingley has normal reception arrangements and accommodates all sentence lengths including life sentence prisoners. As part of its reception criteria prisoners must:
- be fully prepared to participate in the regime and work a full working week
- have a minimum of 24 months to Non Parole Date (NPD)/Conditional Release Date (CRD) when applying (prisoners on the RAPt programme will be considered with less time if they can complete their course before their release date)
- be willing to sign a Voluntary Drug Testing Compact

2.2 Accommodation

The original four wings were extended several years ago and the new wing completed in 2008.The majority of accommodation is single cells with a small number of double cells on F wing (converted from the old inpatient healthcare facility). Cells are located across five wings. Four of these have electronic unlocking sanitation and one has integral sanitation. In cell TV and DVD are available on all wings for standard and enhanced prisoners. PIN phones are also available on all the wings.

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 total population in custody across the prison estate on 30th October 2009 was 84,622 a rise of 3625 from a year earlier. The male prison population had increased to 80, 329[8]. More recent national data is currently available due to technical difficulties with the roll out of the P-NOMIS system which has resulted in the Ministry of Justice suspending the monthly statistical bulletin.

Overall prison expenditure has increased from £2.8bn in 1995 to £3.8bn in 2007-08[9]. 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 October 2009 Ministry of Justice Statistics Bulletin states that the in use Certified Normal Accommodation at HMP Coldingley is 494 (this includes accommodation available for immediate use, excluding damaged cells and cells affected by building works or staff shortages). The operational capacity of the prison (the total number of prisoners that an establishment can hold taking into account control, security and proper operation of the planned regime) is 513 and the population was 501 (including prisoners on authorised absence). This is 101% population occupancy when compared to the CNA. The most recent national ethnicity available from June 2009

stated that 20 of the prisoners in Coldingley were foreign nationals and 486 were UK nationals.

The last full announced inspection by Her Majesty's Inspectorate of Prisons was in November 2005 which was followed up by a short unannounced inspection in September 2008.

As demonstrated in Table 2.1 there has been a significant increase in the HMP Coldingley prison community since the last planned inspection report, 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 Coldingley's operational capacity & occupancy between 2005 and 2009

	2005	2009	Change (%)
CNA	370	494	124 (+34)
Total population	388	501	113 (+29)
Operational capacity	390	513	123 (+32)

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 Coldingley and the three comparator prisons for Quarter 4 (08/09) are shown in Table 2.2. A rating of 4 (maximum rating) indicates exceptional performance, 3 is good performance and 2 requires development.

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

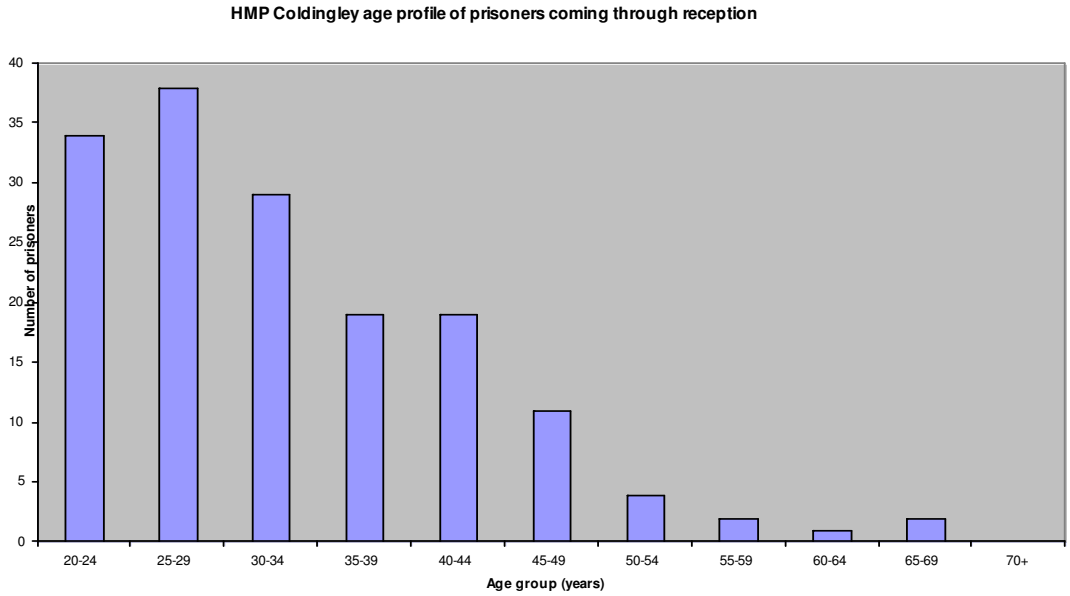
Establishment	Rating	Performance against last quarter
HMP Coldingley	3	No change
HMP Camp Hill (Isle of Wight cluster)	3	No change
HMP Featherstone	4	Improvement
HMP Dartmoor	2	No change

Source : Ministry of Justice

2.6 Prison receptions by age

Due to the turnover of inmates any demographic information can only provide a 'snapshot' of the population. An audit of new receptions for the period June to August (inclusive) 2009 shows that during that time period the majority of new receptions were aged 25-29 (23%), with 20-24 year olds (20%) and 30-34 year olds (16%) making up the next largest groups. There were a total of 167 new receptions in that period – an average of 56 receptions per month. During the 12 month period to June 2009 there were on average 65 new receptions per month (range 44 to 99)[10].

Figure 2.1 HMP Coldingley prison receptions by age (June-Aug 2009)



2.7 Prison population by age

The snap shot of the prison population in September 2009 broadly mirrored the receptions into the establishment over the preceding months. The majority of the population were aged 25-29 years (23%), with those aged 30-34 years (19%) and 20-24 years (16%) the next largest groups. 39% of the population were under the age of 30. The number of prisoners in each age band over 30 gradually decreases. Only 7% of the population were aged over 50 (Figure 2.2). In common with other similar areas of the prison estate and partly as a result of overcrowding and current sentencing practice churn data suggests a trend towards younger and shorter term prisoners at the establishment.
The 2008 HMIP report found that 56% of prisoners had children under the age of 18.

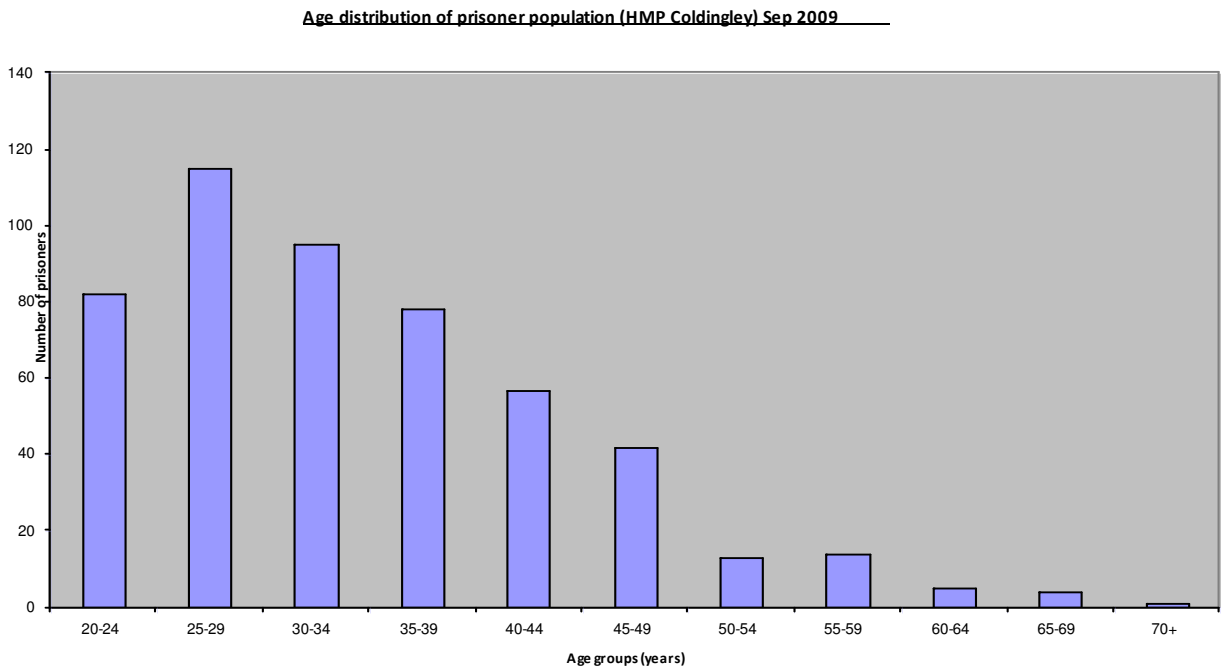


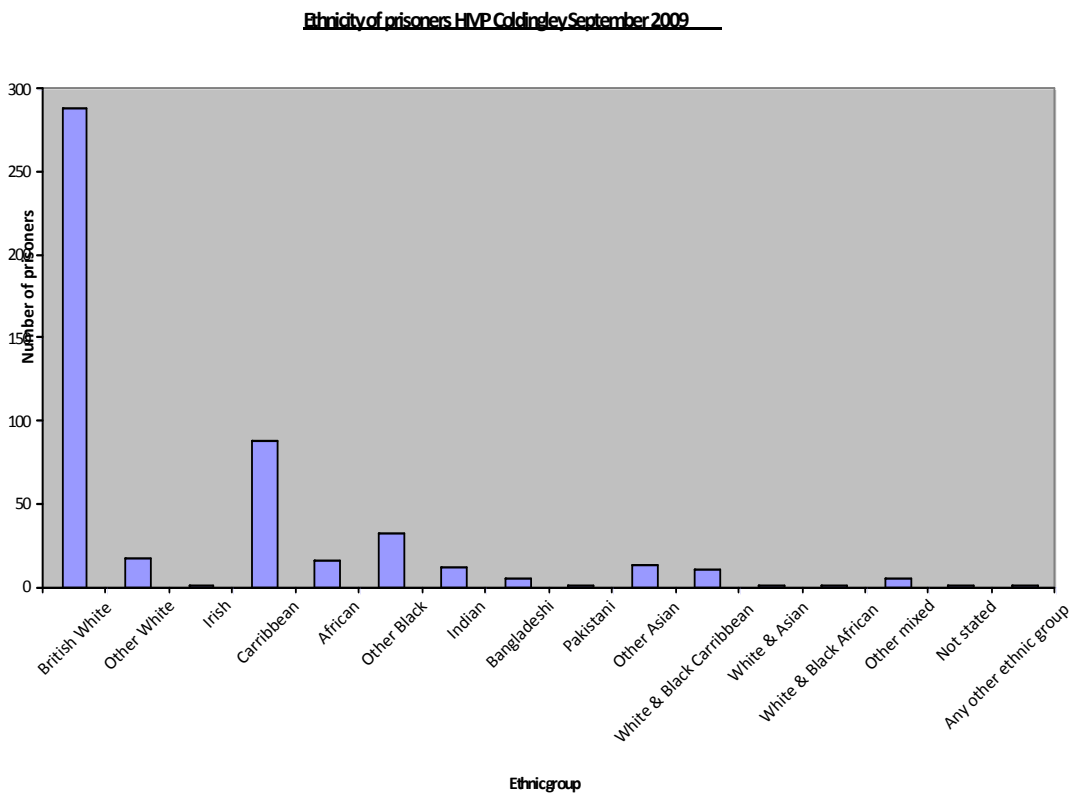
Figure 2.2 Age distribution of prisoners HMP Coldingley September 2009

2.8 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 Coldingley has a higher BME population (43%) than the national average of 25%. In September 2009, the majority of prisoners in the establishment were White British (57%), followed by Black Caribbean (18%) and Other Black (7%) (Figure 2.3). The South East region offender needs analysis [6] shows that the offender population in the South East is overwhelmingly white, male (91%) and aged 25-40. However in the South East region as a whole, offenders from a BME background made up 34% of the survey participants.

Figure 2.3 Ethnicity breakdown of prisoners in HMP Coldingley (Sept 2009)



2.9 Foreign nationals

Foreign nationals make up 4% 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 30 June 2009 were Jamaican nationals [11].
The 2007-08 IMB report states that 10% of prisoners were due for deportation on completion of their sentence[12]. The most recent national ethnicity available from June 2009 stated that 20 of the prisoners in Coldingley were foreign nationals and 486 were UK nationals.

2.10 Population by sentence length

HMP Coldingley has a relatively stable population with an average length of stay of 14 months. In September 2009 the majority of the population (42%) had a sentence of greater than 4 years or more (excluding indeterminate sentences). A significant proportion had sentences of 12 months to less than 4 years (15%) or indeterminate sentences (including life) (12%) (Figure 2.4). Most prisoners have more than six months left to serve on their sentence and the majority had been in at least two other prisons prior to coming to HMP Coldingley. 68% of those surveyed in 2008 had been in prison at least twice before. Data from the South East region offender needs analysis[13] undertaken in September 2009 indicated a proportionately higher number of previous convictions in prisoners in the region compared to the national sample.

The proportion with no previous convictions was similar between the survey group and the national profile. Nationally, 47% of adults in prison are reconvicted within one year of being released.
The 2008 HMIP report stated that for the majority of prisoners their main offence was violence against the person (33%) [1]. In the South East region as a whole violence against the person was also the largest offence category (27.2%).

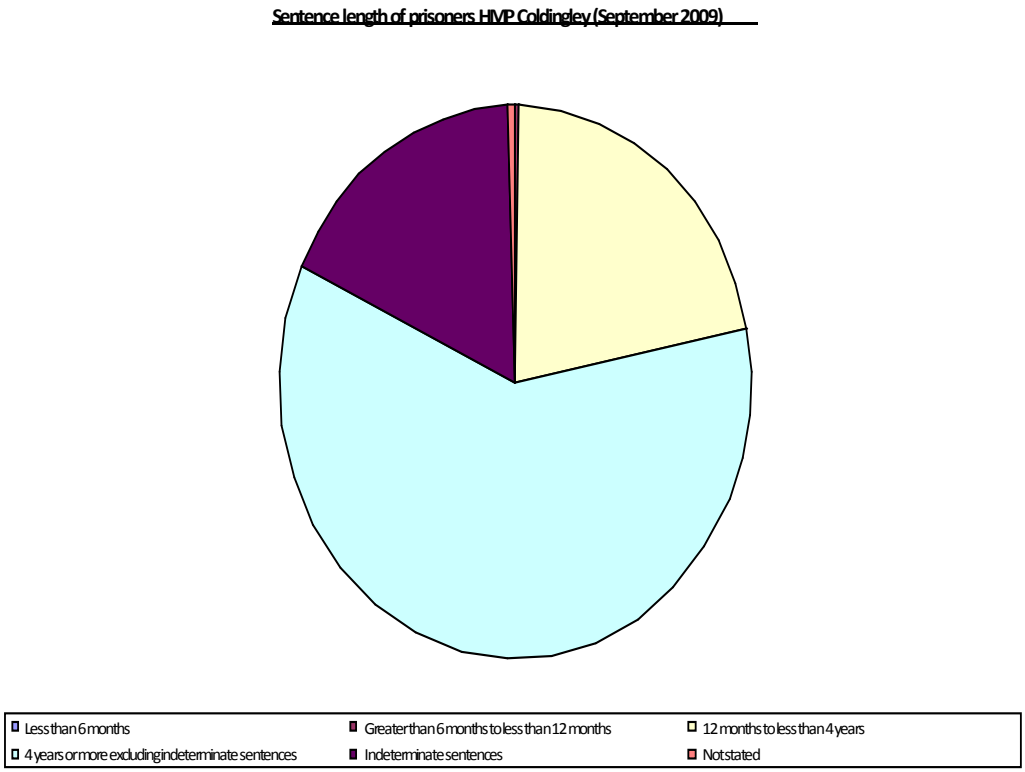
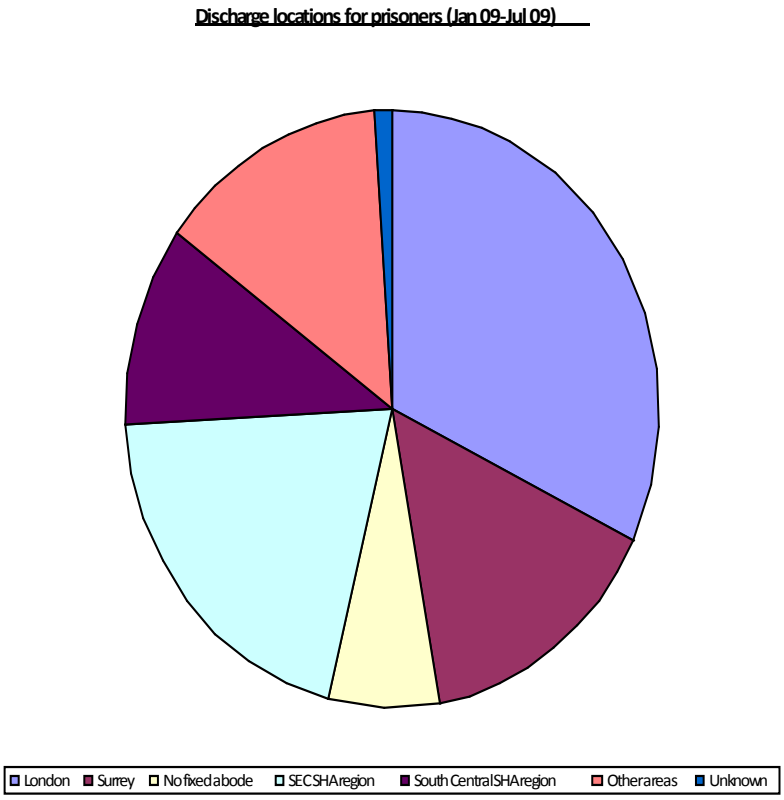


Figure 2.4 Sentence length of prisoners HMP Coldingley (September 2009)

Discharge records for individuals being released into the community show that there were on average 14 discharges per month between January and October 2009. The majority of those stated their discharge area as London (32%) reflecting the fact that many prisoners originate from the Greater London area. 15% of discharge areas were stated as Surrey and 20% as the rest of the South East Coast SHA area (Figure 2.5). 6% of prisoners were discharged to no fixed abode. In the South East region as a whole 42% of prisoners described themselves as coming from the area and 33% from London.

Figure 2.5. Discharge areas for prisoners (Jan-Jul 2009)



2.11 Population by religion

Data from the prisoner survey undertaken as part of the 2008 HMIP report [1] showed that the predominant faith group was Church of England (30%) followed by no faith (28%) and Catholic (23%). Muslims made up 11% of the prison population and Sikhs 4%. Nationally 50% of the prison population are Christian (55% Anglican, 34% Roman Catholic, 11% other), 12% are Muslim, 2% are Buddhists and 33% report having no religion. `

2.12 Other strands of diversity

In the HMIP survey taken in 2008 12% of participants described themselves as having a disability.

In common with many other self reported surveys of prisoners 100% of inmates described themselves as heterosexual. Prevalence data on the number of men who have sex with men in prison is unavailable. Self reporting is notoriously inaccurate due to stigma, denial and fear of repercussions.

2.13 Feeder & transfer prisons

Of the prisoners that came through reception between June and August 2009 the majority were from HMP Elmley (16%) followed by HMP Wandsworth (11%) and

HMP High Down (10%). The feeder prisons were a mixture of mainly Category B, Category C and young offender establishments.

During the period May to October 2009 there were on average 42 transfers out of the prison per month. Prisoners are transferred out to the entire prison estate including HMP High Down.

2.14 Population by regime

In September 2009 the majority of prisoners were on an enhanced regime (60%) with the majority of the rest were on standard regime. Only one individual was on a basic regime. Those on standard and enhance regimes have increased access to privileges such higher allowances of private cash, higher rates of pay, in cell TV, longer association times and more frequent visits. The establishment has attempted to make the incentives and earned privileges scheme more meaningful by making it more difficult to move from the standard to the enhanced regime. However this had lead to a perception of inequity amongst prisoners [1].

3 Comparative health needs assessment

3.1 Summary

All three comparator prisons had similar staffing structures to HMP Coldingley. No prison had inpatient facilities but outpatient provision was variable with some prisons not providing the in house GUM, physiotherapy or pharmacy services present in HMP Coldingley. Dental provision was at recommended levels in three of the four prisons but all experienced problems with long waiting lists. Substance misuse services addressed drug addiction but there was limited availability to support alcohol dependency. Mental health services were in crisis at HMP Dartmoor but in other prisons there was provision that was under pressure due to demand. Health promotion provision was variable with good smoking cessation services and gym provision but little overarching health strategy. Communicable disease control was generally poor amongst the comparators. There appeared to be limited consultation with prisoners in the comparator prisons despite high levels of need and low levels of satisfaction with healthcare.

3.2 Identification of appropriate comparators

Three comparator prisons were identified through discussion with prison authorities, public health colleagues and literature searching: HMP Featherstone, HMP Dartmoor and HMP Camp Hill. The choice of comparators was agreed with the Health Needs Assessment Steering Group.

3.2.1 HMP Featherstone

HMP Featherstone is one of six prisons located in South Staffordshire PCT. It is a category C training establishment for male adult prisoners. In 2008 the operational capacity of HMP Featherstone was increased from 623 to 687.

The health needs assessment (HNA) steering group decided that HMP Featherstone was an appropriate comparator as it has the same categorisation as HMP Coldingley. The main difference is that HMP Featherstone has a larger population.

3.2.2 HMP Dartmoor

HMP Dartmoor was built in 1809. The establishment is an adult male category C training prison with an operational capacity of 620.

HMP Dartmoor was chosen as a comparator as it has the same categorisation as HMP Coldingley. The main differences are that HMP Dartmoor has a resettlement wing where some prisoners access employment in the community, in cell sanitation facilities and the prison has a significant population of sex offenders. At the time of the health needs assessment, there were 146 prisoners (with current/previous sex offences) located in the prison.

3.2.3 HMP Camp Hill

HMP Camp Hill is a closed category C training prison holding adult men on short, medium and long term sentences. Prisoners are received from the local prisons of Winchester, Lewes and the London area. HMP Camp Hill has an operational capacity of 595.
HMP Camp Hill is part of a cluster of three prisons on the Isle of Wight.

HMP Camp Hill was chosen as a comparator due to its categorisation. HMP Camp Hill has a larger population of foreign national prisoners (17.1%) than HMP Coldingley (4%)

3.3 Information sources

A number of sources of information were utilised:
- Independent Monitoring Board reports
- the most recent report from Her Majesty's Prison Inspectorate
- relevant national guidance, legislation and policy
- academic papers
- Prison Health & Quality Performance indicators
- any available needs assessments

3.4 Prison populations

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

Characteristic	HMP Coldingley	HMP Camp Hill	HMP Dartmoor	HMP Featherstone
Operational capacity	513	595	620	687
Lifers (%)	12	Information not available	4	3
Young offenders (%)	0	0	0	0
Foreign nationals (%)	4	14	11	10
Sentenced (%)	100	Information not available	Not Available	100
White British ethnic group (%)	57	Isle Of Wight-73	85	69

Percentages in brackets

Table 3.1 demonstrates the differing profiles of the comparator prisons with HMP Coldingley. Whilst HMP Coldingley has a larger BME population, compared to the other prisons, there are a lower number of foreign national prisoners. The operational capacity at HMP Coldingley is the lowest of the four prisons but it has the highest proportion of lifers. All four prisons are adult establishments with no young offenders in their populations.

3.5 Staff structure

At HMP Camp Hill nursing services were provided by prison employed staff. The total number of nursing staff to cover the three prisons in the cluster was equivalent to 43 wte (including specialist substance misuse staff). A skill mix and needs analysis showed that 56 wte staff were required to run the prison effectively[14].
The health services manager post at HMP Featherstone was vacant for a long period and this had a negative impact on staff morale. All other posts were filled and all staff were employed by the PCT[15].
At HMP Dartmoor the service was managed on a day to day basis by a part time non clinical principal officer who acted as a practice manager. Despite some vacancies

the HMIP felt that the overall nursing mix was good and staffing levels were appropriate[16].
HMP Coldingley has the highest number of wte nursing staff but the lowest proportion with a mental health nursing background.

Table 3.2 Comparison of staffing in HMP Coldingley, HMP Dartmoor, HMP Camp Hill and HMP Featherstone

Area of health care provision	**HMP Coldingley**	**HMP Dartmoor**	**HMP Camp Hill**	**HMP Featherstone**
Staff structure				
No. of WTE general nursing staff	9.6	6	7	8
Proportion of general nursing staff with a mental health background	10%	33%	42%	25%

3.6 Inpatients

All the comparator prisons provide primary care based healthcare service. They do not have inpatient facilities.

3.7 Out patients

HMIP's expected outcome for prison healthcare services is that prisoners should be cared for by a health service that assesses and meets their needs while in prison and which promotes continuity of health and social care on release.

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[17] [18] and that Primary Care Trust boards should agree and sign off these services[19]. 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"[11] [11].

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The last HMIP report of HMP Camp Hill [8] highlighted the lack of skilled staff in primary care. They also commented on the length of the waiting list (50) for the optician and the fact that physiotherapy sessions were not undertaken. However prisoners with musculoskeletal problems were well supported by gym staff.
The IMB report at HMP Featherstone[20] reported concerns around services provided by the PCT, namely the lack of an optician and insufficient dental time. The HMIP report also commented on the long waiting list for other primary care services such as vaccination clinics.

The HMIP report on HMP Dartmoor[10] described a good range of health clinics with chronic disease managed through a lead nurse. There was pressure on the optician and chiropodist clinics that had waiting lists of two and three months respectively.

3.8 Dentistry

The 'Strategy for Modernising Dental Services for Prisoners in England' was published in 2003[21]. 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, HMP Coldingley, HMP Dartmoor and HMP Camp Hill are currently providing a dental service that meets the recommendations for their populations.

HMP Camp Hill held four sessions of dentistry per week and an additional two sessions provided by a dental therapist. The local PCT was also considering bringing in an oral health educator. HMP Camp Hill received recommendations from the HMIP on the standard of dental records and reorganising the dental waiting list so that priority is given to those with the greatest need [8].
HMP Featherstone has developed standardised triaging processes and care pathways and is addressing obstacles to accessing emergency care. However at the last HMIP report the waiting list was 156 with a waiting time of 9-10 weeks. Oral health education was provided on a 1:1 basis[9].
HMP Dartmoor provided a core dental service including oral health promotion on a 1:1 basis with patients. Additional sessions were provided as required[10].
HMP Coldingley provides a comparable number of dental sessions and has begun a number of additional sessions to reduce waiting times.

3.9 Pharmacy

The Department of Health guidance[22] 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.
HMP Camp Hill had its pharmacy provided by the in house pharmacy at HMP Parkhurst. There was no opportunity for prisoners to see a pharmacist. At HMP Featherstone there has recently been improved pharmacy input into the prison but prisoners were still unable to speak to a pharmacist directly. At HMP Dartmoor there were also no pharmacist led clinics and no direct access to a pharmacist.

3.10 Other services

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 Coldingley, HMP Dartmoor, HMP Camp Hill and HMP Featherstone

Area of health care provision	HMP Coldingley	HMP Dartmoor	HMP Camp Hill	HMP Featherstone
Number of inpatient beds	N/A	N/A	N/A	N/A
GP sessions per week	8	5	4	5
Dental sessions per week	4	3	4	2
Optician sessions per week	Monthly	Monthly	Monthly	Monthly
Physiotherapy sessions per week	Monthly	Monthly	Not available in the prison	Not available in the prison
Chiropody/ podiatry sessions per week	1 per month	Monthly	Monthly	Monthly
Pharmacy	Monthly	Not available in the prison	Not available in the prison	Not available in the prison
Sexual health sessions	Monthly	Information not available	Weekly	Not available in the prison

3.11 Substance misuse services

3.11.1 Best practice

The HMIP expectation is 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.

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.

HMP Camp Hill, HMP Featherstone, HMP Dartmoor and HMP Coldingley 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 [11~~11~~].

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3.11.2 Service provision

HMP Camp Hill offers a secondary detoxification service with access to a specialist GP and nurse. There were concerns raised at the last HMIP [8] inspection about the arrangements for administering methadone, particularly around privacy.
HMP Featherstone provided a wide range of support for drug users including CARATS, P-ASRO and a VDT scheme that operated independent of prisoner location. The last HMIP report[9] found that IDTS was often working in isolation without proper access to clinical records, administrative support or a suitable clinical environment.
HMP Dartmoor supports the Clinically Enhanced Programme (CEP) as part of its IDTS programme. Overall demand for IDTS was low.
HMP Coldingley is beginning to expand its IDTS capacity. The establishment must ensure clear protocols are in place for transfer of IDTS inmates into the prison.

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 most of these services did not address the scale of the problem.

3.12.2 Service provision

HMP Featherstone has a well integrated drug and alcohol strategy which was overseen by the head of offender management. However the provision for alcohol consisted of a two day alcohol awareness programme and Alcoholics Anonymous self help groups [9]. CARATs were not contracted to work with primary alcohol users.

HMP Dartmoor had an alcohol policy. The CARATs team had a dedicated alcohol worker who delivered 1:1 work and a two day alcohol awareness course every month. Alcohol testing was undertaken in the resettlement unit for prisoners going out of the prison where a zero tolerance policy was enforced.

HMP Camp Hill has a cluster drug and alcohol policy but there was a lack of alcohol provision. A one day alcohol module was available but the CARATs team were not contracted to provide 1:1 Care with primary alcohol users.

HMP Coldingley currently only offers formal alcohol support to prisoners with a drug dependence. The prison has recently rolled out the use of the AUDIT screening tool but there remains a gap in service provision for prisoners identified through this process.

Table 3.4 Comparison of substance misuse services in HMP Coldingley, HMP Featherstone, HMP Dartmoor and HMP Featherstone

Area of health care provision	HMP Coldingley	HMP Dartmoor	HMP Camp Hill	HMP Featherstone
Substance misuse				
Detoxification wing	Yes	No	No	Yes
CARAT programme	Yes	Yes	Yes	Yes
Voluntary drug testing	Yes	Yes	Yes	Yes
Alcohol screening & treatment	Limited	Limited	Limited	Limited

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[23] addressed implementation of the Mental Health National Service Framework [24] 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[25].

3.13.2 Service provision

The last HMIP report of HMP Camp Hill [8]highlighted the lack of skilled staff in mental health particularly around LD and primary care mental health. There was only one stand alone dedicated CPN working at the establishment dealing with a caseload of 50. Referrals were accepted from prison staff but not prisoners.

The 2009 IMB report for HMP Featherstone[14] has stated that mental health referrals had increased over the preceding year from a variety of sources. Primary care mental health support was only available on a 1:1 basis. Project support and funding is also in place to support development of specialist mental health services in the prison.

The 2009 IMB report [26]for HMP Dartmoor highlighted concerns about the lack of mental health provision in the prison and a lack of staff training in managing mental health issues. Due to sickness levels in the prison in-reach team no service was being provided at the time of the last IMB report. This was a deterioration from the

situation described in the 2008 HMIP report which described both in house and in reach services.

HMP Coldingley provides a range of services via the inreach team. In addition to clinics there is service input from a psychologist, counsellor and movement psychotherapist.

Table 3.5 Comparison of mental health services in HMP Coldingley, HMP Camp Hill, HMP Dartmoor and HMP Featherstone

Area of health care provision	**HMP Coldingley**	**HMP Dartmoor**	**HMP Camp Hill**	**HMP Featherstone**
Mental health services				
Nurse led psychiatric clinics	Yes	No	Yes	Yes
Access (according to need) to a wide range of specialist mental health services	Yes	No	Yes	No
Primary mental health service available	Yes	No	Insufficient	Yes

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 [27] 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[28]- it is estimated that at least 80% of prisoners smoke compared to 24% in the community.

HMP Camp Hill provided smoking cessation services through the gym. At HMP Featherstone smoking cessation services were provided by officers on the healthy living unit. HMP Coldingley and HMP Dartmoor run nurse led smoking cessation services.

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.

HMP Featherstone gym staff ran the prison health trainer programme, walking for life opportunities, an over 55s gym session, remedial gym and were able to treat some soft tissue injuries. Over half the prison population access PE provision with a fair allocation of sessions to all groups and numerous internal events throughout the year. The gym also runs an annual health fair which was well attended.
HMP Dartmoor was also praised by the HMIP for good access to the gym with prisoners attending four or five sessions per week. However the facilities available were limited and there were no suitable outdoor facilities. HMP Camp Hill was praised as a model of good practice for the support of prisoners with health needs and injuries. 70% of prisoners attended the gym at least twice a week. HMP Coldingley has excellent gym facilities. Long term sick leave amongst staff has reduced the number of gym sessions available but a new remedial gym policy is in place.

3.14.3 Other health promotion

HMP Camp Hill provided limited health promotion and there was no overarching health promotion strategy. Any interventions were delivered on a one to one basis and prisoners could request addition information leaflets. There is increasing input from public health around the areas of diet and nutrition.
At HMP Featherstone, HMP Dartmoor and HMP Coldingley a variety of health promotion leaflets were available in the healthcare waiting area. HMP Coldingley has recently established a Health Promotion Action Group (HPAG) which includes prisoner representation.

Table 3.6 Comparison of health promotion in HMP Coldingley, HMP Camp Hill, HMP Dartmoor and HMP Featherstone

Area of health care provision	**HMP Coldingley**	**HMP Dartmoor**	**HMP Camp Hill**	**HMP Featherstone**
Health promotion				
Whole prison multi agency steering group	Yes	Information not available	No	Information not available
Smoking cessation services available	Yes	Yes	Yes	Yes
A range of physical exercise programmes available appropriate to prisoners health needs	Yes	Yes	Yes	Yes
Expert Patient programme in prison	No	Information not available	Information not available	Information not available

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 infectious 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 [29]. 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) [30].

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[31]. 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 achieved red status in the Health Protection Agency HBV surveillance programme (July to September 2009) except for HMP Dartmoor which was amber.

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[32].

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[33].

HMP Camp Hill held weekly sexual health clinics run by the nurse consultant specialist from the local hospital. Chlamydia screening was offered to all patients but was not rolled out across the prison. Condoms were available. HMP Dartmoor has a nurse led sexual health clinic.HMP Featherstone did not have an in house GUM services but a model has been developed and agreed. Barrier protection was available from health service staff and there were posters about sexual health around the prison. HMP Coldingley has a monthly sexual health clinic run by a GUM consultant. Barrier protection is available on request.

3.15.4 Infection control

HMP Camp Hill had not undertaken an infection control audit and it was recommended by HMIP that one was commissioned and any recommendations arising from it actioned. HMP Featherstone had undertaken an audit but the findings were yet to be acted on. HMP Dartmoor and HMP Coldingley both had a designated infection control nurse, an audit had been undertaken and its findings were being acted on.

Table 3.7 Comparison of communicable disease control in HMP Coldingley, HMP Camp Hill, HMP Dartmoor and HMP Featherstone

Area of health care provision	**HMP Coldingley**	**HMP Dartmoor**	**HMP Camp Hill**	**HMP Featherstone**
Communicable disease control				
Access to condoms & lubricant	On request from healthcare staff	On request from healthcare staff	On request from healthcare staff	On request from healthcare staff
HPA's Prison Infection Prevention Team's National Surveillance Programme Hepatitis B vaccine status (July – Sep 2009)	Red	Amber	Red	Red
Chlamydia screening	No	Information not available	No	No

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[34]. 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[35].

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[36].

3.16.2 Service provision

HMP Coldingley has a quarterly Patient Consultative Meeting held between the Lead Nurse and representatives from each of the wings. HMP Camp Hill did not have any structured prisoner groups to discuss healthcare issues at the time of the last HMIP inspection.

Table 3.8 Comparison of user involvement in HMP Coldingley, HMP Camp Hill, HMP Dartmoor and HMP Featherstone

Area of health care provision	**HMP Coldingley**	**HMP Dartmoor**	**HMP Camp Hill**	**HMP Featherstone**
User involvement				
Prisoners views on healthcare sought & acted upon	Yes	Information not available	No	Information not available

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. As part of this prisoners are asked about their health and their views on health

3.17.1 Health problems on arrival

Questions were asked specifically about problems with drugs, alcohol, depression/ suicidality and general health on arrival. The results for the prisons are in Table 3.9. Any significant vulnerable groups within the prison are sampled and analysed in addition to the main population.

Prisoners at HMP Camp Hill reported significantly higher levels of poor general health on arrival in prison but levels were comparable across all four establishments. The levels of drug and alcohol abuse were very high at HMP Camp Hill compared with the other prisons. Levels of suicidality were not different between the prisons but were significantly higher in HMP Dartmoor compared with HMIP comparators.

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

Area of self reported health problem	HMP Coldingley	HMP Featherstone	HMP Dartmoor	HMP Camp Hill
Drugs	23%	23%	11% (12%)	34%
Alcohol	17%	17%	9%* (5%)	30%
General health	20%	20%	21%* (16%)	23%* (18%)
Depression/suicidality	15%	15%	16%* (13%)	12% (14%)

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. Similar proportions of prisoners at HMP Camp Hill reported accessing healthcare at reception and in the first 24 hours. In the other prisons there was a drop off in access in the first 24 hours. Follow up care was received by a significantly higher proportion of prisoners at HMP Camp Hill than local comparators. Reception care was received by a significantly higher proportion of prisoners at HMP Dartmoor than local comparators.

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

	HMP Coldingley	HMP Featherstone	HMP Dartmoor	HMP Camp Hill
Reception	91%	91%	91%* (88%)	89% (92%)
Access in first 24 hours	81%	81%	73% (72%)	86%*(74%)

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. Prisoners at HMP Camp Hill were significantly more satisfied with the quality of healthcare than those in other comparator prisons. Prisoners at HMP Dartmoor had similar levels of satisfaction to other HMIP comparators. Direct comparison data was not available for HMP Featherstone. Data for HMP Coldingley was derived from this needs assessment as there were no views sought on healthcare in the 2008 HMIP inspection. Overall only Camp Hill had more than 50% of prisoners giving a positive view on the quality of healthcare services.

Table 3.11 Prisoners views on overall healthcare quality

	HMP Coldingley	HMP Featherstone	HMP Dartmoor	HMP Camp Hill
% stating overall quality of healthcare good/very good	2%[#]	38%	43% (45%)	53%* (47%)

Figures in brackets are the average from local comparator prisons. Those marked * show statistically significant difference between the jail being inspected and local prisons
[#] data from needs assessment

3.18 Prison healthcare quality & performance indicators

In 2005 ministers agreed that a set of indicators should be developed specifically to measure the quality of prison health services and to help achieve the objective of NHS equivalent standards. It is intended that the indicators should drive up performance, provide quality assurance for stakeholders and strengthen local partnerships and commissioning. Prison health should also integrate into mainstream performance systems.

The indicators for 2009 were presented by relative performance (compared to prison type) and variance from average. The areas in which individual establishments were above average for other prisons of their type is presented in Table 3.12. Information on the indicators were not available for HMP Dartmoor.

Table 3.12 Relative performance compared to prison type

	HMP Coldingley	**HMP Featherstone**	**HMP Camp Hill**
Indicator group			
Safety	• Patient safety	• Patient safety • Medicines management • Personal development plans • Continuity of case management	• Patient safety
Clinical & cost effectiveness			
Governance	• Personal development plans	• Clinical governance	
Accessible & responsive care	• Substance misuse (non IDTS) • General health assessment • Secondary health screen	• Prison dentistry • IDTS • General health assessment • Secondary health screen • Supporting diversity • Service user involvement • Health needs assessment • Access and waiting times	• Prison dentistry • IDTS • General health assessment
Mental health	• Section 117 • CPA Audit • Suicide prevention	• Section 117 • CPA • Suicide & self harm	• Section 117
Public Health	• Communicable disease control • Exercise	• Health Promotion Action Groups • Exercise	• Sexual health

HMP Featherstone reported above average for a large number of indicators. None of the prisons performed above average for clinical and cost effectiveness.

3.19 Examples of best practice from other prisons

- HMP Featherstone runs a Drug Peer Support service that offers help and advice to prisoners
- HMP Featherstone has a well managed and coordinated drug and alcohol strategy
- HMP Dartmoor has developed a protocol on care for older prisoners with a named nurse lead. This approach provides a holistic approach to patient management, and regular mental and physical health monitoring has enabled early health interventions to be put into place.

3.20 Examples of good practice at HMP Coldingley

- The patient consultative group was highlighted in the 2008 HMIP report as an example of good practice in user involvement

- The prison is establishing a prisoner council with members elected by fellow inmates. The council will be chaired by the Residential Governor and will address a number of issues including health. Prisoner representatives from the HPAG will also sit on the Council.

- HMP Coldingley's management of a norovirus outbreak in December 2009 is being used as the basis of best practice guidance for other prisons. The outbreak was managed and contained despite the lack of in cell sanitation in the majority of the establishment.

4. Corporate Health Needs Assessment

The Corporate Health Needs Assessment gathered the views and opinions of offenders, prison staff and healthcare staff.

4.1 Focus groups

Focus groups were arranged through a Senior Officer, with a focus group scheduled to be held on each of the five wings. In total, four focus groups were delivered and the fifth had to be cancelled due to unforeseen circumstances on the day.

Posters were put on each wing advertising the date, time and venue of the focus group. All wing officers were asked to encourage prisoners to participate. Prisoners were able to attend the focus group through their own choice, reducing the chance of the sample being influenced

Each focus group had five participants. Focus groups were facilitated by members of the NHS Surrey Public Health Team. One facilitator had previous experience of leading focus groups, the other had experience of leading and delivering group based support.

At the start of the group, all prisoners were informed that the purpose of the group was to gain information for the health needs assessment and to help improve health services. All participants were informed that their views were confidential and anonymous. With the agreement of the participants, the group was recorded using a Dictaphone. The recording was then transcribed, analysed and then destroyed. Notes were also made to validate the transcription.

On the day of the focus groups, some participants had arranged to come to the group and others were on the wing at the time and were opportunistically invited to participate.

A focus group schedule was developed to ensure that a standardised approach was adopted (See Appendix A)

In addition to the focus groups, during association time and wing visits, twenty prisoners chose to participate in mini-interviews. To maintain confidentiality, no monitoring information was collected from the participants.

4.2 Results

The feedback was transcribed and key themes were identified. A thematic approach was used to analyse the findings, which were then grouped and split into different categories.

4.2.1 General Health concerns

Gym

- Prisoners were concerned that it was becoming increasingly difficult to make healthy choices as there were too many obstacles.
- An example described in all the focus groups was difficulty in using the gym as there were limited opportunities and trying to fit it into duties, prison regime and visits was challenging. Prisoners reported that the remedial gym was good when it worked, however access was difficult. The most common

reason for this was that when prisoners got referred to the gym the officers refused to accept their form.

Motivation

- Many of the prisoners felt that they didn't have anyone encouraging them to improve their health through changing their lifestyle. As a result many prisoners reported that they had seen other prisoners *"give up through lack of motivation"*

Diet

- Prisoners felt that there were limited opportunities to eat healthy food; many described the food as lacking in nutrients.
- When asked about the purchase of healthy food options available through the canteen list, prisoners reported that they could not afford to buy them as they were too expensive. Prisoners reported that the weekly prison wage of £2.50 had remained consistent for some years; however the overall price of the canteen list had increased.
- A concern for some of the prisoners was their poor relationship with food. When asked for more information, two prisoners reported ordering biscuits and several Mars bars from the canteen and eating them all within a few hours. They felt that for a few hours it made them feel "happier", but this was followed by low moods. They reported witnessing :-

    - Binge eating
    - Comfort eating
    - Eating then making themselves sick (Bulimia)
    - General poor eating habits, e.g. consistently choosing food with high carbohydrate and fat content from the menu

Communication

- The lack of communication about Swine Flu was a major concern for prisoners. Many felt that the information received were limited and contained mixed messages

Mental health

- In all the focus groups, prisoners reported that they had on occasions experienced low moods and didn't feel that they could talk to an officer on the wing. When asked if they could access anyone else to speak with informally the most common response from prisoners was that they lacked knowledge of who to speak to. Prisoners felt uncomfortable accessing the listeners, and felt that there wasn't any information about mental health on the wings. Many felt that HMP Coldingley could do more to increase the awareness of mental health issues by providing accessible information on what to do if you feel low.

Healthcare

- A small number of prisoners reported that they had a good experience of healthcare; however a large number of prisoners felt that there were not enough healthcare staff and as a result they were always rushed and busy.

- Many prisoners reported that they choose to self- medicate for minor ailments as this was viewed as quicker than waiting to see healthcare. Some prisoners also felt that it was inappropriate to go to healthcare for complaints that they could manage themselves. An example of these complaints included headaches, vomiting and diarrhoea, general aches and pains.

- In all the focus groups prisoners reported experiencing a long wait to obtain treatment. When asked how long, prisoners reported that they could see a nurse within days but had to wait a few weeks to see the doctor. Many said that in that time their health complaint had either resolved or got worse. Some prisoners reporting witnessing other prisoners health complaints getting so bad that they had to go to hospital
- Prisoners reported feeling frustrated at the waiting times to see a doctor. Some prisoners had seen nurses being confronted by other inmates about this issue during wing visits.
- Several participants complained of waiting months for an external appointment and felt that when they asked healthcare staff they had no information on how long they would be waiting.
- Prisoners felt that there was no continuity of care; some felt that it was up to them to justify their existing health complaints.
- Prisoners reported that when they did receive healthcare appointment slips it was normally after the appointment so they ended up missing their slot.
- Prisoners felt that new comers weren't receiving the same health checks that they used to two years ago. They reported a "rushed" health check at reception. Some prisoners reported waiting in reception for health care staff.
- Prisoners reported concerns that health care refused to prescribe medication that had been prescribed to them before coming to Coldingley. Prisoners were aware of some of the reasons for this, but felt that better communication from healthcare would have relieved their concerns and anxieties.

4.2.2 Healthcare Staff

- Prisoners felt that the nurses were quick to respond to medical emergencies.
- A quote from a prisoner about healthcare staff described the feedback that was repeated in all the focus groups *"The nurses do a really good job, some of them- the ones that we see often are always helpful and talk to us like we are human. They go out of their way to help us. Unfortunately some of the nurses look down at us like we are dirt, the doctor doesn't do anything"* There was a strong feeling from prisoners that the nurses lacked autonomy- they felt that nurses appear to be doing the majority of the healthcare and should be allowed to make more decisions. Some prisoners reported that "*sometimes you can see the frustration in the nurse's faces; their hands are tied behind their back, they know exactly what to do but aren't allowed to".*
- Prisoners reported varied experiences of healthcare staff. There was consistently negative feedback about their experiences of seeing a doctor. Prisoners were asked for examples of why they were unhappy with the doctors. The responses included the doctor talking down to them and they felt judged and degraded. Some prisoners reported that the doctor did not examine them and prescribed paracetamol or remedial gym. They felt that the doctors failed to take people seriously. Several prisoners described the doctor as "*assuming that everyone was after sleeping tablets"*.
- Several prisoners felt that the some healthcare staff did not address their health concerns, and reported coming away from the appointment feeling low, not valued and degraded.
- Some prisoners felt that there was a lack of investigation into health complaints by some healthcare staff. They felt that they were sent away with antacids and paracetamol.
- In all the focus groups, some prisoners reported that they felt that they did not have confidence in the healthcare staff.

4.2.3 Officers

- In all the focus groups, prisoners reported witnessing a lack of communication between the healthcare staff and officers.
- One prisoner felt that the lack of communication between officers and healthcare staff was responsible for him not finding about a hospital appointment until his escorts arrived to take him to the hospital. He explained that he had waited months for an appointment. When he got to the appointment he was told he should have fasted for his investigation. As a result, he was unable to have the tests and then had to wait months for a new appointment
- Prisoners were unhappy with officer's responses to the F35. They had experienced officers refusing to accept the F35 form issued for pillows or a new mattress

4.2.4 Dental care

- Prisoners were very unhappy with the dental care at HMP Coldingley. They felt that there were not enough dental appointments available. Many prisoners reported waiting longer than six months to see a dentist for treatment. They felt that it was a battle to see a dentist and had put in duplicate applications before they were seen. Prisoners were able to get pain relief from a nurse.
- Prisoners felt that the standard of treatment from the dentist was good.
- The dental care available was unclear to prisoners. They were unaware of what treatment the dentist could administer. Some prisoners asked why they couldn't have their teeth cleaned and polished as they felt this would have prevented subsequent infections.

4.2.5 Substance misuse

- HMP Coldingley had a well established drug treatment programme that prisoners were aware of. They felt that the access to drug treatment was efficient, and the treatment itself was very good.
- Prisoners reported that there was lots of advice and information in the prison on substance misuse.
- One prisoner reported successfully completing the RAPt programme and found this had a positive and powerful impact on his life. However, he did feel that since graduating from RAPt there was no follow up or through care.

4.2.6 Medication

- During dispensing of medication prisoners described incidents when prisoners causing disruption. As a result prisoners had to wait longer to get their medication and this affected the daily schedule. Prisoners felt that *"a lack of officer presence was the cause of these problems"*. On instances when an officer had been called by healthcare, the medication was administered promptly and without disruption.
- Prisoners reported going without medication for a few days as the repeat prescription had not arrived on time

4.2.7 Health improvement

- A prisoner led health promotion service was available at HMP Coldingley. The health promotion officer provided advice on weight management, physical activity and healthy eating. Many prisoners were aware of this facility and were happy with the support received. Some prisoners felt that more

health promotion workers were needed to ensure that more people had the opportunity to benefit from this service.
- Prisoners felt that there was a lack of time in the prison schedule to exercise.
- Many prisoners reported that whilst the stop smoking clinic works really well, there was a long waiting time.
- Prisoners felt that the quality of the food was poor and that the food lacked nutrients. However, the majority of prisoners reported that there are always healthy food options available.
- Some prisoners reported a lack of hygiene at meal times. The routine was to queue for food then take the food back to their cell. After collecting their meal, they had to walk past the food queue. Prisoners felt that a cover for their plate would prevent people coughing into their meal.

4.2.8 One change

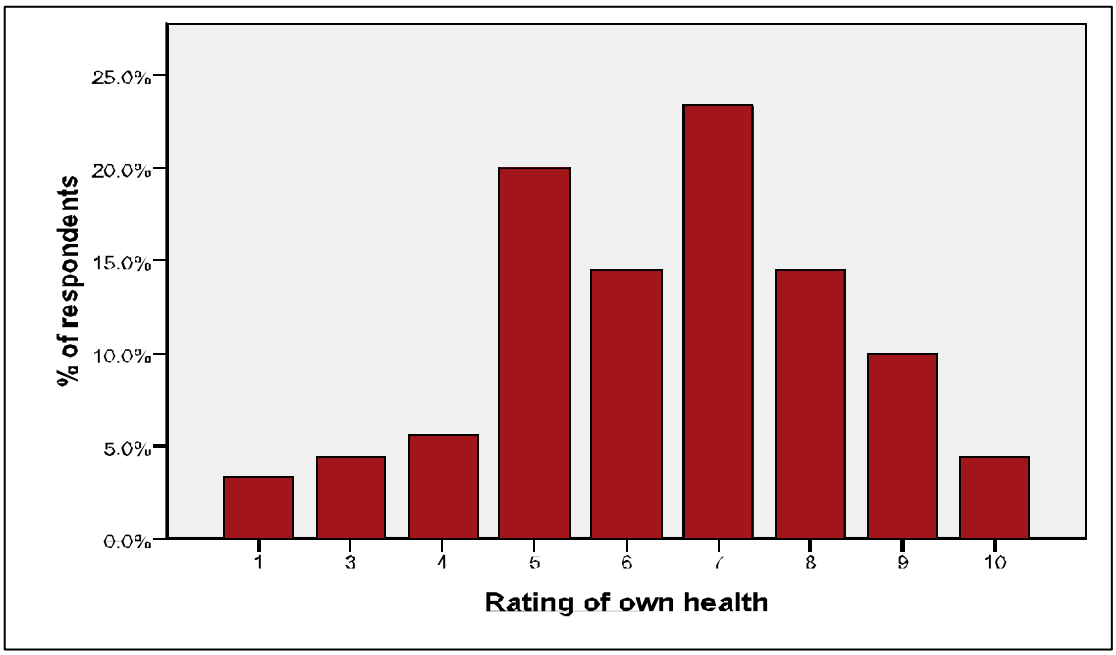
- Prisoners reported that in the past the Orderlies had a meeting with the Governor to discuss issues and complaints. They felt that reinstating this meeting would mean that they have the opportunity to voice the concerns of the prisoners. They felt that better communication from healthcare staff would resolve many of the prisoners concerns.
- Prisoners felt that healthcare staff should invite prisoners for a “health check” appointment. This would give prisoners the opportunity to prevent health issues developing.
- Private dental care access was a common theme for prisoners. Many prisoners felt that if they had access to a private dental care facility in the prison, they could be seen promptly and it would also take the pressure off the existing NHS dental care provision.
- Prisoners reported a need for better communication between healthcare staff and officers.
- All the prisoners that participated in the focus group felt that there should be more opportunity to exercise.
- Prisoners felt that HMP Coldingley officers and healthcare staff needed to respect them as people.
- The centralised Healthcare facility was seen as a barrier to establishing a rapport with healthcare staff. Many Prisoners suggested that each wing could have allocated nurses. In their opinion prisoners would be able to establish a rapport with the healthcare staff and in turn feel more confident that their treatment was being delivered efficiently and effectively. This they felt would also improve communication between the officers and the nurses.

4.3 Questionnaires

Every prisoner received a questionnaire through a cell drop. A box was left on each wing for the return of the questionnaires. Of the 513 questionnaires delivered, 90 questionnaires were completed and returned, a response rate of 18%. All prisoners were given a month to return their completed questionnaire.

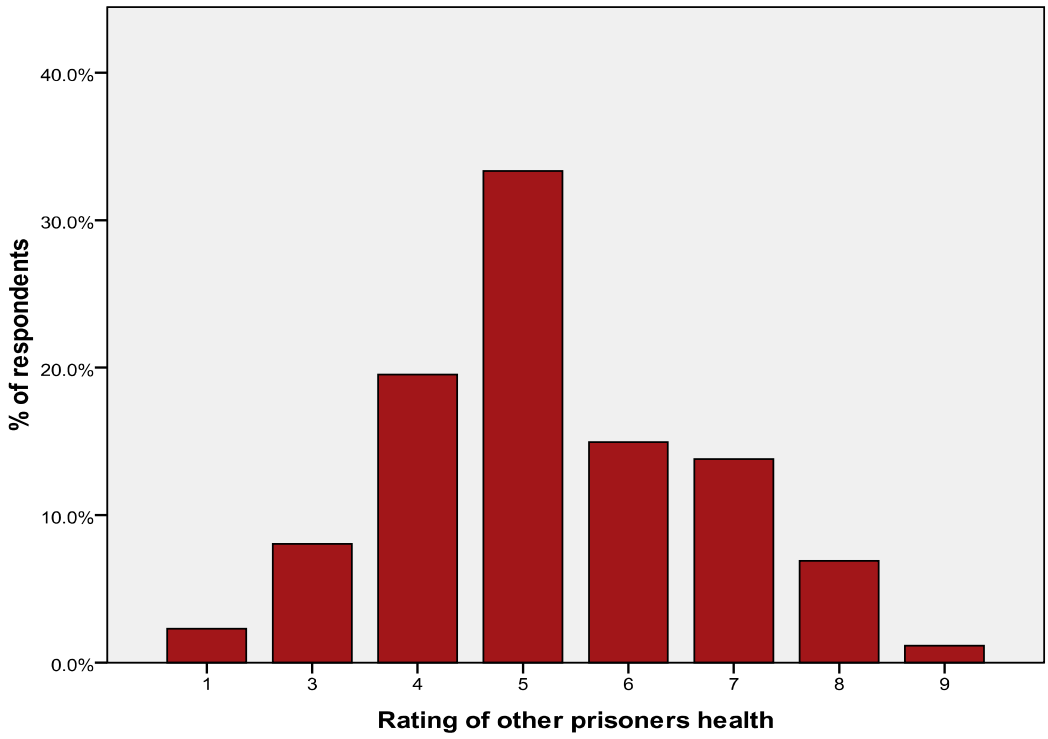
4.4 Results

Figure 4.1Prisoner's rating of their own health



Prisoners were asked to rate their health on a scale of one to ten, One being bad, ten being very good. The mean for the prisoner rating of own health was 6.4.

Figure 4.2 Prisoners rating of other prisoner's health



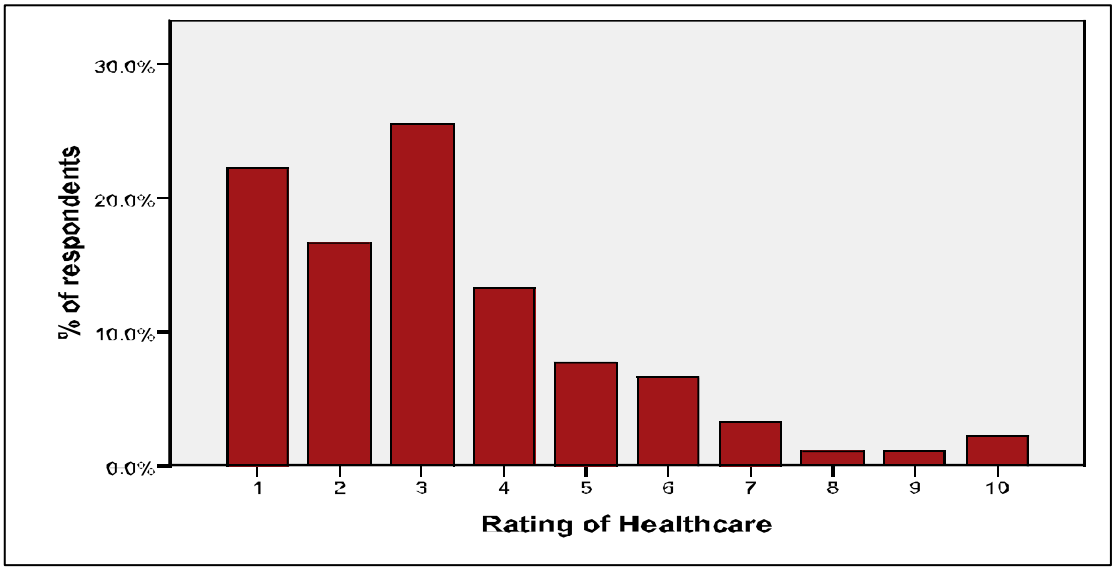
Prisoners were asked to rate the health of other prisoners on a scale of one to ten (one- bad, ten- very good).The mean for the prisoner rating of other prisoner's health was 5.

Table 4.1 Prisoner visits to healthcare

Prisoners who had visited	Yes	No
Doctor	80%	20%
Nurse	93%	7%
Optician	28%	72%
Dentist	39%	61%
Other	17%	83%

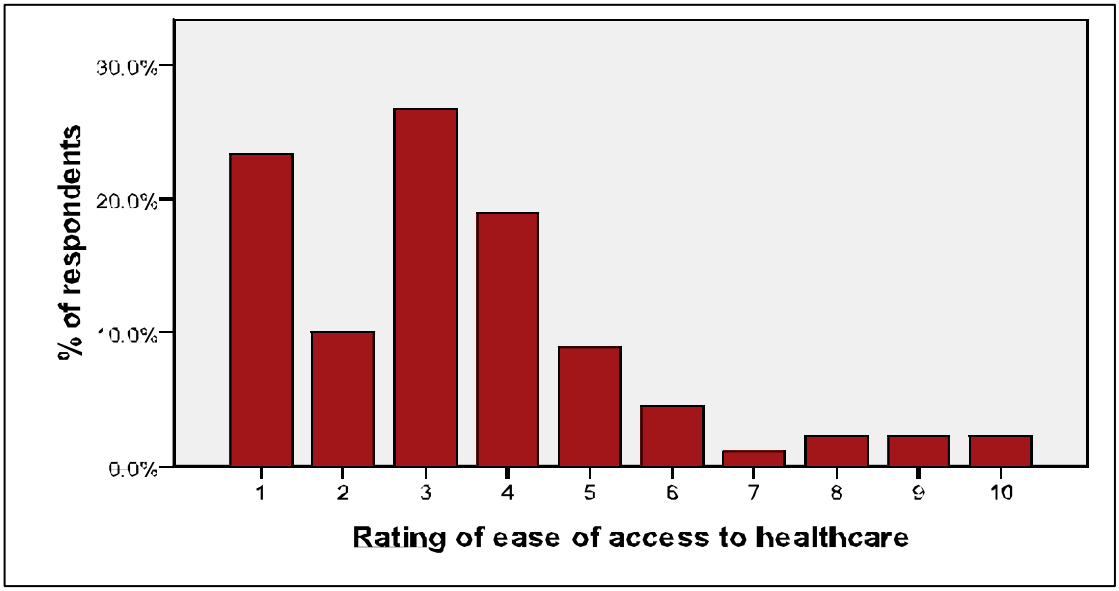
Prisoners were asked if they had visited a nurse, doctor, dentist or optician during their stay at HMP Coldingley. Most prisoners had seen a nurse (93%) or a doctor (80%) since they had come to HMP Coldingley. The other services that prisoners had visited whilst at HMP Coldingley included the chiropodist, physiotherapist, pharmacist and mental health.

Figure 4.3 Prisoner rating of healthcare services in HMP Coldingley



Prisoners rated healthcare on a scale of 1 (very bad) to 10 (very good). The mean healthcare rating by prisoners was 3.28. 22% of the respondents rated healthcare as very bad compared with 2% of respondents rated healthcare as very good.

Figure 4.4 Prisoner rating of ease of access to healthcare services



Prisoners rated access to healthcare on a scale of one (very bad) to ten (very good). The mean rating for access to healthcare at HMP Coldingley was 3.4. 23% of respondents rated healthcare as very bad compared with 2% of prisoners who rated access to healthcare as very good.

The ratings of ease of access to healthcare were very similar to the rating of healthcare.

4.4.1 Reception
40% of prisoners reported that they were able to discuss all their health problems at reception. 33% reported that they were only able to discuss minor problems whilst at reception. 24% of prisoners reported they could not discuss health problems.

4.4.2 What works at healthcare in HMP Coldingley
30% (27) of respondents could not provide an example of what worked well in healthcare. Of the 70% (63) of prisoners that responded 49% (31) felt that nothing worked well in healthcare. 11% (7) reported that the nurses worked well. 8% (5) felt that everything worked well. 6% (4) reported that the nurses' appointments worked well.

4.4.3 What could be better at healthcare in HMP Coldingley
83 prisoners provided an example of what they felt could be improved in healthcare at HMP Coldingley. Of the 83, 16% (13) respondents felt that everything in healthcare could be improved. 14% (12) felt that waiting times needed to be reduced. 10% (8) felt that the attitudes of staff could be improved. 7% felt that the dental care could be improved.

As part of the questionnaire prisoners were given statements and asked whether they agreed, don't know or disagreed with the statements presented.

Table 4.2 Degree of prisoner agreement with statements on healthcare

Statement	Agree	Don't know	Disagree
I feel cared for by staff on the healthcare unit	27%	27%	46%
Healthcare staff are interested in helping me with my physical health concerns	32%	28%	40%
Healthcare staff show understanding for my mental health and emotional concerns	12%	41%	47%
I am happy with the treatment I have received for my health problems	19%	17%	64%
I always get the medicine I have been prescribed when I should	28%	18%	54%
When I am given medicine I am told how to use it and problems to look out for	32%	20%	48%
If I was really ill, I would be seen quickly by healthcare	17%	34%	49%
Healthcare staff explain things clearly to me	25%	26%	49%
The doctors here always believe me when I tell them about my health problems	14%	21%	65%
I can get information and advice on how to stay healthy in prison	36%	34%	30%
Coldingley is good at helping people if they feel low	9%	37%	54%
I would know where to go for help if I felt low	35%	26%	39%
Coldingley is good at helping people who might hurt themselves	12%	63%	25%
Statement	**Agree**	**Don't know**	**Disagree**
My privacy and confidentiality are respected			
At reception	39%	33%	28%
At the hatch	22%	30%	48%
When I make an application for health care	39%	39%	22%
When I'm seeing a doctor or nurse	49%	31%	20%
Prisoners are treated with respect by health care staff no matter what their:			
Sexual orientation	30%	58%	12%
Disability	31%	48%	21%
Race/ Nationality	39%	43%	18%
Age	41%	41%	18%
Religion	39%	46%	15%

4.4.4 Interaction with Healthcare staff

The responses to the statements reflected a negative view of prison healthcare. Almost half (49%) of the prisoners felt that healthcare staff did not explain things to them. Only 27% of the prisoners felt cared for by healthcare staff. When asked if they were happy with the treatment that they had received only 19% agreed and 64% disagreed. 49% of respondents felt that if they were really ill, they would not be seen quickly by healthcare.

65% of respondents felt that the doctor didn't believe what they said about their health problems.

A large percentage of prisoners were unhappy with the prescribing and dispensing of medication. Over half (54%) of the respondents believed that they could not get the medicine prescribed for them when they needed it. Only 48% of prisoners felt that when they are given medicine they are told how to use it and problems to look out for.

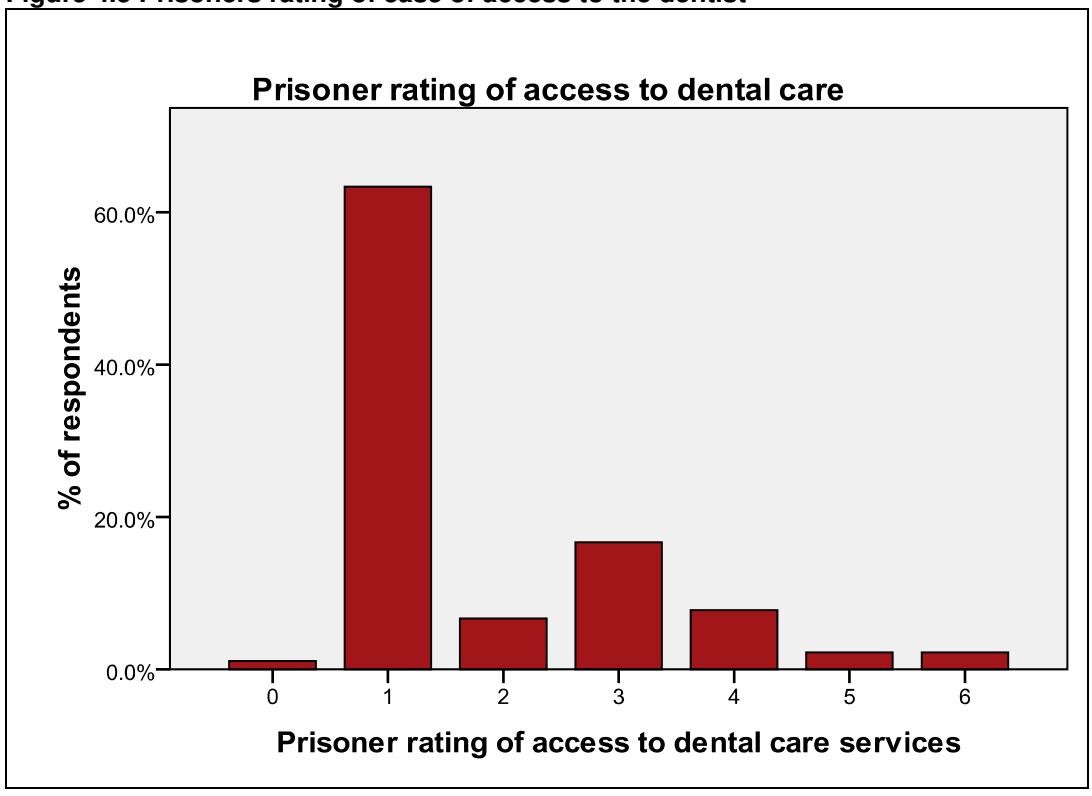
Only 12% of respondents felt that Healthcare staff showed an understanding for their mental health and emotional concerns and 47% disagreed.

Between 30% and 41% of prisoners felt respected by healthcare. 49% of prisoners agreed that their confidentiality was respected when they are seeing a nurse or doctor. 48% of prisoners felt that their confidentiality was not respected at the hatch.

63% of prisoners agreed that if they needed to make a complaint about healthcare, they knew how to do this. Only 9% agreed that their complaints were listened to, with 49% disagreeing that their complaints were listened to.

56% of Prisoners believed that they were not asked for their ideas on how healthcare could be improved.

Figure 4.5 Prisoners rating of ease of access to the dentist



Prisoners rated access to dental care on a scale of one (very bad) to ten (very good). The mean rating for access to dental care at HMP Coldingley was 1.8. Over 60% of prisoners believed that access to dental care was very bad.

Table 4.3 Attendance at the dentist in prison

Accessed dentist in prison	Total	Percentage
Less than one month ago	5	6%
1- 6 months	21	23%
6 months- 1 year	18	20%
1- 3 years ago	18	20%
longer than 3 years ago	9	10%
never	14	15%
not stated	5	6%
Grand Total	90	100%

As Coldingley has prisoners with long sentences and life sentences, it was irrelevant to ask when they had last seen a dentist outside prison. Instead prisoners were asked if they had accessed a dentist outside prison. Only 30% (27) prisoners had accessed a dentist outside prison.

51% of prisoners reported that it had been over six months since they had last visited at dentist. 15% of prisoners reported that they had never seen a dentist in prison.

Table 4.4 Last reported incident of self reported dental pain

	Total	Percentage
last 24 hours	20	22%
past week	14	16%
past month	16	18%
past 6 months	21	23%
longer	18	20%
never	1	1%
Grand Total	90	100%

22% of prisoners reported that they had experienced dental pain in the last 24hours.

4.4.5 Healthcare experiences outside HMP Coldingley

67% of prisoners were registered with a GP outside of prison. 89% had visited a nurse or GP outside of prison**.** 82% of these prisoners felt that the health care was better in the community.

98% of prisoners had accessed healthcare in another prison. 70% of these prisoners felt that the healthcare was better in another prison. 6% felt that the healthcare was better at Coldingley. 22% felt that the healthcare was the same.

4.4.6 Health Promotion and Healthy Lifestyles

- 36% of prisoners agreed that they could get information and advice on how to stay healthy in prison, 30% disagreed
- Over a third (35%) of prisoners agreed that they knew where to go to if they felt low. 54% disagreed that Coldingley was good at helping people that felt low. 63% didn't know if Coldingley was good at helping people that might hurt themselves.

- 52% (47) of prisoners reported that they smoked. 68% (32) of the prisoners that reported to smoking agreed that they knew how to access support to stop smoking. 9% (4) reported that they did not know how to access stop smoking support.
- A third (33%) of prisoners agreed that the food at Coldingley was good for them. 36% disagreed
- Over half (53%) of the prisoners agreed that they could buy healthy food options from the canteen.
- 54% of prisoners agreed that they could exercise every day.
- Only 22% of prisoners agreed that they could get a special programme at the gym.
- 55% agreed that if they had a problem with drug use, help was available.
- 48% of prisoners agreed that they were offered the hepatitis B vaccination when they came to HMP Coldingley.

4.4.7 Improvements

Prisoners were asked which health improvements would be most beneficial. The prisoner's responses are ranked in order of popularity.

1.	Healthier food	86%
2.	More exercise	84%
3.	Information on how to stay healthy	77%
4.	Special gym programme to help with health problems	61%
5.	Help planning for when returning home (re health)	57%
6.	Injections to stay healthy in prison	56%
7.	Help to deal with emotions (e.g. feeling worried, angry or sad)	40%
8.	Help to manage long-term health problems (e.g. diabetes, heart disease)	38%
9.	To give up smoking	34%
10.	Advice/ information about sexual health (e.g. contraception)	26%

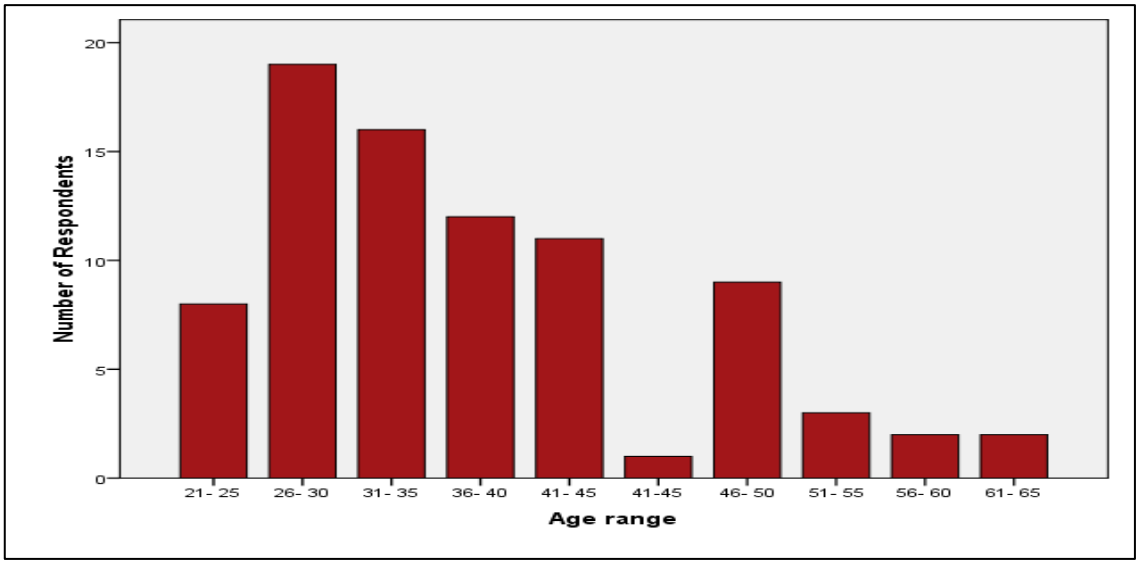
86% of prisoners felt that they would benefit from healthier food options. 84% of prisoners felt that they would benefit from more exercise.

4.4.8 One change
Prisoners were asked for one change to improve health at HMP Coldingley. These are ranked in order of frequency.

Improve diet- quality and quantity of food	9%
Waiting times- to see a doctor/ dentist	7%
Gym	7%
Doctor	6%
Healthy lifestyles clinic- exercise/ diet advice	4%
Nothing	4%
Staff	4%
Efficiency	3%
Increase opportunity to exercise	3%
Staff attitude	3%
Medication time	2%
stop smoking support waiting time	2%

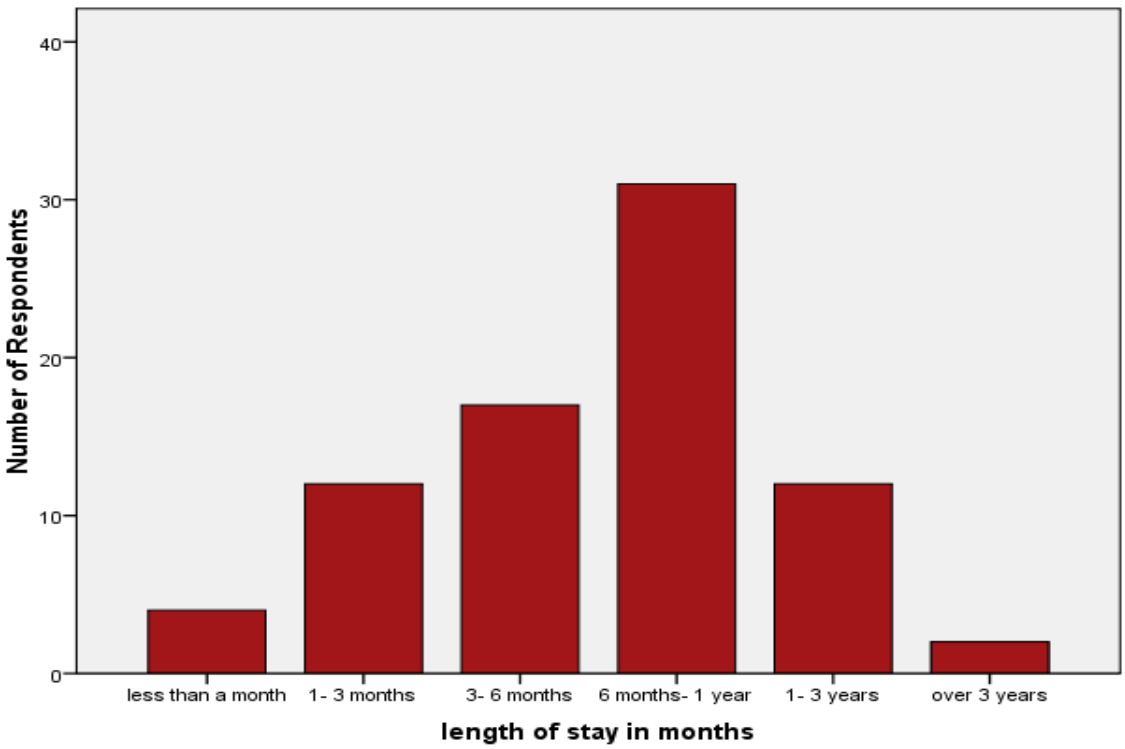
4.5 Demographics

Figure 4.5 Age distribution of the respondents



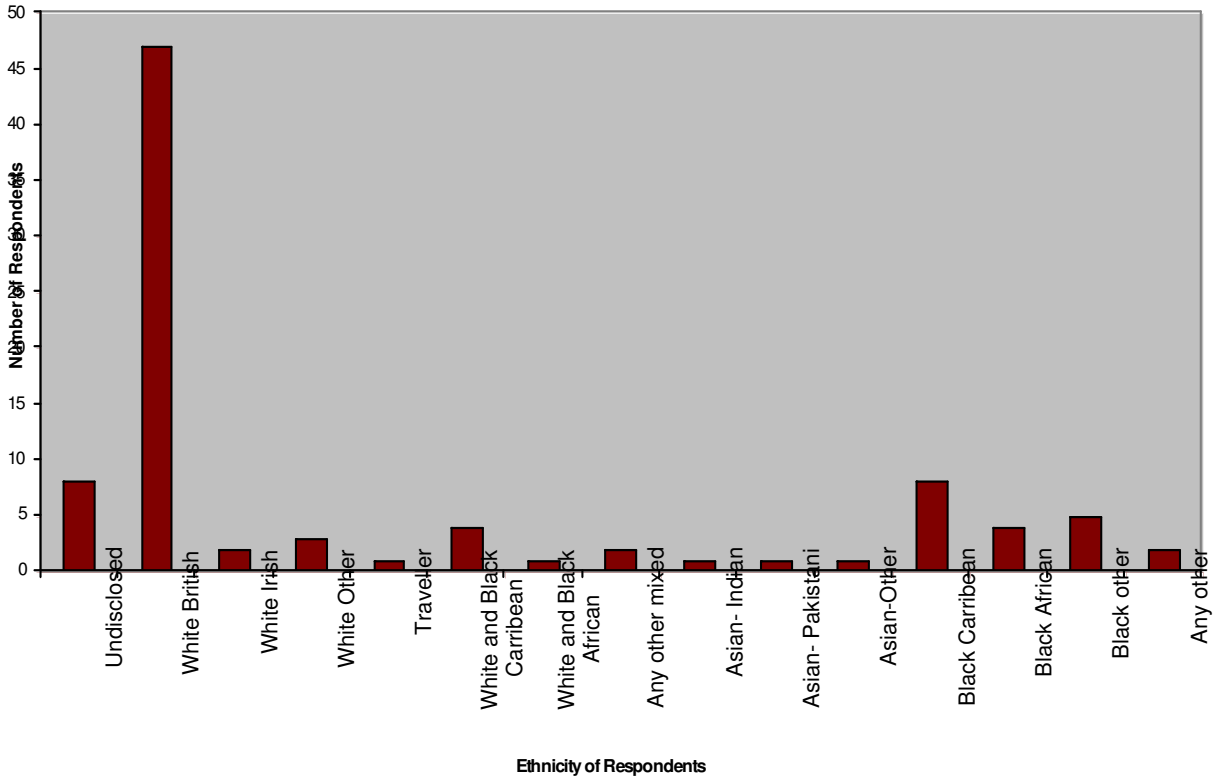
Prisoners were asked how old they were, 83 prisoners stated their age, and 7 prisoners choose not share their age. Of this 83, 23% of respondents were 26- 30 years old. Based on age of the population on the prison, there was a good reflection of the age groups at HMP Coldingley. However there was an underrepresentation of prisoners in the 21- 25 age range.

Figure 4.6 Length of stay in HMP Coldingley for questionnaire respondents



The average amount of sentence that prisoners had served at HMP Coldingley was 10 months, with a large proportion already serving between 6- 12 months at HMP Coldingley.

Figure 4.7 Ethnicity of respondents



The ethnicity of the respondent was a good representation of the overall population at HMP Coldingley.

4.6 Prison Staff

A focus group was arranged through a Senior Officer at the prison. In total, seven officers participated in the focus group. Three were senior officers and four wing officers. The group was facilitated by two members of the Public Health Team.

The participants were informed that the purpose of the group was to gain information for the health needs assessment. The officers were informed that this would help understand the health needs of prisoners and improve the services.

Officers were asked:-

1. What do you think are the three main health concerns for prisoners in Coldingley?
2. Describe the process of a prisoner accessing healthcare
3. What training have you had to deal with out of hour's health emergencies?

4. Are there any other training courses that would help you to improve/ understand the healthcare of the prisoners
5. What health related training have you received

4.7 Results

4.7.1 Prison Regime
Officers felt that there was lack of understanding of the prison regime by healthcare. They had experienced many incidents when healthcare appointments conflicted with the prison regime.

4.7.2 Reception screening
Officers felt that healthcare needed to understand more about the reception screening process and attend promptly to see prisoners and prevent any delays. They felt that whilst the healthcare screening is important healthcare staff took too long and failed to turn up when they were required.

4.7.3 Relationships with healthcare staff
Officers felt that there was no relationship or interaction between themselves and healthcare. The only time that there was interaction was at reception and in the segregation unit. As a result officers felt that they didn't understand what healthcare provisions the healthcare unit offered.

Officers felt that there wasn't time in the prison regime to interact with healthcare staff. The high volume of agency staff was also seen as a barrier in developing relationships with healthcare.

4.7.3 Prisoner health
Officers felt that the long waiting time to see a dentist was the biggest concern for prisoners. The gym was seen as an excellent facility, but was underused because prisoners choose not to use it.

Officers expressed concerns that healthcare staff sent prisoners to A&E for ailments that they felt healthcare staff should be dealing with.

4.7.4 Out of Hours Healthcare Provision
Concerns were consistently raised about the out of hour's healthcare provision. Officers felt that NHS Direct and Thames-doc were providing a service; prisoners should not need to be sent to an outside hospital. In these instances, two officers would be needed for escort. As a result there would be staff shortages and wings would have to be closed.

4.7.5 Prison Population Management
The healthcare governor at HMP Coldingley reported that it was difficult to inform the healthcare team of what prisoners were arriving at HMP Coldingley as they themselves were often unaware of who was arriving and with what need. Therefore the needs of the prisoners could only be assessed through the reception process. There had been a number of incidents where prisoners arrived with complex health needs and had to be transferred to another prison.

4.7.6 Prisoner Health Development
HMP Coldingley management were undertaking a number of changes in order to address the health needs of prisoners:

1. Addressing the support that healthcare staff required during medication time through the prison reprofiling exercise.
2. Development of a prisoner council, elected by prisoners. The purpose of the council was to address a range of issues. This group would be supported and chaired by the Residential Governor. and would include members of the health promotion action group.

4.7 Healthcare Staff

4.7.1 Method

Questionnaires were sent to all healthcare staff with individual letters. The healthcare manager also encouraged staff to complete the questionnaire. There was a poor response to the questionnaires so individual interviews were conducted by a member of the public health team.

On the day of the interviews the healthcare staff on duty were asked to participate in interviews. In total, six staff were interviewed with views from a further four staff obtained via questionnaires.

4.7.2 Results

Staff felt that the new healthcare centre would have a positive impact on the delivery of health services in HMP Coldingley. The communication, morale and relationship between healthcare staff were seen as very good despite the recent challenges of staff shortages. On a ten point scale with one being poor and ten being very good the staff rated their satisfaction in their job role as eight.

4.7.3 Officers

Staff felt that the communication with officers was poor and needed to be improved, they felt that officers lacked an overall understanding of the healthcare team. Some staff felt that they had experienced rude behaviour from officers. The communication between healthcare staff and the reception was seen as very poor. Some staff felt that the reception team were rude and failed to understand that healthcare had to sometimes prioritise medical emergencies over reception screenings.

4.7.4 Reception screening

Healthcare staff felt that the reception screening was very good and effective at picking up major health problems. They also believed that it allowed the prisoner the opportunity to discuss wider health concerns.

4.7.5 Prisoner communication

Healthcare staff expressed mixed views on the relationship between themselves and prisoners, with some staff experiencing confrontation and rudeness. Other healthcare staff felt that there was good communication between nurses and inmates. They expressed empathy that the long waiting times for dental care and the poor GP service had led to prisoners becoming frustrated.

During the dispensing of medication, healthcare staff felt that they had experienced incidents of aggression and disruption from inmates and had to call for officer support. .

4.7.6 Prisoner health concerns

Staff believed that the general health of prisoners was poor when they came into HMP Coldingley, resulting in a greater need to access health services. The main health concerns of the prisoners included:-

- Substance misuse

- Poor oral health leading to a high volume of applications for dental treatment.
- Skin complaints
- Toileting, in particular the prisoners had experienced poor bowel habits
- Weight issues
- Mental health
- Night sanitation was seen as a significant issue as some prisoners urinated in their cell or disposed of urine out of their cell window.

Healthcare staff acknowledged that working prisoners had better health, and more motivation than prisoners that were not working.

4.7.7 Mental health
Whilst officers received ACCT training, some healthcare staff felt that they would benefit from more training on mental health.

Officers were seen as very supportive of prisoners' mental health and when necessary approached the Inreach team for advice and support. The Inreach team reported a good relationship between themselves and officers.

The issues that healthcare staff expressed about mental health at HMP Coldingley included-

- Prisoners new to HMP Coldingley often arrived with complex mental healthcare needs. They believed that the previous prison had been treated this through inappropriate prescribing of anti-psychotics and other medications.
- With the expanding IDTS provision, there may be a greater need for a dual diagnosis worker.
- When the mental health worker wasn't available the IDTS nurses were used for primary care intervention. There were concerns that this would become increasingly difficult as the provision of IDTS was expanding.

1. Whilst HMP Coldingley recognised that mental health was important; there was no short term provision of a safe comfortable place for prisoners that were at risk of self harm. The use of the segregation unit was seen as having a negative impact on the mental health of the prisoner.

4.7.8 Intermediate Drug Treatment Service (IDTS)
Healthcare staff believed that the IDTS worked very well. The IDTS staff reported that the partnership working with the CARATS, Prison officers and RAPT was very effective.

5 Epidemiology health needs assessment

5.1 Information and data sources

HMP Coldingley 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. PNOMIS
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

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.

In the last prisoner survey at HMP Coldingley 15% of inmates surveyed stated they had a mental health problem and 20% stated they had a physical health problem on entering the prison.

HMP Coldingley has recently revised its remedial gym policy.

5.4. Asthma & Chronic Obstructive Pulmonary Disease (COPD)

Asthma clinic is currently provided by a pharmacist.

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 (there are no men of this age in the establishment at the current time). 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 8 and 32 inmates in HMP Coldingley with the condition.

Prescribing data indicates from November 2009 indicated that 14 patients were being treated for asthma and 3 were being treated for COPD. The chronic disease register in September 2009 has 29 inmates on it who had asthma or other respiratory disease. The discrepancy in the figures may arise as the prisoners had left the prison by November, the register is inaccurate, prisoners may self report disease but not

require medication or there may be under detection of the condition. Using these figures the prevalence of respiratory disease in the prison is between 3.3% and 5.6%.

5.5 Epilepsy

An academic paper auditing 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, only 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.

Prescribing data from November 2009 indicated that 5 patients were being treated for epilepsy. The chronic disease register in September 2009 has 1 inmate on it who had epilepsy. The discrepancy in the figures may arise as new prisoners with the condition had entered the prison by November, the register is inaccurate, or there may be under detection of the condition. Using these figures the prevalence of epilepsy in the prison could be between 0.2% and 1.0%.

1.6 Diabetes

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.

Prescribing data from November 2009 indicated that 8 patients were being treated for diabetes. The chronic disease register in September 2009 had 4 inmates on it who had diabetes. The discrepancy in the figures may arise as new prisoners with the condition had entered the prison by November, the register is inaccurate, individuals may self report the condition but not require medication for it or there may be under detection of the condition. Using these figures the prevalence of diabetes in the prison could be between 0.8% and 1.6%.

5.7 Coronary heart disease (CHD) and hypertension

The prevalence within the prison is 5.4% compared to that seen in the general population (3.7%) but differs significantly from prevalence rates seen in other prisons (14%). Prescribing data from November 2009 indicated that 27 patients were being treated for cardiovascular disease (including hypertension). The chronic disease register in September 2009 had 21 inmates on it being treated for hypertension, 9 being treated for hypercholesterolaemia and one for other cardiac disease. The discrepancy in the figures may arise as some prisoners may have more than one co-morbidity, prisoners with the condition may have left the prison by November, the register is inaccurate, or there may be under detection of the condition. Using these figures the prevalence of hypertension in the prison could be 4.1% and hypercholesterolaemia 1.8%.

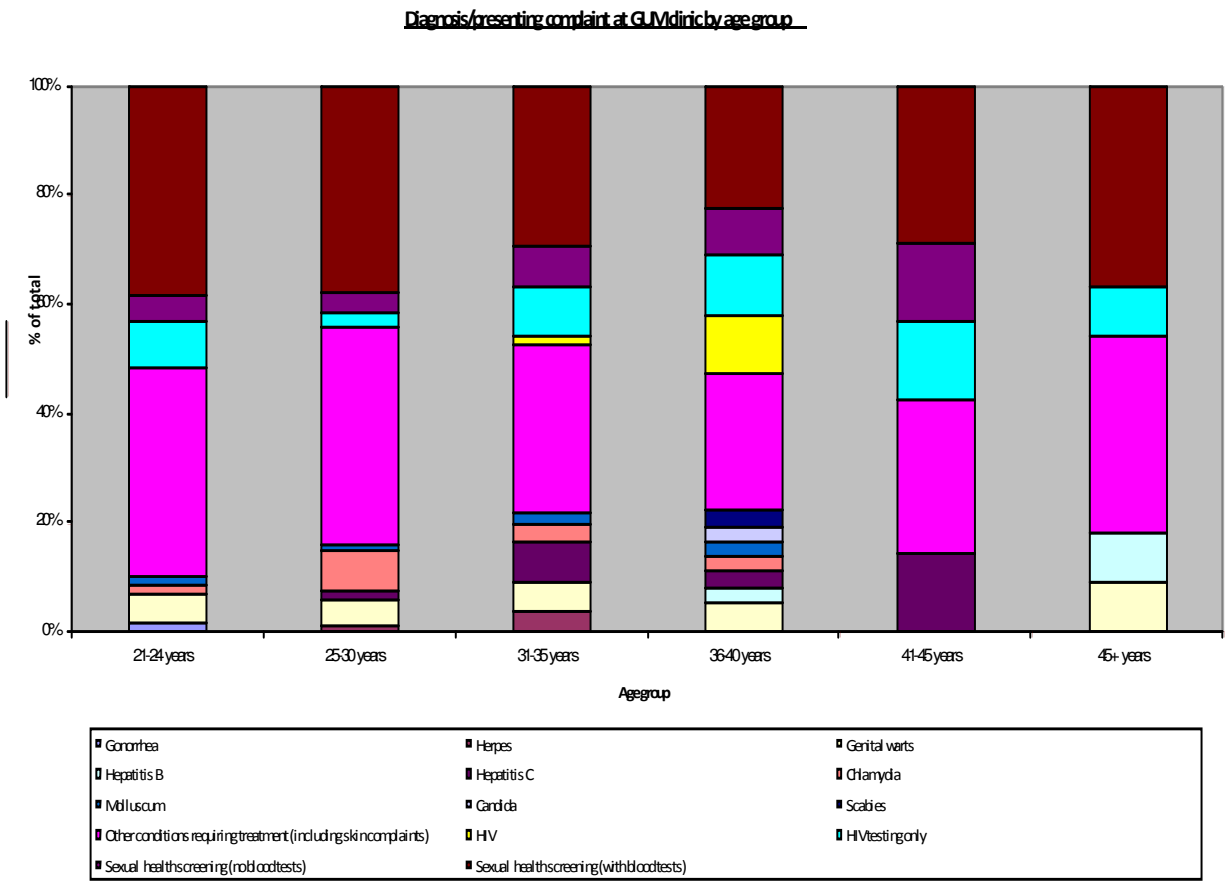
The prevalence of hypertension in the UK is 12.8% which is higher than rates seen in some US studies (9.8%, 12%). The CARDIA study[37] demonstrated that imprisonment is associated with increased risk of hypertension with rates of 12% compared with a control group prevalence of 7%. The association persists after adjustment for smoking, alcohol and illicit drug use. Using these prevalence rates there could be between 35 and 64 inmates with undiagnosed hypertension.

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 Coldingley has a sexual health clinic that runs monthly and is provided by Ashford & St Peter's NHS Trust. Figure 5.1 displays the number of patients seen in the sexual health clinic, their age groups and their diagnoses over a twelve month period.

Figure 5.1 Number of patients seen in sexual health clinic by age group and diagnoses



All offenders attending the genito-urinary medicine (GUM) clinic at HMP Coldingley are offered a comprehensive sexually transmitted infection screen. During this period the full screen (including blood tests) was taken up by 33 % of clinic attendees. Chlamydia tests are offered to attendees but this does not constitute systematic screening.

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%. STI testing on adult prisoners in France found that 16% had at least one STI. If these figures were applied to the HMP Coldingley up to 80 offenders may have an STI. 47 were seen for an STI at the GUM clinic in the time period for which data is presented. Between 20 and 60 offenders may have Chlamydia. 10 prisoners attended clinic with this diagnosis. This may be between 17% and 50% of the true number of prisoners with the disease in the establishment.

Each of the prisons in the Surrey estate should undertake 52 Chlamydia screens per month. For the period April to October 2009 no screens were undertaken. The target for 2010/11 is (I will find out)

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. HIV infection rates amongst IVDUs in London is currently 5% and outside London has increased to 1%. One third of IVDUs are unaware of their infection. It is estimated that 16% IVDUs are infected with Hepatitis B.

Sharing drug use 'paraphernalia' within prison can also increase the risk of contracting blood borne viruses. Sterilising tablets dispensers have been removed as prisoners were swallowing them in order to negate the results of urinary drug testing. Currently there is no needle exchange service within English and Welsh prisons.

Information from the GUM clinic shows that only one prisoner was seen for HIV in the time period for which data is available. However, 18 attended for HIV screening alone and a further 82 had a sexual health screen with blood tests. 7 patients were seen with Hepatitis C and 2 with Hepatitis B.

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%. A Hepatitis C specialist nurse from Royal Surrey County Hospital visits HMP Coldingley as required. Prisoners can also be sent out to see the specialist.

5.10 Tuberculosis (TB)

Vigilance, screening and early diagnosis are essential cornerstones of good practice in the management of TB.

There are no screening questions for TB are part of the initial health screen when an offender arrives at reception at HMP Coldingley. At present there are no prisoners receiving medication for TB at HMP Coldingley.

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.

5.11 Accidents and self harm incidents

Minor injuries are usually treated by the 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.

The prison management are obliged to complete a F213 form (injury to inmate 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.

An accident book is kept in healthcare for recording when an individual is treated for an injury. This is completed inconsistently by all parties although it is a legal requirement for accidents and near misses to be recorded. It also serves as an audit trail. F213 forms are well completed by healthcare.

If an accident occurs in the gym or workshop the supervising officer should complete the accident book, an F213 and an accident/near miss form. If an issue arises from an accident a local investigation is undertaken by the responsible member of staff overseen by the prison health and safety manager (including a review of safety systems in place). Procedures are then revised accordingly and there may be further risk assessments undertaken.

Between 6/4/09 and September 2009 there have been 10 accidents formally reported and investigations completed. The majority of these were sports related (60%) predominantly strains or pain associated with using weights in the gym. The rest of the accidents were cuts or burns.

Assaults are not reported as Health & Safety incidents as they are not associated with work. It is also difficult to define an assault as an accident (e.g. head butting) so they are often not documented via this route. The Safer Custody Coordinator ensures that any unexplained/non-accidental injuries are investigated as part of the prisons violence reduction strategy. The prisoner involved will be interviewed to ascertain the cause of the injury. The Safer Custody Coordinator has been in post

since July 2008 and has instigated this new system. From July 2008 to mid-September 2009 22 investigations have been completed. If the findings of an investigation prove an assault/fight or act of self harm has taken place (rather than an accident) a number of management options are available. For the former there can be disciplinary action taken against the perpetrators, the victim moved to a place of safety and even referrals to the police. For cases of self harm the ACCT process is available if necessary.

One ACCT was open in September 2009. 35 documents had been opened and closed by September 2009. This was an increase of 10 on the previous year. On average 3 to 4 ACCTs are opened per month. Most plans at the establishment are open for a relatively short time period but in 2009 there were two plans that were each open for nearly 3 months.

5.12 Oral health

The strategy for modernising prison dental services (2003) estimated that the level of untreated dental disease among all prisoners was approximately four times greater than that found in a similar population coming from similar social backgrounds.

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[38] 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. Other risk factors for poor oral health include smoking, poor nutrition and increased levels of neglect of oral health care. Generally the prison population has low levels of literacy and low expectation and knowledge of oral health.

5.13 Other physical health problems

The chronic disease register in September 2009 had no inmates entered for haematological disorders or arthritis. Two inmates were classified as 'Other' but no further information was available.
In November 2009 2 prisoners were on warfarin in the prison. They were both IDTS inmates.

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.

The chronic disease register in September 2009 had 15 inmates on it for mental health needs.

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.

Reasons for referral

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.

Recent national evaluations of the mental health in reach service provides comparator data. The most prevalent disorders were psychosis (22%) and major depression (20%). 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.

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.

All deaths in custody are reported to the coroner and are considered Serious Untoward Incidents (SUIs).Fortunately it has been longer than five years since the last suicide at HMP Coldingley. Peer support from six listeners is available to prisoners.

5.16 Learning disabilities (LD)

Very little data is available on the prevalence of learning disabilities within the prison population. A study by the Prison Reform Trust -"No One Knows"[39] 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. Over half of prison staff believe that prisoners with LD are more likely to be bullied or victimised than other prisoners. Translating the prevalence estimates to HMP Coldingley there could be between 40 and 150 inmates with these problems within the prison.

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, more likely that they will return to prison repeatedly, delays their parole dates and affects their resettlement opportunities. This is potentially a violation of Articles 5 and 14 of the European Charter on Human Rights and falls under HMPS' responsibility under the Disability Equality Duty.

Four fifths of offenders with LD have problems reading prison information, three quarters had difficulties completing forms and two thirds had problems making themselves understood. Prisoners with LD are five times as likely to have been subject to control and restraint techniques and more than three times as likely to have spent time in segregation than prisoners without these problems.

Training for prisoner officers in how to recognise and manage prisoners with learning disabilities is being rolled out across the country. Establishments should have a local policy on the management of prisoners with disabilities and an identified Disability Liaison Officer. PSO 2855 gives guidance on the management of prisoners with disabilities.

There is currently no screening tool to recognise LD for use by prison staff although a pilot tool is being researched.

5.17 Ex-servicemen in prison

There are no precise figures on the number of ex-servicemen in UK prisons. According to the National Ex-Services Association as many of 7% of the total prison population in the UK is made up of veterans. This may mean that up to 35 prisoners in HMP Coldingley are ex-servicemen. The "Vets in Prison" group conducted its own research amongst inmates at several prisons and found that the ex-services population was 9.8%. The "Vets in Prison" survey found that over 95% of inmates were former army personnel even though the army only makes up 55% of the total armed forces.

5.18 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%)

Screening and other assessments at HMP Coldingley are generally effective at identifying histories of drug and alcohol misuse. If prevalence figures from the survey were applied to the current HMP Coldingley prison population, the estimated numbers of prisoners with a history of/active substance misuse problems would be as demonstrated in Table 5.5. In the 2008 HMIP report 23% of prisoners surveyed felt they had a problem with drugs when they entered the prison.

Prescribing data shows that HMP Coldingley currently has no prisoners on Subutex. 8 prisoners were on methadone. The number of IDTS prisoners will increase to around 80 when the prison is at full capacity. All IDTS prisoners will be on wing A where IDTS staff will be responsible for the health of the prisoners. Officers on A wing will be trained in overdose management, drug awareness and on how to use a defibrillator.

Table 5.5 Estimated prevalence of previous/active substance misuse in HMP Coldingley

TOTAL NUMBER OF PRISONERS	TYPE OF SUBSTANCE MISUSE	PREVALENCE	ESTIMATED NUMBER
501	Moderate Drug Dependence	10.5%	52
501	Severe Drug Dependence	36%	180

A report by the Home Office[40] 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.

Mandatory drug testing (MDT) results show approximately 2-3% opiate positives (no buprenorphine) from random testing i.e. less than 5% of the prison population. Suspicion testing shows up to an additional 9 positives (average 3-4) per month. These figures have reduced from a high of over 30%.Taken together these figures suggest that while supply reduction measures are successful to some extent, the level of illicit opiates in the prison is such that it is likely that prisoners could access opiates if sufficiently motivated. In the 2008 HMIP report 9% of inmates surveyed felt they had developed a problem with drugs while in the establishment. There may be some prisoners who when detoxed/withdrawn will turn to the illicit market for supplies. IDTS may not necessarily increase the risk of this occurring and should act

as a viable alternative. There will also be a group of prisoners who may continue to use illicit drugs in addition to IDTS. The 2008 HMIP report praised the establishment for stemming the flow of drugs into the prison. A drugs reduction committee meets monthly with input from the security and drug strategy committees. Two active and two passive drugs dogs are in place with two handlers. There have been a number of drug finds over the past year (IMB ref) both in the prison and being carried by visitors.

The IMB report suggested that further action is needed to detect and confiscate mobile phones within the prison as their presence encourages the circulation of drugs. The IMB report also highlighted that over a number of years the levels of positive tests in both MDT and VDT has reduced while the levels of drugs in the establishment are likely to have remained at similar or slightly reduced levels.

Type of drug used by ethnicity

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.

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.

Applying the research figures to HMP Coldingley gives an estimate of 315 prisoners with a history of hazardous drinking and 150 inmates with a history of severe alcohol problems.

In the last prisoners survey 17% of participating prisoners stated that they had a problem with alcohol when they came into the prison. 3% stated that they had developed a problem with alcohol in prison. The last HMIP report survey suggested that 6% of inmates would have an alcohol problem on release. Data from the South East region offender needs analysis demonstrated that the most commonly cited reasons for committing the index offence were alcohol, drugs and money problems (in that order). 46% of participants in the survey identified themselves as heavy habitual or binge drinkers; 36% said they were heavy habitual drug users and 46% were in debt [6].
The South East offender needs analysis also identified alcohol misuse as an area of unmet criminogenic need with a level of need twice that found for drugs. The offence category that exhibits the highest level of need around alcohol misuse is criminal damage.
Alcohol screening using the AUDIT tool is underway across the prison estate and is currently being audited.

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.

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 Coldingley there would be 90 inmates with a degree of disability. In the last prisoners survey 12% (60 prisoners) of responding prisoners described themselves as having a disability.

The 2008 HMIP report[1] stated that the process for identifying prisoners with disabilities and informing the relevant departments was not clear.
HMP Coldingley has two disabled access cells on E Wing and a Disability Liaison Officer is in post.

5.21 Pharmacy & medication

There are a number of mechanisms by which prisoners can access medication in the establishment – homely remedies, patient packs and prescriptions.

5.21.1 Homely remedies
These are medications that are licensed as General Sale List (i.e. a member of the public could purchase them from any retail outlet including a pharmacy). Homely remedies are aimed at treating common minor ailments. Homely remedies can be provided after triage by a nurse and are held as stock by prison healthcare so they can be accessed immediately. As they are available without prescription they are the most commonly used medication in the prison. The items on the list are:

1. Paracetamol
2. Ibuprofen
3. Gaviscon tablets
4. Bonjela
5. Clotrimazole cream (1%)
6. Loratadine 10mg
7. Transvasin cream
8. Eurax cream
9. Loperamide capsules
10. Aciclovir cream
11. Dioralyte sachets
12. Yellow soft paraffin
13. Potter's pastilles

Paracetamol and ibuprofen are the most commonly requested products on the list. There can be seasonal demand for some items e.g. loratadine during the summer.

5.21.2 Patient packs
These are medications supplied directly to healthcare in specific quantities labelled with directions. They cannot be provided as homely remedies due to their legal classification. The patients name and number are added to the label by the healthcare professional when the drug is supplied to the patient. Prescribers are aware of which medications are available as patient packs and can write specific prescriptions for their supply. Medications available as patient packs are:

1. Beclomethasone nasal spray
2. Diclofenac tablets 50mg
3. Antibiotics (amoxicillin, flucloxacillin, erythromycin)
4. Ibuprofen 400mg
5. Salbutamol inhaler
6. Beclomethasone inhaler
7. Corsodyl mouthwash
8. Chloramphenicol eye ointment
9. Gentisone HC drops

Inhalers and analgesia are the most commonly prescribed patient packs.

5.21.3 Prescribed medication
This medication is prescribed by a doctor for a patient and supplied by pharmacy directly. The top twelve items prescribed by volume by doctors at HMP Coldingley in September (excluding the medications in the patient packs) were (in order of frequency, most common first) :

1. Paracetamol
2. Mirtazapine
3. Simvastatin
4. Diclofenac
5. Omeprazole
6. Tramadol
7. Moisturisers
8. Low dose aspirin
9. Co-codamol
10. Amlodipine
11. Citalopram
12. Meloxicam

Similar prescribing data from November 2009 showed a broadly similar breakdown but with lansoprazole, salbutamol and beclometasone replacing low dose aspirin, amlodipine and tramadol.

1. Paracetamol
2. Mirtazapine
3. Salbutamol inhaler
4. Diclofenac
5. Moisturisers
6. Simvastatin
7. Beclometasone inhaler
8. Omeprazole
9. Citalopram
10. Lansoprazole

Tramadol and co-codamol usage is decreasing due to pain clinics run by the prison pharmacist. These drugs are often abused by prisoners and therefore can be traded.

Paracetamol is not available on the canteen list. This was at the request of the pharmacy as there were concerns that the drug would be hoarded and used for suicide attempts. There was also concern that lack of understanding about other medications (e.g. that co-codamol contains paracetamol) could lead to accidental overdose.

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.

Pharmacy estimates that the average value of a prescription is around £12. This is considerably less than a community pharmacy as no dispensing fee is charged. If a fee were charged the cost would be around £15.

A large number of prescriptions are dispensed as weekly or daily medications (i.e. a box that would be dispensed as one unit in the community is split into daily or weekly doses). At present the pharmacy dispenses 600-700 items per month to HMP Coldingley. This equates to between 1 to 1.5 items per prisoner. As the IDTS population in the prison increases it is expected that the number of items dispensed could rise to around 800 to 1000 items per month (at peak IDTS occupancy of 60) due to the complex needs of this client group.

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.

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%. Applying these figures to HMP Coldingley this would translate into 390 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

HMP Coldingley has a fully equipped gymnasium with a badminton court, weights and cardiovascular equipment. Industry standard gym qualifications are taught. There is also an outside sports field.

Across the prison estate only 40% of prisoners participate in exercise and so can take advantage of its physical and psychological benefits. At HMP Coldingley this would mean that 300 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.

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 quarter July to September 2009 HMP Coldingley scored red on the rating system indicating less than 50% of new prisoners are vaccinated within 31 days of entering the establishment[41]. During this period there were 139 receptions in total. 12 prisoners declined the vaccination (13%) and 46 were already vaccinated (33%). 30 prisoners were vaccinated within one month. Vaccine coverage was 55% and vaccine uptake was 37%.

During the quarter 60 prisoners received at least one dose of vaccine. Of these 38 were new receptions and 22 were prisoners who had been in the establishment for over one month. 37 prisoners received their thirds dose of vaccine. Of these 8 were new receptions and 29 had been in the establishment for over one month. In totall110 doses were given during the quarter. 51of these were to new receptions and 59 were to prisoners who had been in the establishment for over one month. Therefore in order to meet the amber target at least 23 reception prisoners need to be vaccinated every month. To reach the green target (80%) this would have to increase to at least 36 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 49 inmates would require these vaccinations (around 4 aged over 65, 31 with cardiovascular disease, 8 with diabetes, 3 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.

5.23.4 Screening

Four main screening programmes are applicable to the inmates are HMP Coldingley – 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 4 inmates at HMP Coldingley. Retinopathy screening should be undertaken annually on all patients with diabetes aged over 12. There should be at least 8 prisoners eligible for this screening. Bowel cancer screening is targeted at the 60-69 year old age band and this will involve approximately 10 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 9% of the current prison population.

All screening programmes are voluntary.

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[42] 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.

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[43].
Services for mental health have been commissioned from Surrey and Borders Partnership NHS Foundation Trust since 2005.

GP services are commissioned from Harmoni who took over from Wayside on 1st November 2009. Their contract expires in March 2010. Thamesdoc provides out of hours cover.
GUM services are commissioned from Ashford & St Peter's NHS Trust

6.3 Information and data sources

HMP Coldingley is currently using a paper based records system in healthcare whilst awaiting the installation of a computerised patient data system. Computerised records of clinics are held. A combination of information and data sources have been used to estimate the activity levels of services:

1. Healthcare activity information e.g. waiting lists
2. Referrals to psychiatric services
3. Referrals to secondary care
4. Appointment applications
5. Collated attendance figures from specific departments e.g. sexual health
6. Clinic information form completed by healthcare professionals
7. Reception ledger

6.4 Healthcare organisational structure

Within the prison Governor Dave Turner has a designated interest in healthcare.
Senior Officer Lee Jones has a designated interest in IDTS.

6.4.1. Current staffing

Healthcare manager (Band 8a) 1 wte
Nurse practitioner (Band 7) – RGN – 1 wte
Lead nurse primary care (Band 6) – RGN – 1 wte
Senior staff nurse (Band 5) – 4 x RGNs, 1 x RMN – 7.6 wte
Healthcare assistant (Band 3) – NVQ Level 3 – 1 wte
Administrator (Band 3) – 1wte
Administrator (Band 3) - 1 wte

Regular agency staff – RMN/RGN staff nurse

There are currently three vacancies at Band 5 level.

6.5 Healthcare structures

HMP Coldingley has Type 1 healthcare status with no inpatient facility. Healthcare is located in a brand new purpose built facility that opened in 2009.

Healthcare provision is comprised of the following services:

- Primary care including GP sessions and nurse-led out patients clinics
- Mental health in-reach
- Integrated Drug Treatment Service
- Dental service
- Podiatry
- Optometry
- Genito-urinary medicine (GUM) service
- Pharmacy
- Reception health screening

The 2008 HMIP report stated that prisoners received a "reasonable service" but was concerned by the over reliance on agency healthcare staff in the establishment which lead to a lack of consistency in care. The report was also concerned that the skill mix of healthcare staff did not meet the prisoners' needs.

- **During future recruitment rounds HCC should consider increasing the number of nursing staff with a mental health background/qualification**

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.

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[44]. 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
The time pressure to provide a comprehensive initial health screen poses a significant challenge to the nurses working in the reception department. The number of prisoners coming into reception on a single day varied from one to twenty two in the time period monitored. This presents a significant logistic and planning challenge to both the prison officers and the attending nurse. Nurses are not permanently situated in reception and are called to attend.

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

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

A basic physical health check is undertaken including peak flow and BM if applicable. Patients also sign an in possession medication compact following a risk assessment by the staff member. Specific forms are also completed for the chronic disease registers, BBV screening, Hepatitis B vaccination and fitness for gym.

If the reception nurse has any medical concerns the prisoner can be referred to healthcare for further assessment and where necessary an Assessment, Care in Custody and Teamwork (ACCT) document opened. Prisoners are given an induction pack which includes information on accessing healthcare services. The induction leaflet includes information on medication and special sick times, types and frequency of clinics and how to make an appointment. In the 2008 HMIP report 59% of prisoners reported that they had been offered information on health services on day of their arrival at the prison.

In addition a health promotion orderly discusses how to access healthcare services at the induction for all new prisoners. A PALS orderly also explains the service at induction. The healthcare orderly also takes prisoners on informal visits to healthcare to show them where it is located.

Each wing also has a healthcare orderly.

6.7.2 Throughput
Between June and August 2009 167 prisoners passed through reception and all of them received a reception health screen. Of these, 64 prisoners (38%) were deemed fit and well and were not referred on to any other services.

6.7.3 Referrals from reception
Of the remaining 103 prisoners, 32 (31%) were referred to the GP, 12 (12%) were referred to the dentist and 12 (12%) were referred to the mental health in reach team. Some prisoners received referrals to more than one service. The referrals to services are shown in Figure 6.1.

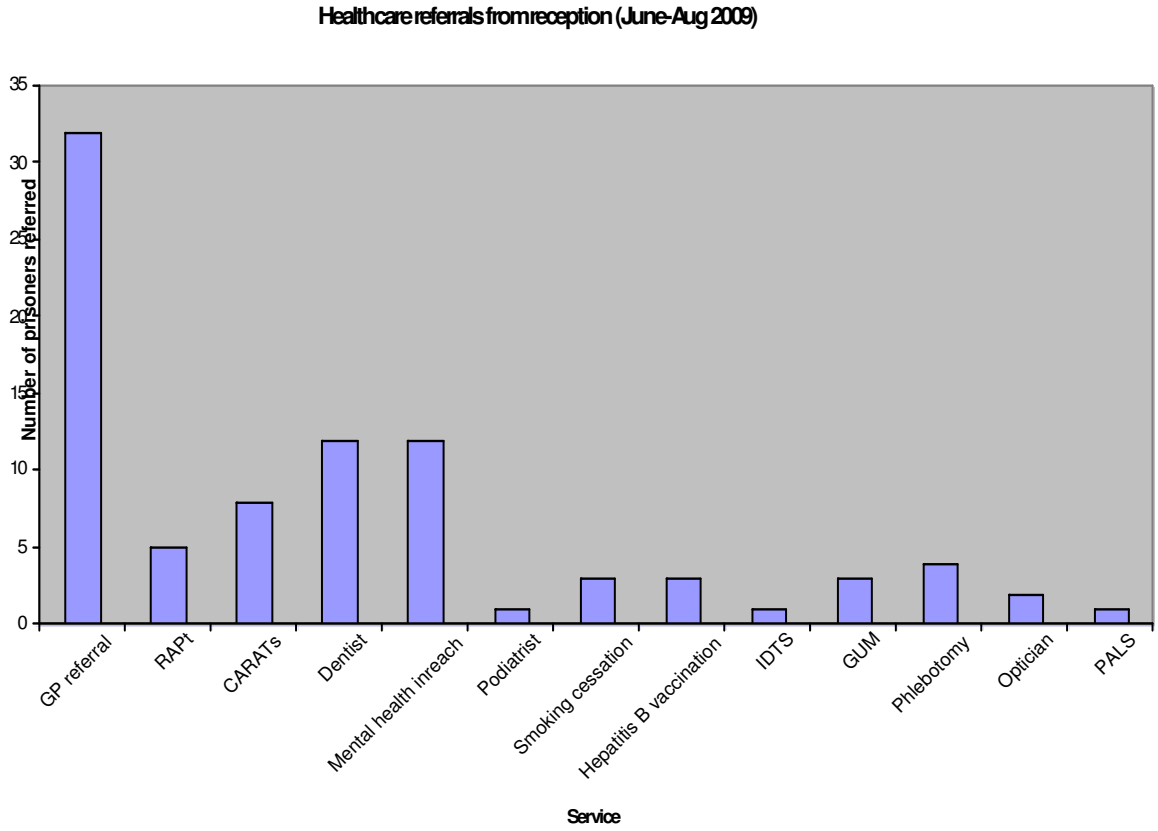


Figure 6.1 Referrals to healthcare from reception (June-Aug 2009)

14 % of those seen at reception were recorded as being referred to the detoxification services (IDTS, CARATS, RAPt).
Only 1 inmate was recorded as receiving any health promotion leaflets.

6.7.3. Diagnosis recorded at reception
Some diagnoses were recorded in the reception ledger but this is not a comprehensive overview of the pathology seen in reception during this time period.

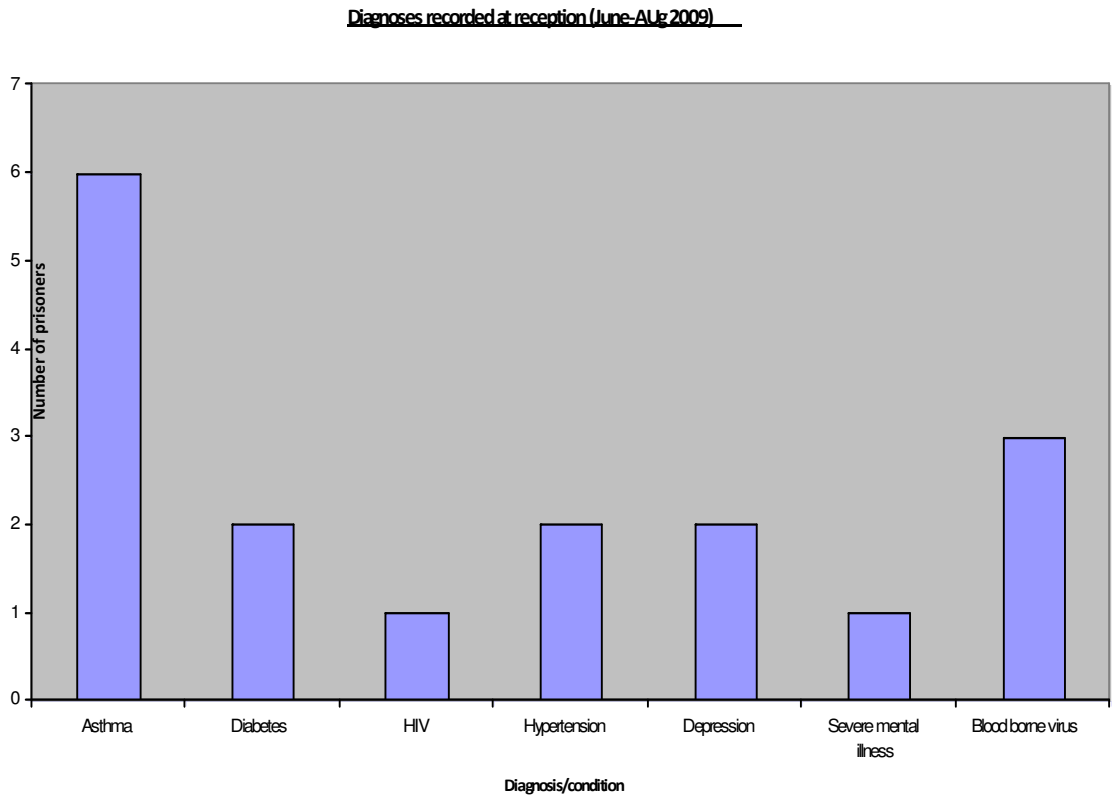


Figure 6.2 Conditions recorded at reception (Jun-Aug 2009)

6.7.4 Reception data collection
At present the reception system is paper based .

6.7.5 Environment
Reception health screening is undertaken in a single room in the reception area. Static handwashing facilities are not available in the health screening room,

6.8 Accessing healthcare

Prisoners requesting healthcare services complete an application form and submit this to the Healthcare Centre. Applications are available from the wing office. On E wing there is a box on the wall containing application forms. During unlock hours healthcare has walk in access and prisoners can pick up application forms. Forms are submitted directly to healthcare reception or posted in a box when healthcare is closed. Applications are triaged daily by a nurse. 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 administrative staff in the healthcare centre arrange all other healthcare appointments within the prison.

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

6.9 GP Service

GP sessions are held daily and each session is held in the healthcare department. There is currently a four day wait to see the GP, however emergencies were prioritised to be seen on the same day.
Six sessions are provided between Monday and Friday.

The GP also visits the Segregation Unit three times a week. During August 2009 59 visits were made to prisoners on the unit.
The current wait for the GP service is 4 days with emergencies seen on the same day. The current waiting list to see the GP is 40.

The GP service was provided by Wayside until 1st November 2009. After this it was taken over by Harmoni. Concerns had been raised by staff over the rate at which prisoners were being seen and the attitude of some of the doctors in the Wayside team. Anecdotal evidence suggests that prisoners are much more satisfied with the new service providers. Thamesdoc provides weekend cover and an on-call over night service.

During August 2009 165 patients were seen by the GP with a DNA/empty slot rate of 3%. The most common presenting complaint/reason for referral were medication (review or initial prescription) (14%), dermatology (13%) and musculoskeletal (13%). The reasons for referral/presenting complaint are presented in Figure 6.3.

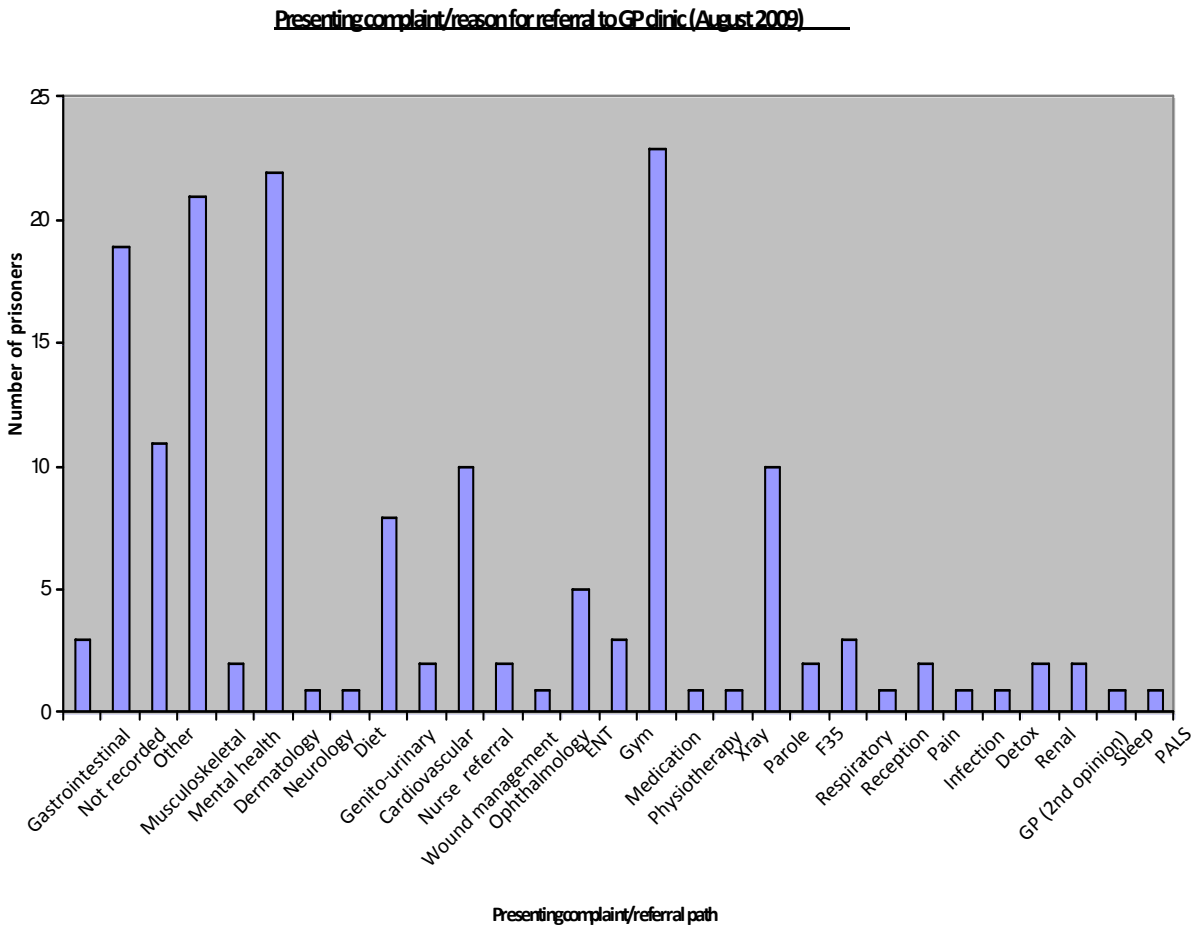


Figure 6.3 Presenting complaint/referral to GP clinic (August 2009)

6.10 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 activity recorded by security (i.e. ambulance call outs). During the period 14th April to September 24th 2009 there were 10 ambulance attendances at the establishment. On three days during this period (24th May, 3rd September, 24th September) there were two separate ambulance callouts to the prison. Information on ambulance call outs will not capture less urgent problems when prisoners are escorted to hospital in a taxi.
Data from Thamesdoc shows that in 2009 (January to October inclusive) there were 25 out of hours episodes. 19 of these were managed with telephone advice, 1 required an ambulance and 5 were managed using a base visit (i.e. the prisoner was escorted to the Thamesdoc base). The clinical coding for the calls does not demonstrate any significant trends and is lacking in detail. However two of the calls were for requests for an inhaler and a prescription.

Escort statistics for HMP Coldingley for April 2008 to March 2009 show there were 377 escorts. Of these 3 escorts were to A&E. The majority of escorts (56%) were to Ashford and St Peters NHS trust. 40 escorts (11%) were to hospital trusts outside Surrey. The most common reasons for an escort were out patients clinic (96/381%), X-ray (65/381%) and maxillofacial clinic (36/381%).
Bedwatch figures for the nine months until 31/12/08 showed a significant overspend.

6.11 Nurse triage clinics

Nurse led clinics are held daily.

The current waiting time to see a house block nurse is 7 days with emergencies seen on the same day as Special Sick. In August 2009 37 prisoners were seen as special sick. Special sick is held twice a day every day of the week. To be seen for special sick prisoners require a movement slip.

Analysis of clinic activity in August 2009 showed that there were 123 prisoner appointments in nurse clinic. The DNA rate/unused appointment rate was 5%. The majority of appointments were regarding dental problems (31%) followed by dermatology (19%) and phlebotomy (12%). Some prisoners presented with more than one complaint. The problems seen in clinic/reasons for referral are illustrated in Figure 6.4.

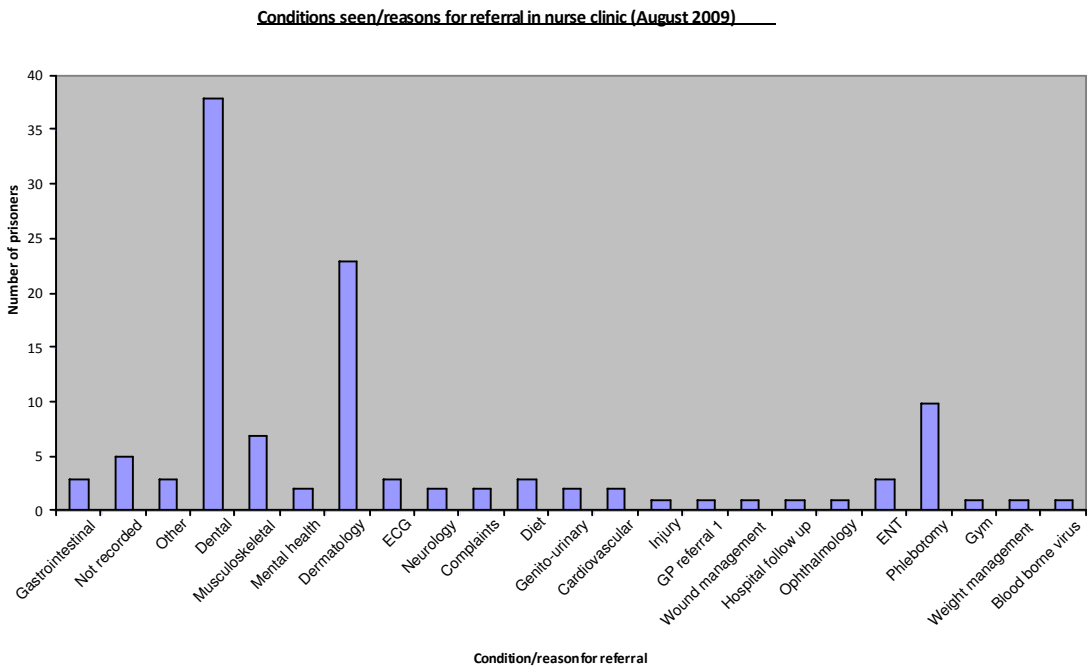


Figure 6.4 Conditions seen/reasons for referral to nurse led clinic (August 2009)

6.12 Out patients clinics

6.12.1 Service provision

Phlebotomy clinic - weekly
Hepatitis B immunisation - weekly
Podiatry – every two months

Dental - 2 days per week

Smoking cessation - weekly
Asthma - weekly
Diabetes - weekly

Sexual health - monthly

Flu vaccinations – seasonal
Physiotherapy - weekly
Optometry - fortnightly
Ultrasound - monthly
Blood pressure – weekly
BM monitoring – weekly
Nurse triage – daily
Special sick - daily

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 can be high in some clinics.

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

6.13 Hepatitis B vaccination clinic

6.13.1 Structure

Clinics are held weekly with patients referred in directly from reception. Prisoners can also self refer. In August 2009, 30 patients were seen in this clinic during the month.

6.14 Genito-urinary medicine (GUM) clinic

6.14.1 Service provision
One clinic is provided per month 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 11patients are seen per clinic. There are currently 20 people on the waiting list.

6.14.2 Other sexual health services
Barrier protection and lubricants are only available if specifically requested. Condoms are available on release from the prison. 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.

6.15 Optometry

Service provision
On average there are 2 optometry clinics a month, but this can vary. An average of 6 appointments are available per clinic. In August 2009 12 patients were seen in the clinic. There are 15 inmates on the waiting list at present.

6.16 Asthma clinic

In August 2009 21 patients were seen in asthma clinic. The majority of these patients were reviews of medications/inhaler technique (46%) as well as new patient reviews, spirometry and symptom checks. All patients receive education and information on managing their condition. The DNA rate was 8%.

6.17 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 [45]. This would equate to approximately 392 prisoners smoking in the establishment. HMP Coldingley is a non smoking prison. Prisoners are allocated smoking cells with other smokers. HMP Coldingley has designated staff smoking areas.

6.17.1 Service provision
A weekly smoking cessation service operates at the prison with a waiting list of 30 prisoners. The service is run by a nurse and there are currently 40 patients on the programme. The service provides advice on techniques to achieve smoking cessation and prisoners are given one cessation aid. All aids are available except for gum (for security reasons). There is a market for nicotine patches within the prison. 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.

6.17.2 Throughput
The DNA/unfilled appointment rate for the service was 20%.
The 4 week quit rate is around 15%.

6.18 Dental Service

All the prisons in Surrey have their dental service provided by Surrey Community Health's special care dentistry service. The dental service is provided in the healthcare centre at HMP Coldingley. The service has been developed and extended considerably since 2007. There is close working between the dental department and the healthcare staff. There are currently 2 dentists and 2 Band 5 dental nurses. These are regular staff in roles that were previously covered by locums. There were originally only 2 sessions of dental care in the prison. An oral health educator works one day a fortnight across all the Surrey prisons. The dental clinical lead covers all the Surrey prisons.

The current process for accessing services is via a nurse who completes dental triage. Following triage the nurse can pass the slip on to the dentist as well as prescribing simple analgesia, discussing the case with the prison GP, calling the Surrey Dental Helpline or speaking with the dentist (if available). The prison GP can see the patient and prescribe antibiotics or analgesia. In some cases they send the patient to A&E. The Surrey Dental Helpline can provide advice or recommend that the prisoner is brought to the dental access centre.
All triage slips are reviewed by the dentist who can either give advice to the referring nurse, see the patient as an emergency or place them on the urgent or routine waiting lists.

6.18.1 Service provision
5 hours of dentistry is provided two days per week. On average 6 prisoners are treated per session. Patients who require urgent care are seen on the same day or at the next available clinic. A new patient session is usually 30 minutes. There are 83 prisoners on the routine waiting list with an 8-10 week wait. The average interval between appointments is 8-10 weeks. The clinic was closed for a seven week period in 2008 during the move of the healthcare premises. There are currently no oral health promotion dedicated sessions provided. It is estimated that the average DNA rate per clinic is 1.2. This rate also includes patients who cannot be seen as no medical records are available. On average 20-30 minutes is lost per session due to poor time keeping by prisoners, prison officers or the late arrival of medical records. A multidisciplinary prison oral health group has been established to coordinate and monitor the provision of dental services and oral health promotion across the Surrey prison estate. 32 one off sessions will be undertaken in 2010 to help reduce the waiting lists.

During August 2009 105 patients were seen by the dental team.

6.18.2 Patient satisfaction
A questionnaire was completed by 40 patients attending the dental clinic at HMP Coldingley in April/May 2009. Of these 85% gave positive responses about the quality of the care that was delivered. 92.5% gave positive responses about the facilities and 59% were very satisfied with the overall service delivered.

6.18.2 Triage
Nurses have been trained by the dentist to carry out dental triage. This service is provided on the same day. 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 around 15-

20 requests are triaged per week. Appointments are allocated according to urgency of problem and length of wait.

6.18.3 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.

6.18.4 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.

6.18.5 Attendance

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

6.19 Blood pressure clinic

Clinic data for August and September 2009 showed that on average 10 slots were available in blood pressure clinic. In August 2009 6 patients were seen in blood pressure clinic. The DNA/unused appointment rate was 36%.

6.20 Diabetes/BM clinic

Data for September 2009 showed that on average 6 patients used the BM clinic. The majority of these patients were being followed up weekly (66%) or fortnightly.
19 patients used the diabetic clinic.

6.21 Phlebotomy clinic

Data for August and September 2009 show that on average there were 14 slots in the clinic. In August 20 patients were seen with 2 slots empty that month. On some days the DNA rate was 30%. There are currently 15 inmates on the phlebotomy waiting list with a wait time of around one week.
The clinic also provides tests for blood borne viruses. This service is advertised on the information leaflet on healthcare that prisoners receive at reception and on posters in reception.

6.22 Referrals to other agencies/secondary care

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. No data was available on how many referrals were new or follow up.

During the period May to September 2009 124 external appointments were kept by prisoners at hospitals. Only 10 of these were recorded as follow up appointments and several appointments were made by individual prisoners receiving a course of treatment. Of the appointments the majority were maxillofacial (20%), ophthalmology (15%) and imaging (10%). The proportion of appointments by specialty is shown in Figure 6.5.

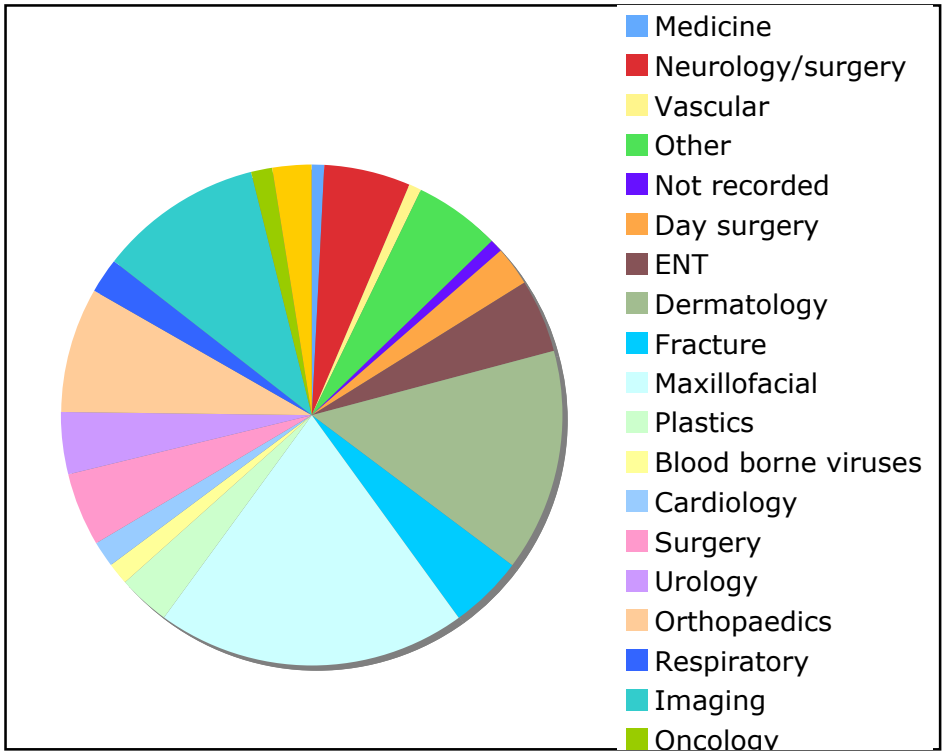


Figure 6.5 Proportion of hospital appointments by specialty

Between September and December 2009 there were 52 scheduled or outstanding hospital appointments that prisoners were due to attend. Many of the outpatient appointments breach the 18 week target due to delays in accessing notes, transferring appointments to local hospitals and the security arrangements that need to be put into place.

6.23 Mental Health

6.23.1 Staff structure and whole-time equivalent

MHIT Lead
MH Practitioner band 6- Full time
Psychiatrist- 0.1WTE
Counsellor- shared with HMPS (there is also a student on placement)
Psychologist- two sessions per month
STR Worker- Full time
RMN- 0.4WTE
Movement psychotherapist- 1 day a week

The provision of mental health services was described as good in the 2008 HMIP report[1].

6.23.2 Provision

Mental health clinics are held twice a week. In the month of August 2009 25 patients were seen.
During August the psychologist saw 26 patients.

6.23.3 Number of referrals

There were 141 referrals of which 93% were accepted for screening or assessment. (figure 6.6). Reasons for refusal of a referral included not enough time to see the individual before transfer/discharge, recommendation that care would be better on the wing or a case that was already open and known to Mental Health In Reach Team (MHIR).

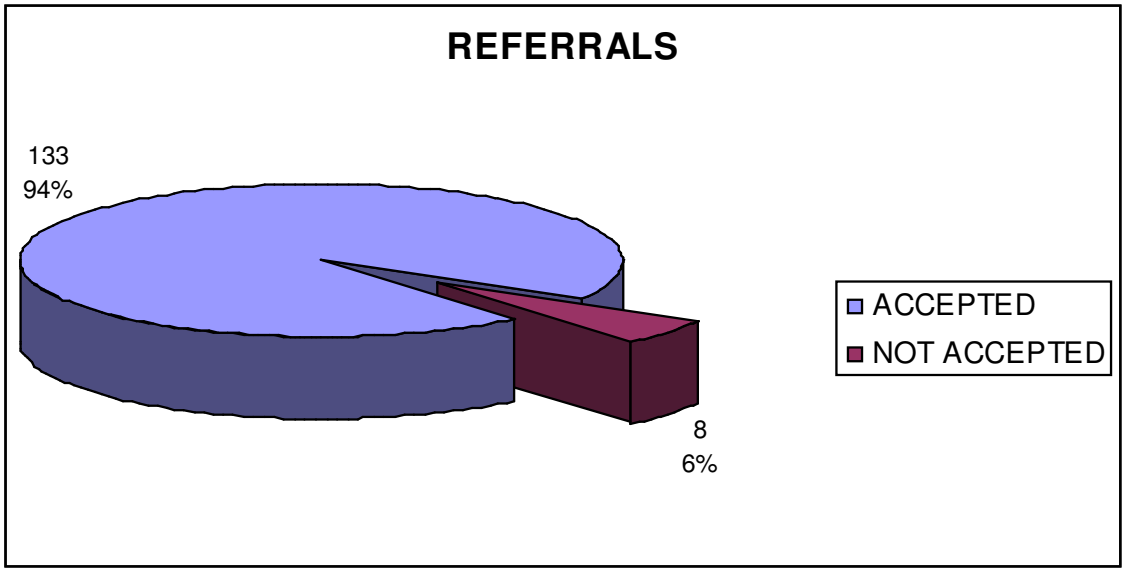


Figure 6.6 Number of referrals accepted by MHIR

6.23.4 Source of referrals

As demonstrated in Figure 6.7 the majority of referrals were from healthcare, Offender Management Unit, CARATs and staff on the wings. Only 2.8% of referrals were made by prisoners themselves.

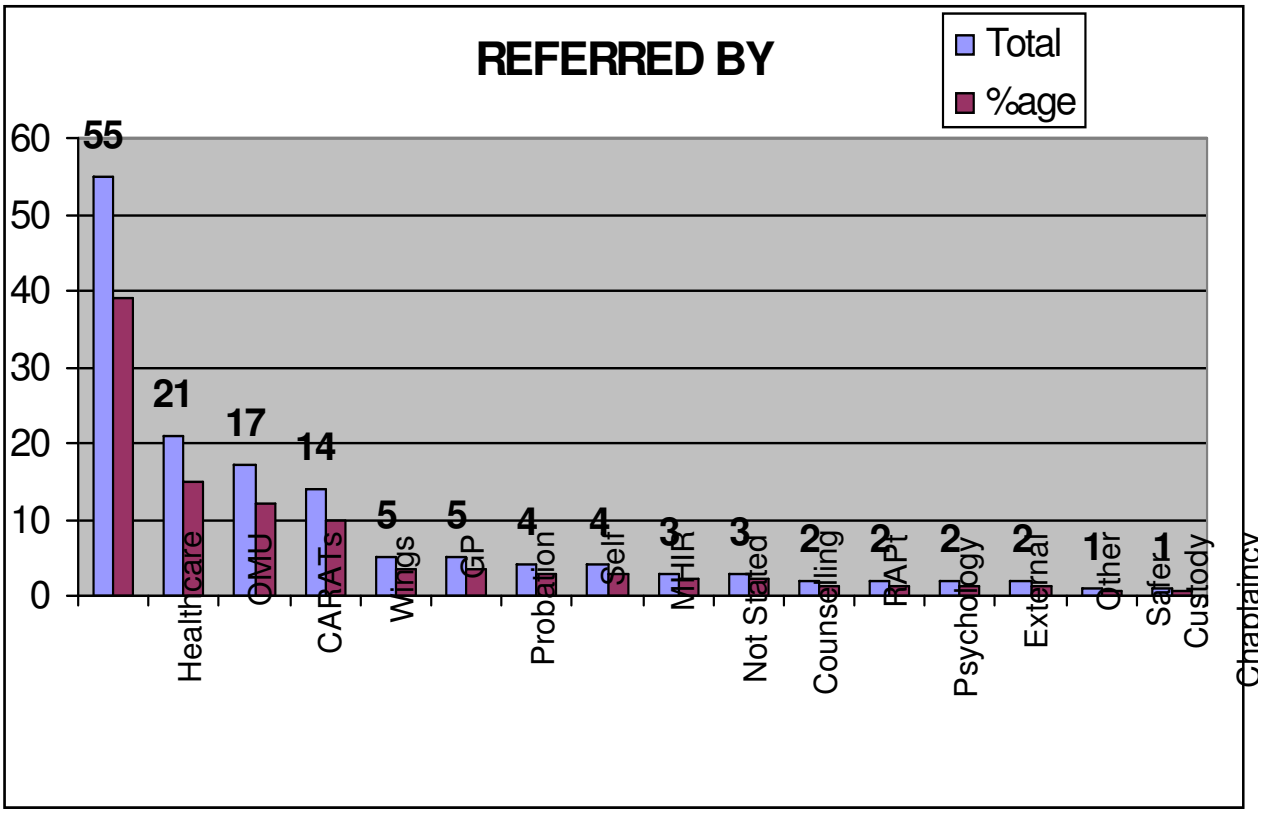


Figure 6.7 Source of referrals to MHIR

6.23.5 Reasons for referral

Figure 6.8 demonstrates that the majority of referrals were for issues around self esteem/relationships (18%) and deliberate self harm (11%). Diagnosed mental illness (depression, SMI, anxiety, PTSD, OCD) accounted for an additional 25% of referrals with depression and SMI the largest contributors to that sub group.
Of the 16 prisoners referred for deliberate self harm (DSH) 6 (38%) had current thoughts of DSH, 7 (43%) had a history of DSH and 3 (19%) had harmed themselves in the prison.
All of the prisoners who were referred due to bereavement were referred to CRUSE.

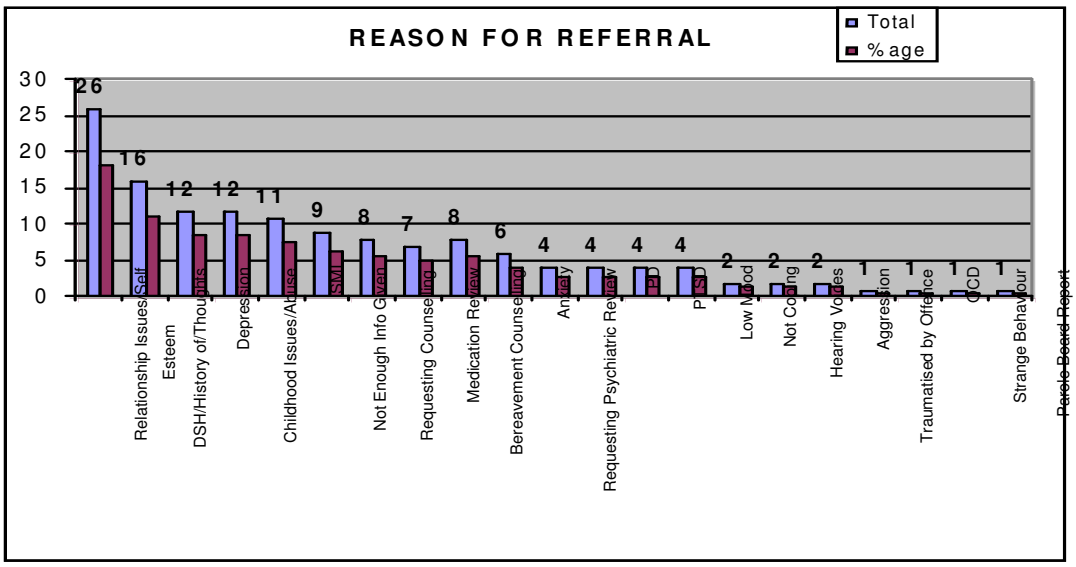


Figure 6.8 Reasons for referral to MHIR

6.23.6 Outcomes of referral meeting

The majority of referrals were screened by MHIR (28%) or referred for counselling (26%). 10% of referrals required more information.

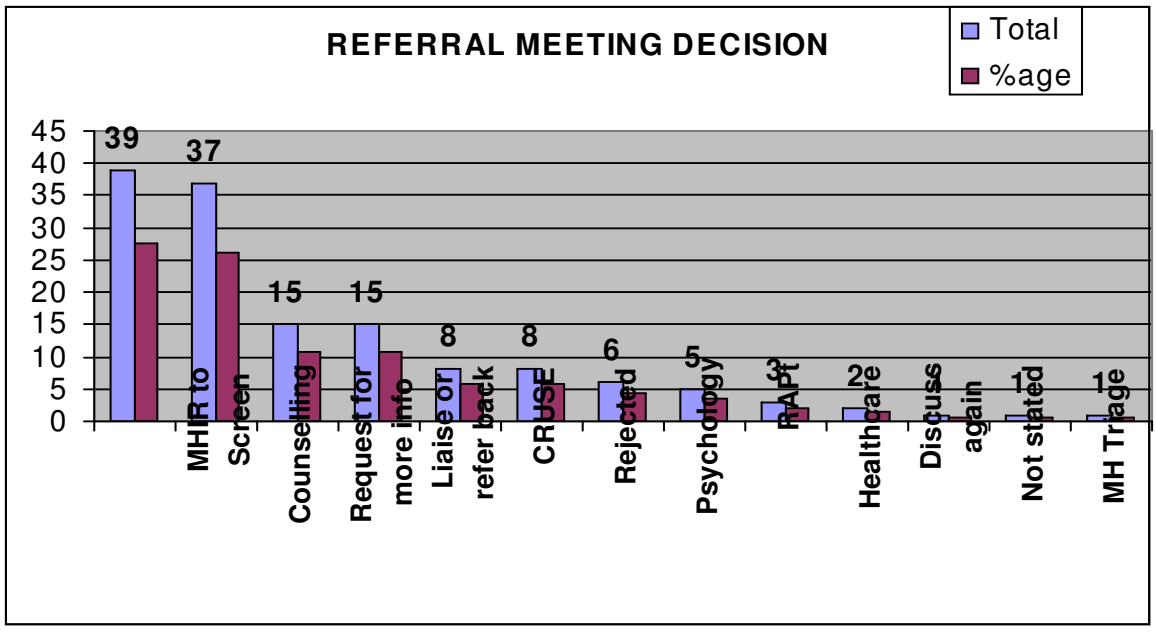


Figure 6.9 Outcomes of referral meeting

6.23.7 Care Programme Approach

CPA is available for those prisoners already subject to it and can be started for those requiring it. All prisoners should either be on enhanced CPA or enhanced care. A CPA audit is undertaken every two months, there are approximately 8- 12 prisoners on CPA at the moment.

6.24 Learning Disability Provision

HMP Coldingley education department were unable to provide figures on the number of prisoners with learning disabilities.

6.25 Suicide Prevention

The Safer Custody coordinator has responsibility for suicide prevention and violence reduction. All night staff have received suicide awareness training as part of ACCT. Transfers of prisoners on open self-harm ACCT documents are monitored by the safer custody team and discussed at their team meeting. Due to the night sanitation it can be difficult to monitor prisoners on self harm ACCTs at night so a transfer protocol has been agreed with HMP Winchester and HMP High Down for prisoners that require frequent monitoring.

The Samaritans provide telephone support and also train and support prisoners to become listeners. Listeners act as Samaritans within the prison environment – supporting and befriending their fellow offenders in times of crisis. Samaritans are also available on request. There are currently 6 Listeners at HMP Coldingley. In its 2008 report Her Majesty's Inspectorate of Prisons stated that although self harm was generally well managed, the Listeners suite was unused and unwelcoming.

6.26 Addiction Services

6.26.1 Staffing & facilities

1x Lead nurse primary care Band 6
2 x senior staff nurses (Band 5)
0.8 IDTS admin (Band 3)
2 GPWSI sessions per week

6.26.2 The programmes

In the majority of cases the main clinical interventions will have been started or completed in the local prison where the prisoner first enters custody. It is unlikely that a prisoner will present for detox in a training prison but this may occur if a new transfer cannot sustain an illicit dependency in the new prison. Where opiate dependency is a new presentation in the prison the current practice is to try and manage the prisoner within HMP Coldingley unless a higher level of care (and therefore transfer) is required.

6.26.3 IDTS Activity

Most aspects of IDTS are up and running although not in their final form. In August 2009 IDTS had 34 patient appointments.

A wing will be the IDTS wing. A wing holds 93 prisoners and it is planned that eventually 40-50 of these at any one time will be IDTS prisoners receiving medication. A wing staff are all IDTS trained. It has been agreed that 6 maintained IDTS prisoners per week are transferred from HMP High Down to HMP Coldingley in order to relieve their backlog. It is likely that capacity will be reached at HMP Coldingley within two months.

6.26.4 IDTS Needs assessment Recommendations

A needs assessment of IDTS undertaken in August 2009 made the following key recommendations:
- IDTS commissioning partnership to agree strategy for managing IDTS treatment demand safely and effectively within available resources, specifically by agreeing guidelines for maintenance, preferably in conjunction with HMP High Down
- PCT to ensure Coldingley IDTS nurse staffing
- IDTS commissioning partnership to generate options for resourcing alcohol provision
- PCT to ensure clear and resourced arrangements re: leadership, coordination, accountability and day to day management of IDTS nursing staff

6.27 Counselling, Advice, Referral, Assessment and Throughcare Team (CARATs)

6.27.1 Activity
CARATs is a harm minimisation service for any offender who has issues with substance abuse and wishes to access support and advice. CARATs runs groups on Motivational Enhancement, Relapse Prevention, Pre-Release and Harm Minimisation. CARATs has been in place in the prison for several years. Between a third and a half of the prisoners are on the CARATs caseload at any one time and others are waiting (approximately 200 referrals per month).

6.27.2 Staff

1 CARAT team leader
3 CARAT workers
2 x 0.5 CARAT officers
Full time CARAT Admin officer
20 hours CARAT Admin Assistant
0.5 Drug strategy officer (A wing)

6.28 Rehabilitation of Addicted Prisoners Trust (RAPt) programme

Prisoners wishing to come to HMP Coldingley to attend the 12 step RAPt programme are assessed and recommended by their local CARATS worker and must meet certain eligibility criteria:
- minimum 6 months left to serve
- willingness to sign up to the Coldingley compact
- willingness to undertake an intensive drug rehabilitation programme
- acceptable behaviour as per normal transfer requirements
- evidence of commitment to stay drug free

RAPt has been in the prison since 1995. Its programme depends on motivation and a peer support system is key to the programme's success. The programme usually takes 4-5 months to complete fully (three phases) and any Home Detention Curfew (HDC) eligibility is requested to be deferred until the programme is completed. The variability in programme length is determined by the number of referrals and waiting list length. The programme is delivered through group and individual therapy, lectures, workshops, significant event sheets and written assignments done in and out of treatment hours. There is also a weekly review by the treatment team.

The 2008 HMIP report described the programme as “impressive” although there were some delays in the transferring in of appropriate prisoners.
In November 2009 there were 43 prisoners engaged in treatment with a waiting list of approximately 14. At the end of November there were 67 starts and 48 completers. The RAPt section of the wing has 60 beds with approximately 45 in use at one time. There are approximately 100 starts a year. The rest of the wing is made up of enhanced prisoners and kitchen workers.

6.28.1. Staffing
The current staffing allocation is one treatment manager and 4 full time counsellors. RAPt has recently provided an additional worker to meet increasing demand.

6.29 Alcohol detoxification

The IDTS needs assessment highlighted that the main component of an effective treatment system that was missing at HMP Coldingley was psychosocial interventions around substance misuse.

Alcoholics Anonymous sends representatives to HMP Coldingley where a group is held regularly.

6.30 Pharmacy

6.30.1 Staff structure

The prison pharmacy team is based at HMP High Down. The whole time equivalent spent dealing with HMP Coldingley is :

Pharmacist 0.4 wte
Technician 0.4 wte
Assistant 0.4 wte

6.30.2 Service provision

Medication is issued twice a day (8.10am -9am and 4.30pm-5.15pm). In many other establishments medication is dispensed three times a day. Medication can be dispensed to individual prisoners more frequently but only in exceptional circumstances. A & E wings have their medications dispensed on the wing. All other prisoners must get their medication from the healthcare centre. The overall aim is for all dispending to be wing based.
Simple medications such as Gaviscon and paracetamol are available overnight. These medications are stored in a locked cupboard with the key available at the main gate and can be signed out by prison officersIf a prisoner needs any other medication overnight the out of hours GP service is called or an ambulance in an emergency. Thamesdoc has an emergency bag that contains key medications.
Around 80% of medications are in possession (weekly, monthly or night in possession) and prisoners with insulin dependent diabetes are allowed their insulin in possession. It is likely that there are more prisoners who are clinically eligible for in possession medication but do not receive it due to other factors e.g. security, self harm risk etc. If an insulin dependent diabetic cannot stabilise their illness using in possession mediation they are moved to a prison with 24 hour healthcare.
There are no special arrangements for coding or labelling medications for prisoners with low literacy levels. The in possession assessment is focused on reducing the

risk of self harm rather than assessing the individual's level of understanding about the drug they are taking.
No over the counter (OTC) medications (e.g. ibuprofen) are available on the canteen list.

If a new medication is prescribed, a new box started or medication is changed the prisoner is provided with the medicine information leaflet contained with the product.

A clinic is run by the pharmacist that undertakes medication reviews, discuss the use of generic/changed medications and decrease analgesia consumption as well as other issues. In August 2009 the clinic saw 24 patients with a waiting list of 8. The majority of these appointments were to discuss medication (37%).

6.30.3 Governance
The pharmacy team are managed by the Head of Pharmaceutical Services and Development for the Prisons in Surrey. They in turn are managerially accountable to the Operational Manager for prison healthcare and professionally to the Chief Pharmacist of Surrey Community Health Services.
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 NHS Surrey.

6.31 Podiatry

Activity data for August 2009 showed that 7 prisoners were seen in clinic.

6.32 Physiotherapy

Analysis of clinic data from August 2009 showed that 12 prisoners were seen in total. This would equate to approximately 144 patients seen per year. There were no DNAs in the time period. Two thirds of these had half hour sessions and the rest had one hour sessions with the physiotherapist. There are currently 10 patients on the waiting list.

6.33 Ultrasound

This monthly clinic saw 8 patients in August 2009 and has a waiting list of 15. Of those seen in clinic the majority (50%) presented with a scrotal mass/pain. Following normal scans these individuals were all discharged. Other presentations were musculoskeletal and renal pain.

6.34 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 a local prison hosted and participated in a multiagency tabletop pandemic flu exercise in October 2008. There is currently no communicable disease steering group to oversee strategy development and implementation.
Flu immunisation was administered in the healthcare centre. All prisoners were targeted.

Swine flu immunisation was taken up by 57 prisoners. There have been 5 cases of swine flu in the prison to date (January 2010). Three of these have been microbiologically confirmed. All of these cases received Tamiflu.
Seasonal flu immunisation was taken up by 63 prisoners in 2009.

In December 2009 an outbreak of norovirus was managed successfully within the prison and the learning from this is to be used as the basis for national guidance.
An infection control audit was undertaken in the healthcare centre in October 2009. A number of minor issues were identified and have been acted on. One infection control audit and one handwashing audit are to be undertaken annually.

6.35 Prisoners with disabilities

National standards state that healthcare should not be the default setting to house disabled prisoners.

6.36 Health promotion

HMP Coldingley has an active health promotion orderly who is also a member of the health promotion action group (HPAG). This role is popular amongst prisoners and prison staff.
The HPAG is being convened in January 2010. This group will develop a prison health promotion action plan. Initial pre meetings have taken place between prisoners and healthcare staff to coordinate the group.

6.37 Exercise Referral Schemes/use of the gym

Referrals are made by the GPs, nurses and physiotherapists for a number of indications including back pain and minor injuries. The remedial gym policy (including assessment criteria) was reviewed and revised in November 2009 following a review of remedial gym provision. The review was prompted due to the high demand for remedial gym. These sessions were being used as a way of circumventing waiting lists, had an additional session per week (compared to other mainstream gym programmes), were attractive due to the smaller group sizes and were running for prolonged periods.
Prisoners are encouraged to integrate (where possible) with mainstream gym sessions. If this is not possible referrals can be made by anyone including the individual prisoner but authorisation rests with the GP, physiotherapist or Head of Healthcare to ensure that criteria are met. The criteria are grouped under the headings: Older prisoners; weight management; mental health; physical rehabilitation; pain management and drug treatment services. The initial referral is for a 6 week course with frequency of sessions based on need with the aim of progress to normal gym as the outcome.

The gym area at HMP Coldingley is used as a multi sports area with recent investment in new fitness equipment. A range of accredited programmes are available. The 2008 HMIP report stated that PE staff had good links with healthcare [1].
Figures from July 2009 demonstrate that there was a significant difference between the planned gym activity and what was actually delivered (Table 6.1)

Table 6.1 Planned and actual gym use figures (July 2009)

	Day	Evening	Weekend	Total
Planned	4217	720	1920	6857
Actual	3430	633	1548	5611

There were a total of 559 prisoners available to attend gym sessions. 380 individuals actually attended the gym (68% of the prison population). The gym is risk assessed to take up to 40 inmates in each class for either recreational classes or certified courses. As PE is voluntary the classes do not always hit the target figure.
On average 11 prisoners attend rehabilitation classes per week. Rehab gym covers many different injuries such as early, intermediate and advanced work for post op cruciate, diabetics, meniscus tears, weight loss, frozen shoulder, Achilles tears etc. These classes are done in conjunction with and under the direction of the GP and physiotherapist.
Due to long term sick leave there are currently no PE staff trained to cardiac rehabilitation phase 4 exercise training level. Therefore no staff can currently work with cardiac referrals. Gym staff are keen to achieve the accreditation. In order to be eligible staff must hold a level 3 qualification in exercise and fitness, be endorsed by a phase 3 hospital/professional prior to attending a course and have at least 2 years teaching experience.

There is a significant interest in body building within certain groups in the prison population. Anecdotal evidence suggests that this has created a culture of intimidation for some other prisoners using the gym and may have fuelled an underground market in high protein food and drinks as well as the abuse of performance enhancing drugs including steroids.

6.38 Medical emergencies

Emergency resuscitation equipment (including a defibrillator) is stored in the treatment room in healthcare. In an emergency prisoners are advised to report to wing officer who can then inform healthcare.
A number of prison staff can offer first aid and offer practical skills such as cut down.

Out of hours, the prison uses the emergency services and Thames Doc to deal with any medical emergencies. There is not always a first aid trained prison officer on duty. There is currently no out of hours mental health provision.

There are no defibrillators on the general wings at HMP Coldingley, however the IDTS wing has a defibrillator. Prison staff on the IDTS wing have also received training to use this.

6.37 Service User Involvement

PALS in prison is an extension of the service provided in the rest of the NHS and confers a number of benefits to service users, providers and commissioners:

- Providing support and access for hard to reach groups
- Promoting health and social care rights and responsibilities resulting in longer term access and engagement with services for offenders throughout the criminal justice system
- Informing the complaints process, helping to improve services, and creating good working relationships between prisons and PCTs

- Exploring, understanding and addressing healthcare concerns raised by HMPI, IMB or MPQL audits
- Helping PCTs meet public health targets and the Prison Health Performance and Quality Indicators
- Providing evidence to support commissioners, patient centred service planning and the equality impact assessment of health and social care services in prison

The aim of the service is to normalise its use amongst prisoners.
Prisoners have access to a Patient Advice and Liaison Service (PALS) through a trained prisoner representative. The PALS prisoner representative is supported by a Public Engagement Manager. The PALS model in HMP Coldingley is the same as that outlined in DH guidance[46] in which NHS Surrey is cited as a model of good practice. The NHS Surrey PALS team developed their knowledge and awareness of prison issues by shadowing the healthcare team at HMP Send. The PALS model developed at HMP Send was rolled out in April 2009. The initial PALS orderly was recruited and following a period of induction promoted the service and dealt with several PALS queries. The orderly was released in June 2009 and his post has been filled. The current PALS orderly has a daily meeting with a senior nurse to ensure that concerns can be addressed and resolved rapidly. As well as induction the PALS orderly has regular 1:1 supervision with the Public Engagement Manager. There is a PALS box on the A&D corridor and on E wing.
During the quarter April to June 2009 39 more informal/less complex cases were dealt with by the PALS orderly. The type of issues managed by this route were issues such as the attitude of the GPs, delays in getting appointments and waiting lists for dentistry. Ten more complex cases were passed to the Public Engagement Manager for resolution. All of these were resolved.

The IMB received 136 applications in 2008 of which 18 (13%) were health issues. This was the same proportion of applications as 2007.

In August 2009 healthcare received 12 complaints. Anecdotal evidence suggests that formal complaints about healthcare have reduced and the prisoners are satisfied with the service offered by PALS. For the year 1st April 2008 to 31st March 2009 there were no formal complaints received by the PCT.

6.40 Expert Patient Programme

An awareness initiative is underway to engage offenders with long term conditions and recruit them to the forthcoming Expert Patient Programme Living Well Course. The programme has been promoted by the PALS orderly and there are now sufficient prisoners enrolled for it to commence.

6.41 Release information

On release prisoners are provided with a form for free medication. Any prisoners under healthcare should receive a discharge letter for their GP. Healthcare is adopting the discharge model currently used by IDTS which provides more information for prisoners on release. The most relevant items in the IDTS discharge pack for general prisoners is information on local services in the area to which they are being discharged, information on safer drinking, condoms, information on accessing services and health promotion information (e.g. 5 a day). The packs have been designed by IDTS service users. All IDTS prisoners are also formally linked in to a GP.

The mental health in-reach team has a CPA planning meeting pre discharge and provide a letter for the prisoners GP with suggested follow up. A one week “staying out” project is also available for prisoners about to be released.

11% of prisoners surveyed in 2008 know whom they could contact about continuity of health services on release and 10% felt they would have a problem accessing services on release.

HMPS provides information on other agencies e.g. Citizen’s Advice Bureau. The prison has a Housing Advice Centre staffed by two orderlies who provide peer advice on housing issues. There is also a weekly visit by a representative from Shelter who provides more in depth advice about issues such as rent arrears and tenancy. An advisor from Job Centre Plus visits the prison once a week and sees prisoners for 15 minute appointment slots to advise on employment, benefits and grants. Prisoners are scheduled to meet the advisor 6-8 weeks prior to release.

6.42 Support for prisoners’ families

A number of agencies are available to support the children and families of prisoners at HMP Coldingley. These include Families Anonymous (who have links with RAPt), the Mothers Union (who run a crèche for visitors on Saturday afternoons and during school holidays), the Friends of Coldingley (who run the Visitors Centre).
NACRO and Action for Prisoners Families produce a booklet called ‘Outside Help’ which provides practical information for the families of people in prison.

6.43 Canteen list

The canteen list is supplied by Booker. The list consists of core items (available in all prisons) and other items which are added to the list at the discretion of the governor. Originally self care items were on the core list but with a change in providers these were then mixed in with the general canteen list choices. Therefore the absence or presence of self-care items on the list is at the discretion of individual governors. Some items on the list have a number of choices and price options.
Prisoners can order from the list using an order form using money earned from work as well as a limited amount of private cash. In order to prevent prisoners making hooch there are limits put on the amount of sugar and juices that can be purchased.

6.44 Menu

Prisoners can choose their meals for the week ahead from a menu card with once main course for lunch and dinner. If the card is completed incorrectly the prisoner is given the default choice for that meal. Vegetarian, healthy option and halal meals are available.
HMP Coldingley has attained a silver Eat Out East Well award from Surrey County Council. The award was developed to reward caterers who make it easier for their customers to make healthy choices. The level of award is based on a scoring system that takes into account the type of food on offer, cooking methods and how food is promoted.
A monthly Food Committee (which includes prisoner representation) provides input into the menu at the prison.
PSO 5000 (April 2008) gives clear instruction on food handling, food management and provision. The PSO states that” an assortment will be offered with varying

nutritional content , thereby promoting a balanced healthy diet by choice". To ensure 6.2).

Table 6.2 Food group and minimum frequency on the menu

Food group	**Minimum frequency**
Meat	Daily
Fruit & vegetables	5 portions per day
Poultry	Twice per week
Fish	Twice per week (one of which should be oily)
Supplementary snack	Per evening

The PSO advises that healthy eating should not be assessed "dish by dish" but over a period of time and that the opinions of kitchen staff and consumers should be regularly surveyed. The results of the surveys and suggestions should be used to review the menu. A suggestion box and a food comments book were also suggested as methods for obtaining feedback.
For the financial year 2009-2010 the maximum catering benchmark has been set as £2.10 per prisoner per day[47].

The Prison Health and Quality Indicators do not specifically included an indicator on nutrition but this is highlighted as an area that should be prioritised by the HPAG.

SUMMARY OF RECOMMENDATIONS

STRUCTURE	**STAFFING**	During future recruitment rounds HCC should consider increasing the number of nursing staff with a mental health background/qualification
	GUM	The service provider should investigate the need for and feasibility of providing an additional GUM clinic
	HYPERTENSION CLINIC	SCH should review whether the HT clinic service is the best use of clinical time and provides the most appropriate, evidence based support to individuals with hypertension
	NHS CONSTITUTION	Healthcare staff must integrate the NHS constitution into the services that they provide to ensure that services are delivered in line with the general population and prisoners are treated with respect and dignity.
	PHLEBOTOMY	Healthcare providers need to review access to, and advertising of the PHLEBOTOMY clinic, to reduce the DNA rate and the waiting list
PROCESS	**COMMUNICATION WITH PATIENTS**	The healthcare team must work with prisoners and officers to develop an effective and a consistent method of communication to prisoners on changes in healthcare services. Prison Officers and Healthcare staff at all levels must develop a mechanism for effective and efficient communication, free from professional barriers and negative attitudes.
		The provider should consider including directions to healthcare/ a map in the prisoner induction pack. Better signage (including information about the provider) of healthcare facilities is required
		PATIENTS should receive an acknowledgement of their healthcare application, AND Communication on the progress of external appointments AND healthcare tests should be improved with more information available in line with the regime's security policies
	EXERCISE	HMP Coldingley should review existing opportunities to exercise in collaboration with the HPAG and maximise these
		61% of prisoners wanted a gym programme to help with health problems. Greater cooperation between the gym and healthcare staff is essential to ensure that only appropriate referrals are made.

Outcomes from remedial gym referrals must be effectively communicated back to the referrer

Prison officers should verify all gym referrals with healthcare if they have any cause for concern. If gym referrals are refused by HMPS staff the reasons for this should be discussed monthly by the HCC manager and the Governor with responsibility for healthcare

The prison and healthcare should support the PE staff in attaining the level 4 qualification

REGIME & SECURITY

Surrey Community Health Services has a zero tolerance policy that should be fully integrated in any healthcare service. Healthcare staff should ensure they work closely with prison officers in order to maintain their own safety and security.

TRAINING & COMMUNICATION BETWEEN PROFESSIONALS

There are many prison officers working different shifts, officers would benefit from a delegated named nurse on each wing as a point of contact.

Prison Officers must be consulted on major changes to health service provision and receive timely information on any planned changes.

Many officers and healthcare staff felt that joint training opportunities are needed for officers and healthcare to reinforce the understanding of each other's roles whilst developing professional relationship.

A meeting or induction with healthcare staff is recommended to form part of the induction training of new prison staff.

A meeting or induction with reception staff and prison officers is recommended to form part of the induction training of all new healthcare staff.

In line with Surrey Community Health standards, all healthcare staff must have supervision and regular appraisals.

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

RECEPTION 'SCREENING'

In order to facilitate better communication and service the prison officers should inform HCC how many prisoners are expected daily as soon as they receive this information so that nurses can plan their duties accordingly, AND Reception staff must communicate the arrival of new prisoners to healthcare staff in a prompt manner.

Healthcare staff should ensure if there is a reason for their delay at attending reception this is communicated to prison officers in a timely manner and an estimated time of arrival is provided.

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

HEALTH PROMOTION

Health Promotion Action Group (HPAG) must have a focus on the findings and recommendations of this needs assessment

HMP Coldingley catering team must work with prisoner representatives to review the improvement and availability of healthy food options

There should be increased provision of safer sex interventions and messages within specialist and general healthcare services

Healthcare should work with the HPAG to devise a promotion campaign advertising the availability of condoms

The provider should consider increased provision of evidence based complementary alternative activities that can impact on physical and emotional health.

The provider should consider an increased role for prisoners in the delivery of health promotion messages

Ensure that any health improvement interventions around BBVs are evaluated

Due to the high prevalence of mental health disorders within prison the HPAG should ensure that self help information and activities which promote good mental health are provided and promoted

HPAG should identify Easyread materials which would help those with a learning disability effectively communicate in relation to their health needs and the prison regime

HPAG should consider running a ‘self care’ campaign in the prison highlighting how prisoners can manage their minor ailments and the resources available to support them to do this

Healthcare staff should continue to seek prisoner's views on healthcare services and use these to improve services. An improvement in prisoners views of healthcare needs to be demonstrated.

The provision of a comprehensive health promotion programme should be considered by the HPAG with a specific focus on mental health promotion, healthy lifestyles, nutrition, substance misuse and smoking

Oral health promotion should be improved across all prisons. The HPAG should have oversight of its delivery and prisoners themselves should help deliver the programme with proper support and training. Oral hygiene promotion should be increased and the results monitored in the dental satisfaction survey.

PALS AND COMPLAINTS

PALS must be more proactive in promoting the services it provides to both prisoners and their families

The PALS service should ensure that reports and feedback from prisoners are distributed to all healthcare staff and regularly reported to the Prison Health Partnership Board

DENTISTRY

Self care alternatives to seeing a dentist should be considered in all routine cases and appointments for non urgent needs should be more effectively managed

NHS Surrey should monitor dental waiting times.

All recommendations of the forthcoming Oral Health Promotion Strategy that are relevant to prisons should be accepted. The HPAG should have a pivotal role in delivering on these recommendations

Healthcare administrative staff must ensure that all patients have a medical record available for appointments. If records are unavailable appointments must be rescheduled in a timely manner to prevent further delay for the prisoner

A three month pilot should be undertaken assessing the usefulness of Surrey Dental Helpline clinical algorithms in prioritising prisoners for treatment. If successful these algorithms should be used as the basis of a health promotion campaign with prisoners

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 nurse should triage. This could free up considerable amounts of time for nurses to focus on other health needs

	Reasons for DENTISTRY DNAs need to be clarified and approaches to improve this DNA rate should be adopted. Effectiveness of this should be monitored through the contract meeting
ENVIRONMENT	Exposure to environmental tobacco smoke should be minimised
	Disposable sinks should be provided for healthcare staff in reception as soon as possible
SELF HARM AND SUICIDE	Audit of F213 and F213SH against accident register. Increase awareness amongst all staff of what should be recorded as an accident and the duty/procedures to record them
	In high risk prisoners, ensure appropriate prescribing and efficient observation when patients are taking medication to prevent overdose
	ENSURE THAT Positive responses to questions about suicide/self harm at reception should always prompt appropriate referral or intervention
ALCOHOL	Alcohol screening using AUDIT should be mainstreamed and when indicated a brief intervention should be provided
	Results of the AUDIT screening should be used as the basis of a business case for providing structured alcohol interventions and pre-discharge advice to identified prisoners and Results of the alcohol screening audit should be reported through the contract monitoring.
PHARMACY	healthcare and prison management should review the homely remedies protocol to minimise the amounts of paracetamol being prescribed by the GP
	Healthcare staff must improve information provided to prisoners on how to use medication and its potential side effects. Further extension of the role of pharmacists as health educators should be considered
	In high risk prisoners, ensure appropriate prescribing and efficient observation when patients are taking medication to prevent OVERDOSE
	When the initial needs assessments are completed for all Surrey prisons NHS Surrey should undertake a review of CANTEEN LIST provision and prices with a focus on medication, healthy foods and self care items

	The prison management in conjunction with pharmacy and healthcare should promote awareness of homely remedies as source of analgesia for prisoners, to prevent inappropriate GP appointments which could be purely for paracetamol and incur an unnecessarily high pharmacy cost
	All medication must be ordered and delivered in a timely manner AND HMP Coldingley management and healthcare should review whether it would be desirable and feasible to dispense medication three times a day
	Patients should be provided with support and information on the medication they are taking and be offered a medication review especially if medication has been started in another prison. Provider should consider the expansion of the pharmacy review clinic to include the inappropriate prescribing of mental health drugs with MHIT input
	The current dispensing of medication practice which splits boxes into weekly or daily doses, should be reviewed to ensure that it is clinically required and cost effective
	Pharmacy should investigate whether simpler drug information is available/can be developed for the most commonly prescribed medication
	Pharmacy and healthcare should collaborate on a project to inform prisoners about the side effects associated with common medications. The current pharmacy clinic should consider a drop in session where prisoners can come with queries and concerns about the medication they are taking
	Pharmacy should review the use of the gate box to ensure that there is oversight and correct procedure and governance around the use of these medications
SCREENING	Healthcare staff should be aware of the relevant screening programmes and proactively identify the relevant individuals and investigate if screening has taken place through IMRs/GP/hospital records. A named nurse should oversee screening within the prison and actively promote the benefits of screening to the individuals

		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 of these as appropriate
	FOOD	The catering department should consider innovative ways of obtaining prisoner views on the menu and incorporating their feedback into menu planning and this should be formally reported to the HPAG
	SMOKING	The provider should consider increasing the number of smoking cessation clinics available to prisoners
	INFECTION CONTROL	Prisoner officers and prisoners should be encouraged to report any diarrhoea and vomiting illness (even if self medicated) to HCC staff in order for relevant infection control measures and advice to be put in place. In addition, when prisoners are transferring their meal from the dining hall to their call, consider measures to reduce the risk of contamination.
DISEASES	**CHRONIC DISEASES**	Asthma, COPD, Epilepsy, Diabetes, Coronary Heart Disease management should comply with the formal approach to managing long term conditions currently being adopted across the prison estate
		Smoking cessation should be actively promoted to all those with COPD and prisoner response recorded
		A report of epilepsy at reception should lead to a clinical assessment, confirmation of diagnosis and prescription of appropriate treatment. Compliance with this should be regularly audited
		Health care providers should raise awareness of the signs and symptoms of diabetes amongst prisoners and prison staff
		Healthcare should ensure that the chronic disease register is regularly updated and held electronically (as soon as possible)
		Healthcare should consider expanding the chronic disease register to include the appropriate clinical areas in the Quality Outcomes Framework (QOF) such as hypothyroidism, chronic kidney disease, atrial fibrillation, obesity and learning disabilities
		Healthcare staff should be made aware of the potentially increased risk of hypertension associated with imprisonment
	STIs	Due to the high numbers of young men in this prison the Chlamydia screening programme should be formally introduced, activity reporting improved and compliance monitored by NHS Surrey AND patients should be consented for Chlamydia screening at reception

BBV	Empower patients to be aware of BBV risk and request testing. Develop a strategy to reduce BBV risk especially amongst IDUs
	Increase the uptake & monitoring of Hepatitis B vaccination (particularly among IDUs)
TB	Screening for TB should be proactive at reception and during other health interventions and measures should be taken to identify cases. Questions on TB history, contact and symptoms should be included in the reception questionnaire. Any positive responses should be followed up by a detailed assessment and examination by the GP
MENTAL HEALTH	Management of SMI should comply with the formal approach to managing long term conditions currently being adopted across the prison estate. NICE guidance is available for the management of 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 the contract monitoring when established.
	The use of IDTS nurses as back up for mental health workers should be urgently reviewed by both services as this arrangement is not sustainable in the long term
	Referrers to mental health (MH) services should ensure they record the prisoners 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 processes to identify any potential barriers which may prevent BME groups from accessing services. Activity data should include ethnicity data and monitored through the contract meeting.
EIP	Early intervention in Psychosis services in the community should work with the prison mental health in reach service in identifying, assessing and treating prisoners in the early stages of psychosis
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 developed

	LD	Prisoners with LD should be proactively identified during reception and by healthcare, reception and prison staff AND included on a health register
		Health action plans should be developed for all prisoners with LD with all information on key health issues presented in an Easyread format
		All prisons should adopt the LD screening tool (once developed) for use throughout the establishment
	IDTS	An IDTS specific needs assessment should be conducted annually and fed into the IDTS treatment plan
		IDTS staff should be aware of the differences in the type of drug use between ethnic groups and how this would be applicable to the population of HMP Coldingley
PROCEDURES	**EMERGENCIES**	Healthcare should a review of a sample of cases where prisoners have been taken out of the establishment for treatment to see if there are preventative measures that can be put in place to prevent the need for emergency care
		Healthcare should review any OOH activity around prescribing to ensure that prisoners medication needs are addressed within normal hours
		Thamesdoc should provide more clinical information on the reasons why the prison calls them out of hours. NHS Surrey should train OOH provider to be aware of unique prison health needs.
		There should always be a first aid trained prison officer on duty and All first aid trained prison officers should undertake defibrillator training.
	EXTERNAL REFERRALS	Healthcare staff should (where possible) arrange out patient appointments in acute trusts as close to the prison as possible unless this compromises quality or continuity of patient care
		Reasons for DNAs need to be clarified and approaches to improve this DNA rate should be adopted. Effectiveness of this should be monitored through the contract meeting
		Healthcare staff should collaborate with their counterparts in other prisons to ensure that prisoners do not breach 18 week waiting time when they are transferred between establishments
		The provider should consider whether in-reach clinics should be provided for high volume out patient specialities e.g. maxillofacial
		DNA rates should be advertised in healthcare along with waiting times

TRANSFERS FROM OTHER PRISONS	Inappropriate medical transfers should be reported to the prisoner governance committee and raised as an SUI with the PCT of the transferring prison. If transferring prisons do not provide full medical records on transfer this should be addressed through the Partnership Board and raised as an SUI with the PCT of the transferring prison
RELEASE	Education department to review all discharge information to ensure that it is suitable for the literacy levels within the prison AND Education department to run courses on basic form completion with all prisoners prior to release Healthcare should review the information provided to prisoners on release and incorporate best practice from IDTS as soon as possible. Review and update of information available to prisoners on release in order to ensure that they have sufficient information to contact and register with a GP and access medication

APPENDIX A

MEMBERSHIP OF NEEDS ASSESSMENT STEERING GROUP

- Dr Ayesha Ali, SpR, Public Health, NHS Surrey (chair)
- Liz Dodds, Senior nurse, HMP Coldingley
- Tanya Osborne, Healthcare manager, HMP Coldingley
- Mark Girvan, Head of Mental health services, HMPS
- Dave Turner, Healthcare governor, HMP Coldingley
- Sue Davies, Head of prison healthcare, SCHS
- Steve Norman, DH
- Jo-Anne Alner, Consultant, Public Health, NHS Surrey
- Nicky Croft, Lead commissioner prisons, NHS Surrey
- Rajinder Chumber, PH Development Worker, NHS Surrey
- Khurshid Choudry, Pharmacist, HMP Coldingley
- Linda Murray, Clinical Governance Lead, SCHS
- Christine Raven, Public Engagement manager, NHS Surrey
- Sharmila Ramdas, HMPS IDTS
- PO Gary Falcon

APPENDIX B

FOCUS GROUP SCHEDULE

Introduction

- Introduce
- We are looking at how we can help men at Coldingley 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

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Being Healthy/ Healthy Lifestyle

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

2. Are people generally healthy in Coldingley?

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

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

> *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 Coldingley?

> *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 Coldingley? How long does it take?

8. What about other services such as the dentist or optician?

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

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

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

[PROMPT FOR FEEDBACK]

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

Summary

- Summarise main points

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

- Thank you and close

APPENDIX E

REFERENCES

[1] IDTS Needs Assessment HMP Coldingley. Anthony Hewitt Consultancy. August 2009.
[2] Common themes from analysis of 120 Prisons & Probation Ombudsman (PPO) reports. Letter. Department of Health. 23rd May 2008. Gateway: 9221
[3] HMP Coldingley Annual report of the IMB 2007-08
[4] South East Region: Offender Needs Analysis v3. 9th December 2009
[5] SCHS Prison Healthcare Provider Services. Service Plan 2007-09
[6] Wang, E.A., Pletcher, M. and Lin, F. (2009). Incarceration, incident hypertension and access to healthcare: findings from the coronary artery risk development in young adults (CARDIA) study. Arch Intern Med. 13:169 (7): 687-93.
[7] Her Majesty's Inspectorate of Prisons. Report on an unannounced short follow up inspection of HMP Coldingley. 8-10 SeptemberSpetember 2008.
[8] Ministry of Justice. Population in custody monthly tables June 2009. England & Wales. 31st July 2009.
[9] Carter P. Lord Carter's review of prisons, Securing the Future. London: Ministry of Justice, and Justice Committee. 2009.
[10] IDTS Needs Assessment HMP Coldingley. Anthony Hewitt Consultancy. August 2009.
[11] Common themes from analysis of 120 Prisons & Probation Ombudsman (PPO) reports. Letter. Department of Health. 23rd May 2008. Gateway: 9221
[12] HMP Coldingley Annual report of the IMB 2007-08
[13] South East Region: Offender Needs Analysis v3. 9th December 2009
[14] Her Majesty's Inspectorate of Prisons. Report on an unannounced full follow up inspection of HMP Camp Hill 9-13 February 2009.
[15] Her Majesty's Inspectorate of Prisons. Report on an announced inspection of HMP Featherstone 20-24th October 2008.
[16] Her Majesty's Inspectorate of Prisons. Report on an announced inspection of HMP Dartmoor 11-15th February 2008.
[17] Prison Health Performance & Quality Indicators 2008/09. Department of Health. London. December 2008
[18] Developing and modernising primary care in prisons. Department of Health, June 2002
[19] Commissioning healthcare in prisons. The results of joint work between the Healthcare Commission and Her Majesty's Inspectorate of Prisons in 2007/08. February 2009.
[20] Annual report of the Independent Monitoring Board HMP Featherstone 2007-08
[21] Strategy for modernising dental services for prisoners in England. Department of Health, 2003
[22] A pharmacy service for prisoners. Department of Health. London 4th July 2003
[23] Changing the outlook: A strategy for developing and modernising mental health services in prisons. Department of Health, December 2001.
[24] National Service Framework for Mental Health, Department of Health, 1999
[25] Protection and use of confidential health information in prisons and interagency information sharing. Her Majesty's Prison Service. Prison Service Instruction. 29th May 2002.
[26] Annual report of the Independent Monitoring Board HMP Dartmoor 2008-09
[27] Her Majesty's Prison Service. Prison Service Order 3200 Health Promotion. 23rd October 2003.
[28] Choosing Health: Making Healthier Choices Easier. Department of Health. 2004.
[29] Gilbert RL, Costella A, Piper M, Gill ON. Increasing Hep B vaccine coverage in England and Wales: Commun Dis Public Health 2004; 7 (4): 306-11
[30] Health protection Agency. Unlinked anonymous prevalence monitoring programme. http://www.hpa.org.uk/infections/topics_az/hiv_sti/Stats/HIV/Prevalence/default.htm
[31] Sutton AJ, Gay NJ, Edmunds WJ et al. Modelling the Hepatitis B vaccination programme in prisons. Epidemiology and Infection 2006, 134, 231-242.
[32] Better prevention, better services, better sexual health – the national strategy for sexual health and HIV. Department of Health: 2001

[33] Lau R. Improving genitourinary medicine services in prison. Int J STD AIDS. 2008 Jul; 19 (7): 431-2
[34] HM Government. Health and Social Care Act 2001. Section 11. Public involvement and consultation.
[35] HM Government. Health and Social Care (Community Health and Standards) Act 2003. Chapter 9. Complaints
[36] Condon L, Hek G, Harris F et al. Users views of prison health services: a qualitative study. J Adv Nurs 2007 May;58 (3)L 216-26
[37] Wang, E.A., Pletcher, M. and Lin, F. (2009). Incarceration, incident hypertension and access to healthcare: findings from the coronary artery risk development in young adults (CARDIA) study. Arch Intern Med. 13:169 (7): 687-93.
[38] The Scottish government. Scottish Prisoners Dental Health Survey 2002, Feb 06, 2004.
[39] Prison Reform Trust (2008). Prisoners' Voices: Experiences of the criminal justice system by prisoners with learning disabilities and learning difficulties
[40] Differential substance misuse treatment needs of women, ethnic minorities and young offenders in prison: prevalence of substance misuse and treatment needs. Home Office online report 33/03.
[41] Quearterly report on the Hepatitis B vaccination monitoring programme in prisons in Entgalnd & Wales. Annual Quarter 3 2009 July – Spetember. Health Protection Agency. December 2009
[42] Social Exclusion Unit. Reducing re-offending by ex-prisoners 2002
[43] SCHS Prison Healthcare Provider Services. Service Plan 2007-09
[44] The Bradley Report. Department of Health, London. 30 April 2009
[45] Singleton N et al. Psychiatric morbidity among prisoners in England and Wales, 1998
[46] PALS in prison. Department of Health December 2009
[47] Hansard, House of Commons written answers 14 Sep 2009. Col: 2144W