# PRISON HEALTH & SOCIAL CARE NEEDS ASSESSMENT

# HMP BRISTOL

2015

VERSION 1.6 - UNSUPPRESSED VERSION

JANUARY

SQUARED ANALYTICS

## ACKNOWLEDGMENTS

S Squared Analytics would like to thank staff from HMP Bristol for supporting and participating in this Health and Social Care Needs Assessment.

Additional thanks go to those that participated in the interviews, surveys, and the prisoners and staff that participated in the Focus Groups.

## S SQUARED ANALYTICS

This Prison Health and Social Care Needs Assessment was undertaken by the two Directors of S Squared Analytics. S Squared Analytics is a Research and Analytical company specialising in Needs Assessments.

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# EXECUTIVE SUMMARY

## INTRODUCTION

S Squared Analytics were commissioned to carry out the Health and Social Care Needs Assessment (H&SCNA) for HMP Bristol by NHS England (Bristol, North Somerset, & South Gloucestershire).

H&SCNAs are a systematic way of reviewing the met and unmet needs of a population, leading to agreed priorities and resource allocation that will improve healthcare and reduce inequalities.

## METHODOLOGY

This H&SCNA was undertaken using the PHE Toolkit[1] as the framework. As outlined in the PHE template, the use of the tool "is not meant to be a rigid template or a cookbook."

This H&SCNA was carried out by analysing health data, as well as reviewing existing activity and service provision. A literature review was carried out, looking at what works in other prisons, prevalence figures, and other related evidence.

Semi-structured interviews with healthcare and prison staff were undertaken. In addition, a prisoner and staff survey was carried out to gain invaluable information on health and social care in the prison. This information is to be added.

## DATA PACK

A data pack has been produced to accompany the H&SCNA. The data pack contains key facts and figures, and offers a comparison across the five prisons included in the study.

## KEY FINDINGS AND RECOMMENDATIONS

Each sub-chapter in the document includes a table listing key findings, what the finding means for HMP Bristol, and any recommendations arising. For the full recommendations, please see the tables at the end of the individual sub-chapters:

| Chapter | Sub-Chapter | Page Number |
|---|---|---|
| Engagement | Surveys and Focus Groups | 26 |
| Specialist Pathways | Mental Health | 40 |
| | Self-Harm & Suicide | 45 |
| | Learning Disabilities | 52 |
| | Substance Misuse | 70 |
| Social Care | General | 81 |
| Primary Care & Long-Term Conditions | General | 86 |
| Communicable Diseases | Hepatitis | 115 |
| | Sexual Health | 120 |
| | Tuberculosis | NA |
| Other Services | Pharmacy | 125 |

*Above: Figure 1.1.1 - Location of key recommendations.*

## DATASETS

A range of datasets were used for this H&SCNA, including:

- SystmOne data
- Performance and activity data
- Local service data
- Staff interviews
- Prison Inspection report
- NDTMS
- Surveys
- Ministry of Justice Statistics

At the time of this H&SCNA, the collection of the Health and Justice Indicators of Performance (HJIP) were still in progress, and were not suitable to be included.

Non-identifiable or personalised data was used for this H&SCNA. This version of the H&SCNA is un-suppressed, meaning figures less than five have been included.

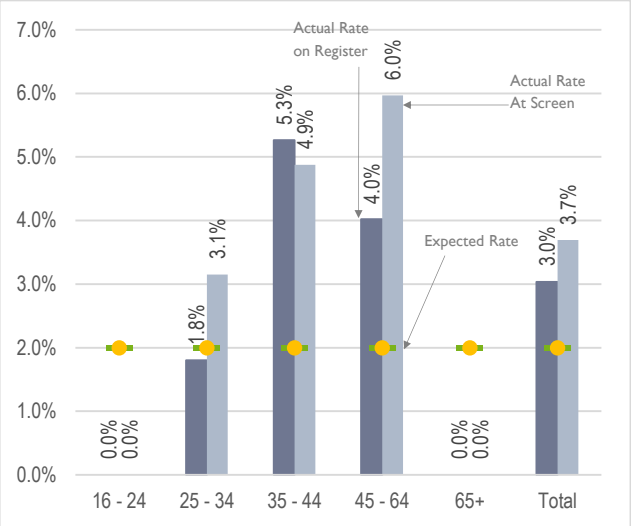
## TIMEFRAME

Data from SystmOne was extracted in October 2014. In general, the analysis relating to SystmOne data covers the 12 months to September 2014. Historical comparisons include the 12 months to September 2012, and the 12 months to September 2013.

Where performance data was used, "2014-15" covers April to September 2014. In some instances, where there were gaps in the performance data, either a "best-fit" approach was taken, or the gap was excluded from the calculation.

## CHARTS, GRAPHS, TABLES, DIAGRAMS

This H&SCNA includes a number of figures to help the reader to visualise the findings. A figure that is used a number of times can be found below.




| Age Group | 16 - 24 | 25 - 34 | 35 - 44 | 45 - 64 | 65+ | Total |
|---|---|---|---|---|---|---|
| Prison Population | 59 | 222 | 152 | 174 | 19 | 626 |
| QOF Expected # | 1 | 4 | 3 | 3 | 0 | 13 |
| QOF Actual # | 0 | 4 | 8 | 7 | 0 | 19 |
| QOF Expected % | 2.0% | 2.0% | 2.0% | 2.0% | 2.0% | 2.0% |
| QOF Actual % | 0.0% | 1.8% | 5.3% | 4.0% | 0.0% | 3.0% |
| Number of Screens | 45 | 127 | 82 | 67 | 4 | 325 |
| Screen Expected # | 1 | 3 | 2 | 1 | 0 | 7 |
| Screen Actual # | 0 | 4 | 4 | 4 | 0 | 12 |
| Screen Expected % | 2.0% | 2.0% | 2.0% | 2.0% | 2.0% | 2.0% |
| Screen Actual % | 0.0% | 3.1% | 4.9% | 6.0% | 0.0% | 3.7% |
| Community Prevalence | | | | | | |

The chart aims to show a number of variables in a single diagram: the expected prevalence rate broken down by age or ethnicity, the actual rate in the establishment identified at the reception screen, and as a snapshot of the disease register as at the end of September 2014.

This allows the reader to view on a single diagram, how the rates differ from cohort to cohort, and where the rates are lower than expected. Where the expected rate is not available by age and ethnicity, the overall rate is used.

# H&SCNA OVERVIEW

## WHAT IS A H&SCNA?

A H&SCNA is an assessment based on health and social care needs, service provision, and activities that impact on a prisoner's health needs. The H&SCNA uses systematic methods to review the met and unmet needs of a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities.

The objectives of a H&SCNA should be:

| | |
|---|---|
| 1 | TO DESCRIBE THE HEALTH AND WELLBEING OF PRISONERS |
| 2 | TO MAP HEALTH AND SOCIAL CARE SERVICES CURRENTLY PROVIDED IN PRISONS |
| 3 | TO EXPLORE KEY INFORMANTS' VIEWS OF THE HEALTH AND SOCIAL NEEDS OF PRISONERS AND HOW THEY ARE BEING MET |
| 4 | TO IDENTIFY GAPS IN SERVICE COMPARED TO THOSE IN THE COMMUNITY, CONSIDERING EVIDENCE RELATING TO CLINICAL EFFECTIVENESS, LOCAL AND NATIONAL STANDARDS AND GUIDELINES, AND TARGETS |
| 5 | TO MAKE RECOMMENDATIONS FOR FUTURE SERVICE PLANNING |

Adapted from: Health Needs Assessment: A Practical Guide, (NICE, 2009)

*Above: Figure 1.2.1 - Summary of the key objectives of a H&SCNA.*

## CHARACTERISTICS OF PRISONERS

The prison population is characterised by having experienced high levels of adverse childhood and social factors, and low levels of educational attainment. The population also has high levels of mental illness. In addition, the prison population has particular health problems linked to offending behaviours, including drug and alcohol abuse and their complications, such as hepatitis B and C.

Levels of many chronic physical disorders (such as epilepsy, asthma, diabetes, coronary heart disease, and cancer) are similar to those found in an equivalent population (young, socially deprived, inner-city). However, because of the social circumstances of the individual prior to entering prison, many of these chronic conditions may have been relatively poorly treated. [2]

The Justice Commission Inquiry into Older Prisoners[3] highlighted that there is "considerable academic and practical debate with regard to the age at which a prisoner is considered old…It is frequently argued that, because of the earlier onset of a range of health problems amongst the offender population, the term older prisoners should be used to refer to those aged 50 and over."

In this H&SCNA, we will explore the wider determinants of health, including demographics such as age and ethnicity. This will be included where possible for each of the chapters. The final chapter also gives an overview of the wider determinants of health.

## METHODOLOGY

This H&SCNA has been completed using the PHE Toolkit and an adaptation of the framework provided by the University of Birmingham Toolkit.[4]

The document is split into six main chapters:

1. Engagement
2. Specialist Pathways
3. Primary Care & Long-Term Conditions
4. Communicable Diseases
5. Other Services
6. Wider Determinants of Health.

Within each chapter, there are sub-chapters detailing individual areas. Where possible, for each area there is an introduction, an overview of the national context, analysis of local data, a summary of the current provision within the prison, and recommendations. These cover the core aspects of the Birmingham Methodology:

| | |
|---|---|
| 1 | EPIDEMIOLOGICAL ASSESSMENT— this looks at the prevalence of various conditions and what services are available to treat them |
| 2 | CORPORATE ASSESSMENT— this looks at the opinions of the various stakeholders involved in prison healthcare |
| 3 | COMPARATIVE ASSESSMENT— this looks at other prisons to see how they approach similar issues in comparison with HMP Bristol |

*Above : Figure 1.2.2 - Approach to the H&SCNA for HMP Bristol.*

The datasets used in this H&SCNA include:

- SystmOne data
- Performance and activity data
- Local service data
- Staff interviews
- Prison Inspection report
- NDTMS
- Surveys
- Ministry of Justice Statistics

At the time of this H&SCNA, the Health Justice Indicators of Performance were available on a limited basis. We were advised that the HJIP were in the process of being completed, and would be fully operational by March 2014.

There were a number of limitations surrounding the data. Data was not available uniformly across the prison. Some services were able to provide more detailed data than others.

As part of the comparative needs assessment, there were two surveys distributed across the prison. The first, a survey of prison and healthcare staff, asked about their opinion on health in the prison, and where they saw areas for improvement. The second, a survey of prisoners, covered the following areas: use of health services, mental health, general health, and demographic information.

As part of the general health section, permission was sought and obtained to use the EQ-5D. The EQ-5D questionnaire is used in the Health Survey for England, and is a standardised instrument used for the measure of a person's health status.[5]

# PRISON OVERVIEW

## INTRODUCTION

HMP & YOI Bristol is a local prison holding male prisoners aged 18 and over. The population is mainly comprised of remand prisoners and newly sentenced prisoners. This establishment mostly holds prisoners remanded or sentenced by courts in the Avon and Somerset area, and receives most of its prisoners from courts in the area, particularly Bristol.

## RESIDENTIAL UNITS

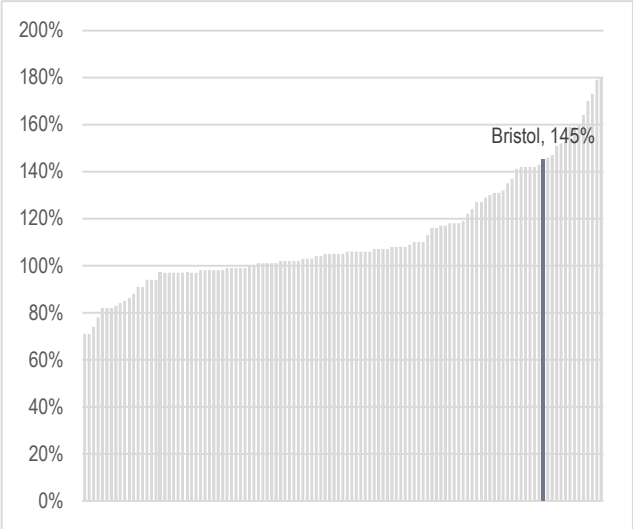
*Below: Figure 1.3.1 - Residential units in HMP Bristol.*

# PRISON POPULATION

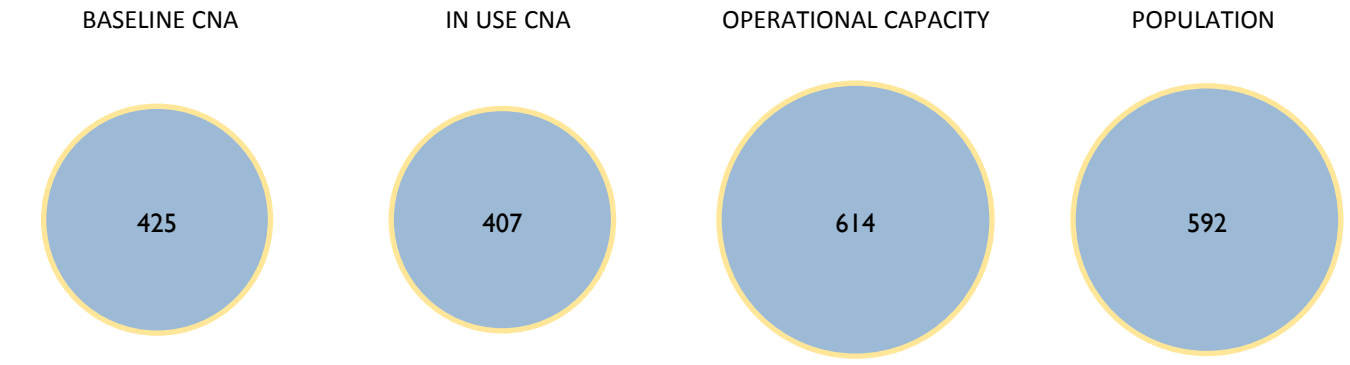
## CAPACITY

The operational capacity of HMP Bristol as at the end of November 2014 was 614, which is 51% greater than the in-use Certified Normal Accommodation (CNA) of 407.

The CNA indicates how many prisoners can be held in decent and safe accommodation. The population to CNA rate in HMP Bristol is 145%. Figure 1.4.1 shows how the establishment ranks against other prisons in England and Wales. The rate of 145% ranks HMP Bristol as the 14th highest population to CNA rate.




*Above: Figure 1.4.1 - Rank of HMP Bristol against prisons in England & Wales based on population to-use CNA*
*Source - MoJ Statistics.*




*Above: Figure 1.4.2 - Various population figures for HMP Bristol*
*Source - MoJ Statistics*

In September 2013, The Howard League for Penal Reform[9] obtained overcrowding statistics through a Freedom of Information request to the Ministry of Justice. The figures obtained show the number of prisoners, on average, who were forced to share an overcrowded cell in 2012-13.

Figure 1.4.3 shows that during 2012-13, 162 prisoners in HMP Bristol shared overcrowded cells designed for one.

*Below: Figure 1.4.3 - Overcrowded cells across the cluster*
*Source - Howard League for Penal Reform*

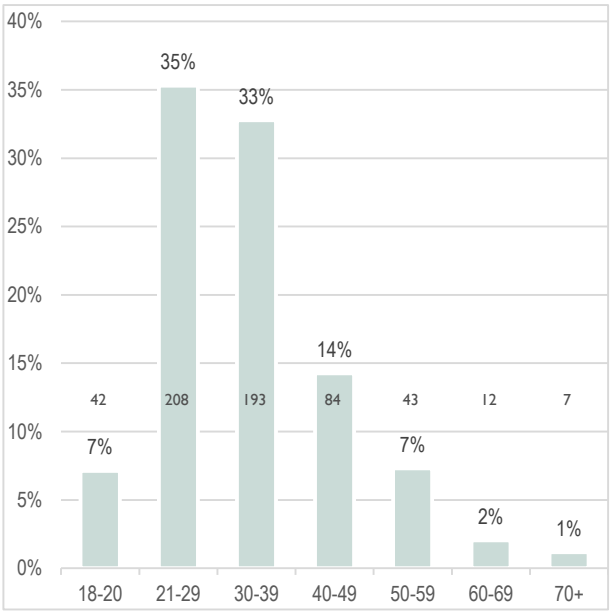
| | Number of prisoners sharing overcrowded cells designed for 1 | Number of prisoners sharing overcrowded cells designed for 2 |
|---|---|---|
| HMP Ashfield | 0 | 0 |
| HMP Bristol | 162 | 0 |
| HMP Eastwood Park | 58 | 0 |
| HMP Erlestoke | 0 | 0 |
| HMP Leyhill | 0 | 0 |

The age profile of HMP Bristol shows a predominantly younger population. 35% of the population are between the ages of 21-29, with a further 33% in the 30-39 age group.

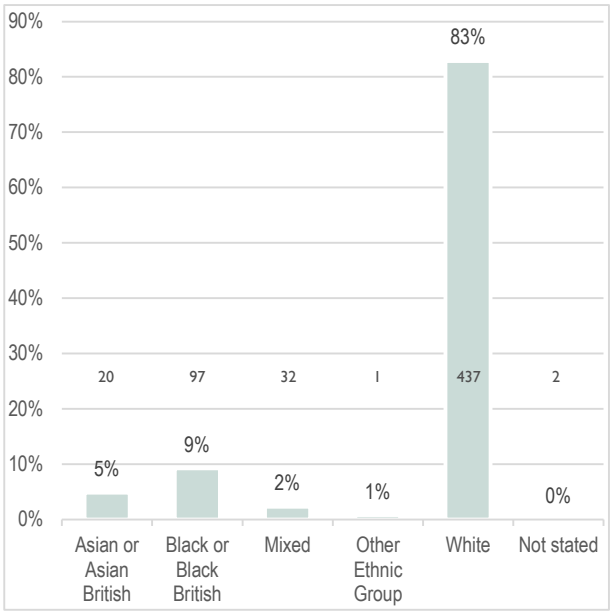
Prisoners over the age of 50 account for 10% of the population.

*Below : Figure 1.4.4 - Demographics of HMP Bristol. Source - SystmOne*

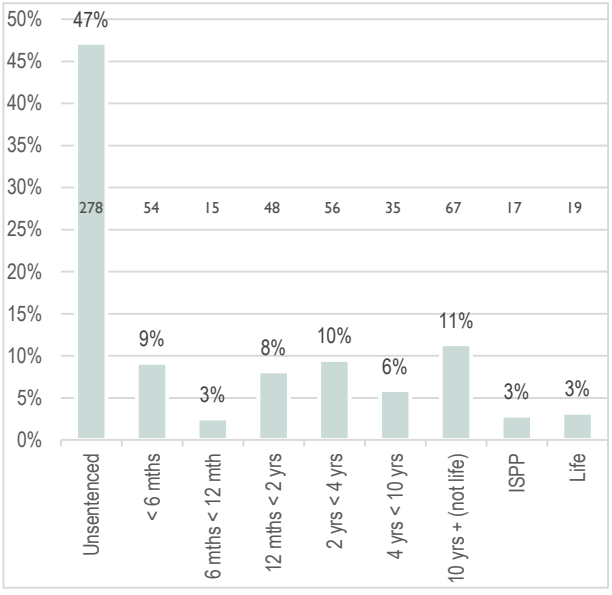
**AGE**



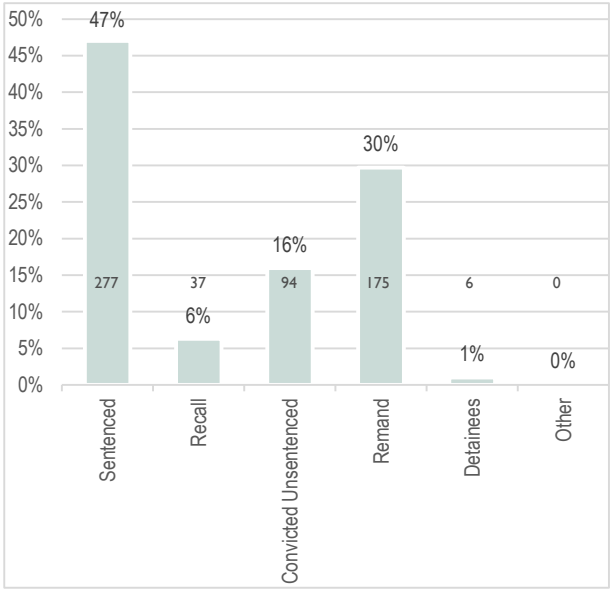

**ETHNICITY**




**SENTENCE LENGTH**




**SENTENCE STATUS**

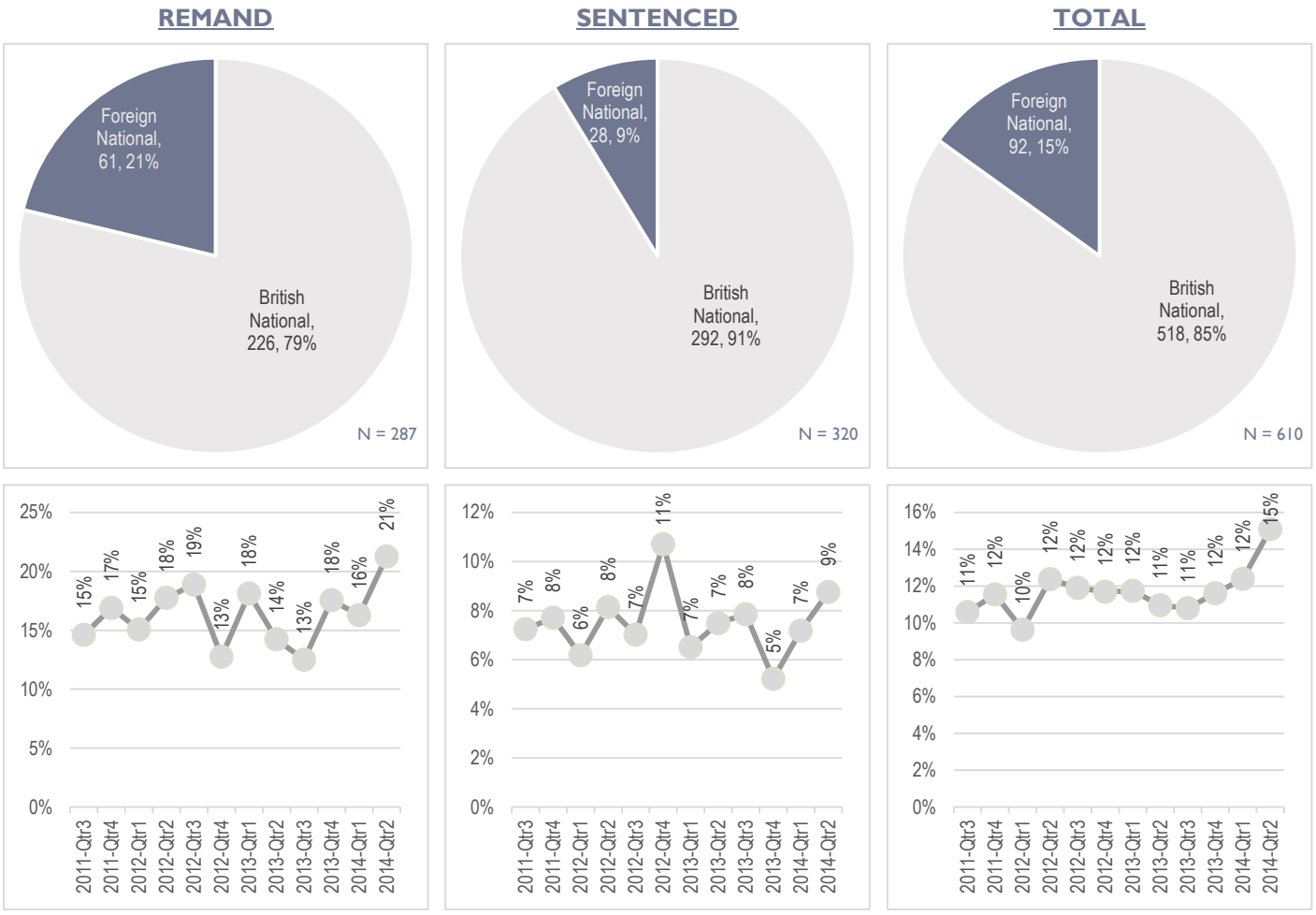


## FOREIGN NATIONALS

Foreign national prisoners account for 15% of HMP Bristol's population. However, there are differences in the rate between the remand and sentenced populations.

Looking at the historical trend, there was an increase of foreign national prisoners in 2014. Between 2011 and 2013, 10-12% of the population were classified as foreign nationals. This increase is more apparent in the remand population.

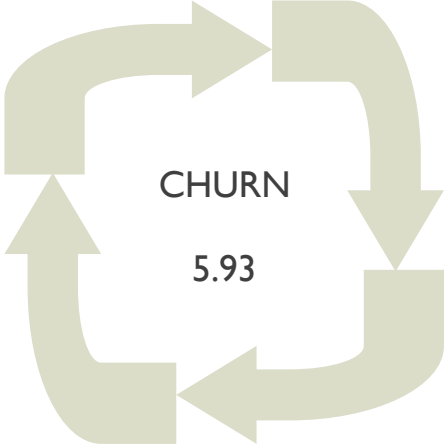
*Below: Figure 1.4.5 - Foreign national population in HMP Bristol.*
*Source: MoJ statistics.*




## TURNOVER

For the 12 months to September 2014, there were 3640 reception screens.

Based on the operational capacity of 614, the churn rate of HMP Bristol is 5.93. The churn rate is essentially the number of times each place is used per year.

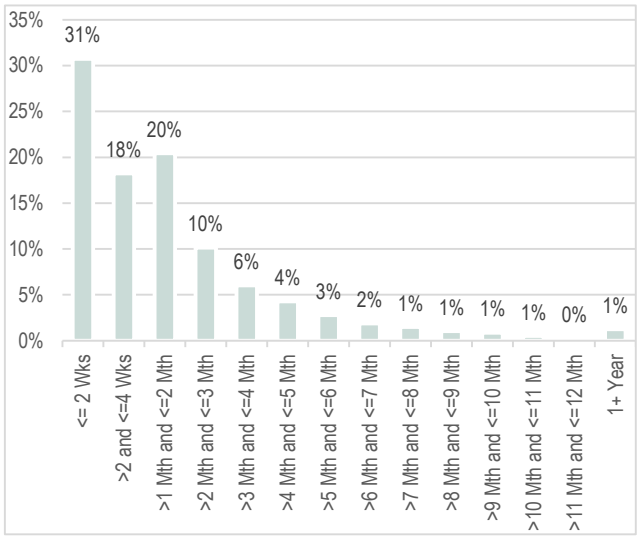


## LENGTH OF STAY

Figure 1.4.6 shows the length of stay for prisoners in HMP Bristol by time band. The calculations were based on prisoners deducted from SystmOne between October 2011 and September 2014.

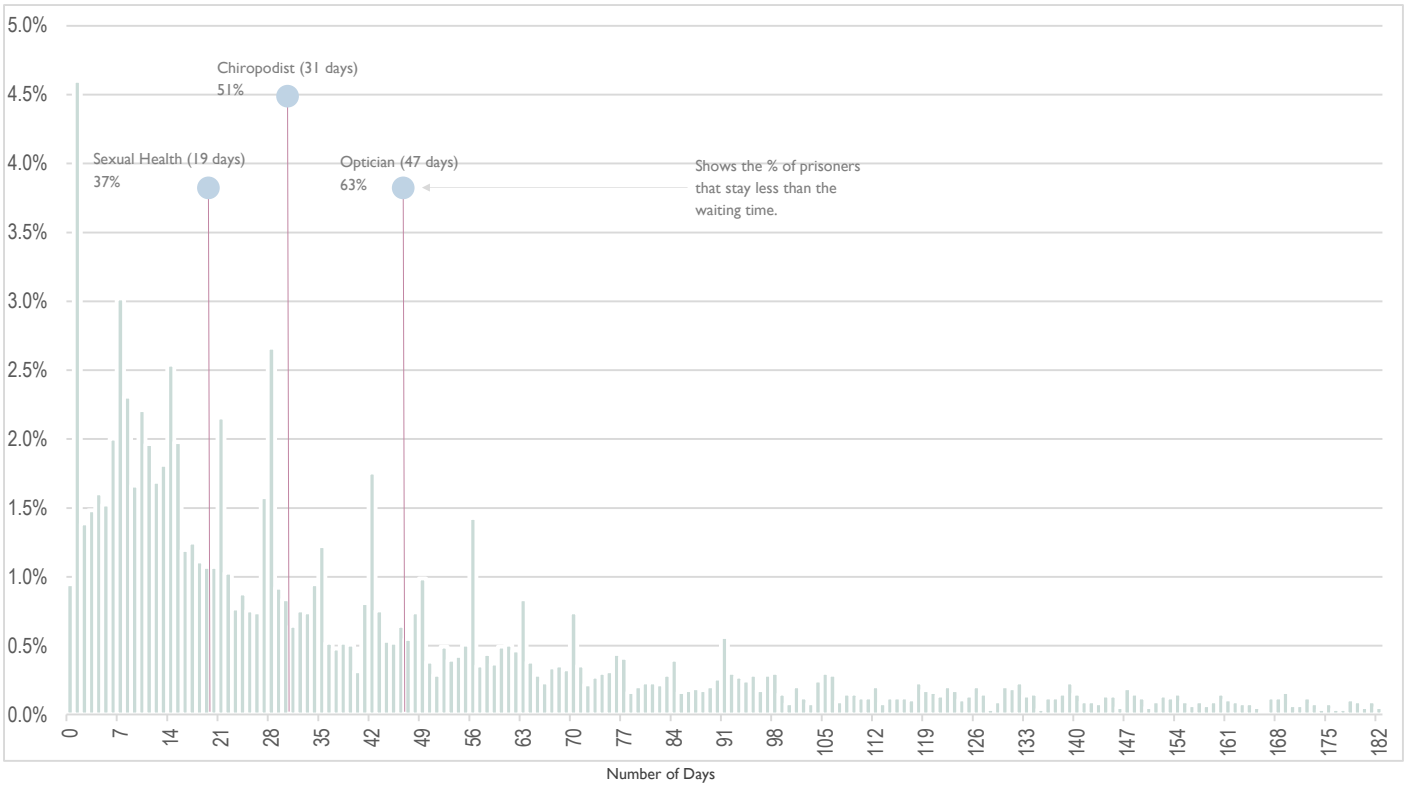
49% of prisoners had a stay of less than one month, 69% less than two months, and 92% less than six months.

Figure 1.4.7 shows the distribution by the number of days. Overlaid on this figure is the maximum waiting time for services. This aims to illustrate the percentage of prisoners that would stay in the prison for a shorter period of time than the maximum wait for the different services.




*Above: Figure 1.4.6 - Proportion of foreign national prisoners.*

*Source - MoJ*




*Above: Figure 1.4.7 - Length of stay in days, and maximum waiting time for clinics.*

*Source - MoJ and SystmOne*

## MOJ POPULATION PROJECTIONS

Figure 1.4.8 shows the long-term trend of the prison population in HMP Bristol, and future projections based on the Ministry of Justice population projections.

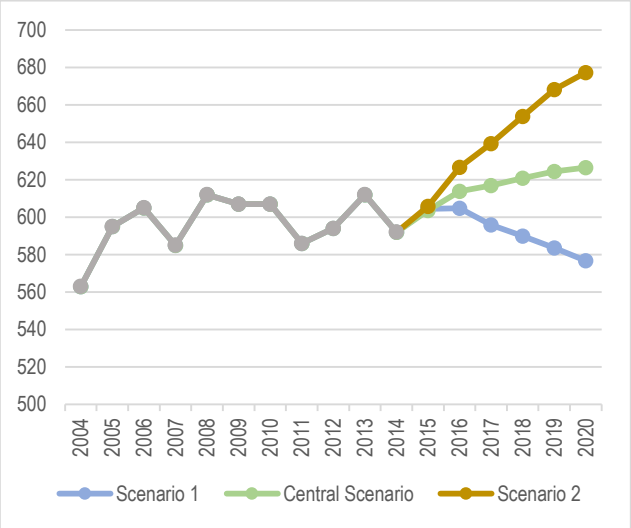
The projections are based on three scenarios:

*"The Central Scenario assumes custodial convictions are broadly in line with recent trends. The average length of sentence is assumed to be flat based on recent trends in sentence lengths. This broadly reflects the assumptions for Scenario 2 in the November 2013 projections.*

*Scenario 1 assumes that custodial convictions will fall against recent trends. The average length of sentence is assumed to be lower than what has been observed in recent trends in sentence lengths.*

*Scenario 2 assumes a rise in custodial convictions when compared to recent trends. Also the average length of sentence is assumed to be higher than what has been observed in recent trends in sentence lengths."*

Applying the Central Scenario to the sentence type of the population in HMP Bristol, the projection shows an upward trend to 2020. This is due to the projected increase in the number of determinate sentences.




*Above: Figure 1.4.8 - Population projections. Source - Adapted from MoJ figures.*

## POPULATION SPECIFICATIONS

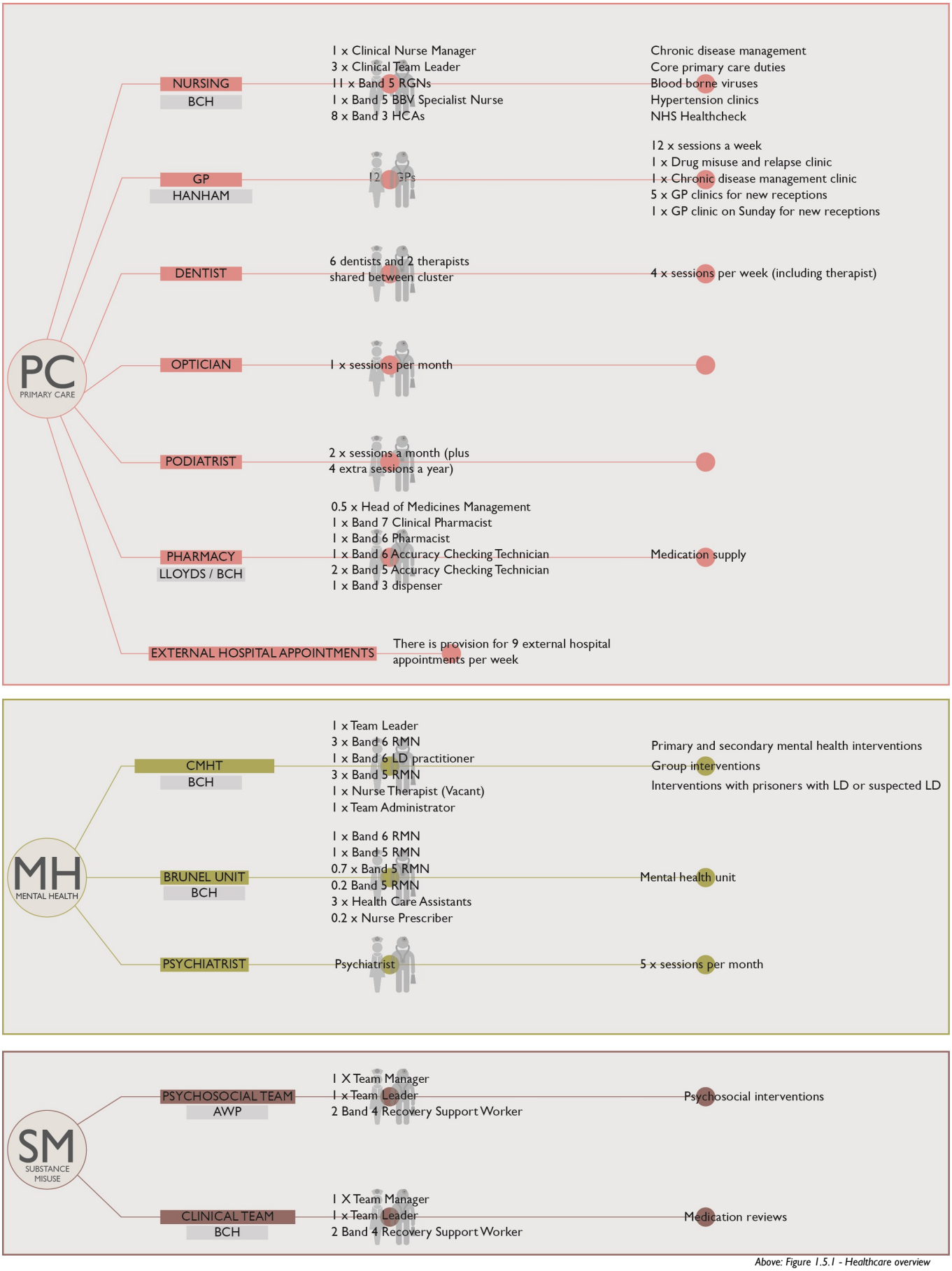
As part of this H&SCNA, the researchers had a conversation with staff at the Ministry of Justice. The conversation covered future changes to the configuration of the population in HMP Bristol.

HMP Bristol has been designated as a resettlement prison. Similar establishments to HMP Bristol would hold all prisoners that are sentenced for less than 12 months.

Due to the high turnover of the population in HMP Bristol, only those that are sentenced for less than nine months will be held, however, there will be a discretionary number of other prisoners.

# HEALTHCARE OVERVIEW

## CURRENT HEALTH PROVISION




*Above: Figure 1.5.1 - Healthcare overview*

## QOF REGISTER

Figure 1.5.2 illustrates the prevalence of the different diseases as outlined on the QOF register, broken down by age group.

For example, there are 65 prisoners on the QOF register for obesity, equating to 11.0% of the population. An analysis by age group shows that the rate increases with age.

Asthma and obesity also report high rates. For this H&SCNA, detailed analysis was undertaken for the more prevalent conditions, for example, the change in the BMI of prisoners in the prison.

*Below: Figure 1.5.2 - Various QOF figures displayed by age.*

*Source - SystmOne.*

| Age | Under 21 | 21 - 29 | 30 - 39 | 40 - 49 | 50 - 59 | 60+ | Total | |
|---|---|---|---|---|---|---|---|---|
| Population | 42 | 208 | 193 | 84 | 43 | 19 | 589 | |
| Atrial Fibrillation | 0.0% | 0.0% | 0.5% | 0.0% | 0.0% | 10.5% | 0.5% | 3 |
| Asthma | 2.4% | 5.3% | 8.3% | 10.7% | 9.3% | 10.5% | 7.3% | 43 |
| Cancer | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 10.5% | 0.3% | 2 |
| Coronary Heart Disease | 0.0% | 1.0% | 1.6% | 3.6% | 4.7% | 5.3% | 1.9% | 11 |
| Chronic Kidney Disease | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 10.5% | 0.3% | 2 |
| COPD | 0.0% | 0.0% | 0.0% | 2.4% | 2.3% | 15.8% | 1.0% | 6 |
| Cardiovascular Disease | 4.8% | 2.4% | 2.6% | 3.6% | 18.6% | 5.3% | 4.1% | 24 |
| Dementia | 0.0% | 0.0% | 0.0% | 1.2% | 0.0% | 0.0% | 0.2% | 1 |
| Diabetes | 0.0% | 0.5% | 1.6% | 3.6% | 4.7% | 15.8% | 2.0% | 12 |
| Epilepsy | 0.0% | 1.9% | 6.7% | 2.4% | 7.0% | 0.0% | 3.7% | 22 |
| Heart Failure | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 10.5% | 0.3% | 2 |
| Hypertension | 7.1% | 4.3% | 8.8% | 8.3% | 25.6% | 36.8% | 9.2% | 54 |
| Learning Disabilities | 7.1% | 9.6% | 4.7% | 2.4% | 9.3% | 0.0% | 6.5% | 38 |
| Mental Health | 0.0% | 9.6% | 9.8% | 14.3% | 14.0% | 0.0% | 9.7% | 57 |
| Obesity | 0.0% | 6.7% | 11.9% | 16.7% | 20.9% | 26.3% | 11.0% | 65 |
| Peripheral Arterial Disease | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 5.3% | 0.2% | 1 |
| Rheumatoid Arthritis | 0.0% | 0.0% | 0.5% | 0.0% | 0.0% | 0.0% | 0.2% | 1 |
| Stroke and Transient Ischaemic Attack | 0.0% | 0.0% | 0.0% | 1.2% | 0.0% | 5.3% | 0.3% | 2 |

# ENGAGEMENT

SURVEYS PG 18

FOCUS GROUP PG 24

# SURVEYS

## INTRODUCTION

For this H&SCNA, the researchers designed two surveys that were distributed across HMP Bristol. One survey was aimed at staff, with the other survey aimed at prisoners.

Of the 598 prisoners, 31 took part in the survey, equating to a response rate of 5%. There were 18 respondents to the staff survey, ranging across a number of service areas. The response rate for HMP Bristol was low, and as such the results should be used as a guide only.

Both surveys included questions relating to the healthcare services in HMP Bristol. This allows comparisons between the views of staff and prisoners.

The prisoner survey also included questions on their general and mental health. The survey included questions used in the Health Survey for England 2012, allowing comparisons between the prison population and the general population.

In addition, the prisoner survey includes questions exploring prisoners' care needs.

The surveys included opportunities for prisoners and staff to leave free text comments. The complete set of comments are available in a separate document.

## WHO RESPONDED?

Figures 2.1.1 and 2.1.2 show the breakdown of respondents by age and ethnicity.

*Below: Figures 2.1.1 & 2.1.2 - Responses by age and ethnicity.*

The response rate improves as the prisoners get older, although it is generally low.

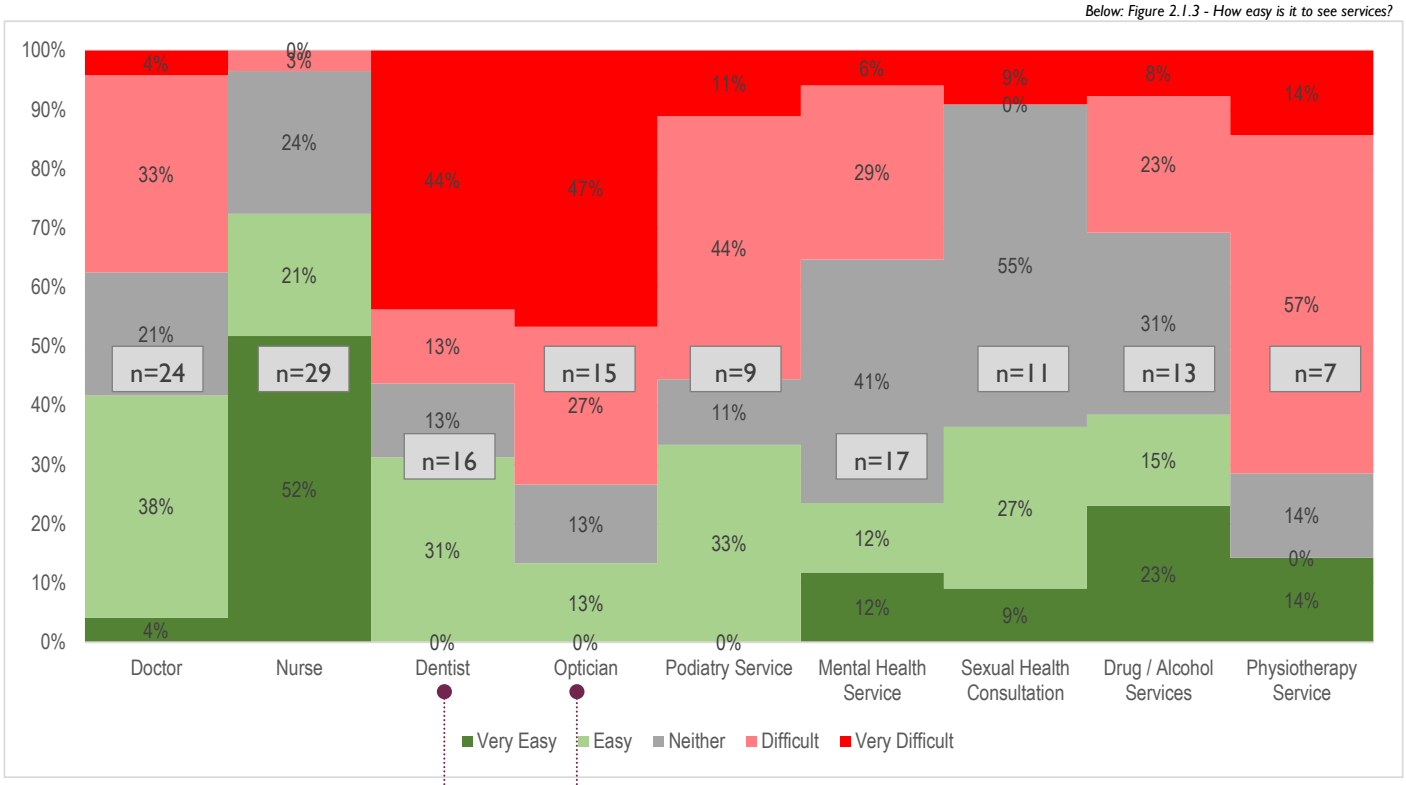
| AGE | Under_21 | 21 - 29 | 30 - 39 | 40 - 49 | 50+ | Not Stated | Total |
|---|---|---|---|---|---|---|---|
| Population | 41 | 215 | 182 | 106 | 54 | 0 | 598 |
| Responses | 0 | 7 | 9 | 6 | 8 | 1 | 31 |
| Response % | 0% | 3% | 5% | 6% | 15% | - | 5% |

The response rate for prisoners of all ethnicities was low.

| ETHNICITY | Asian | Black | Chinese | Mixed | White | Other | Not Stated | Total |
|---|---|---|---|---|---|---|---|---|
| Population | 22 | 67 | 4 | 23 | 481 | 1 | 0 | 598 |
| Responses | 1 | 2 | 0 | 1 | 25 | 0 | 2 | 31 |
| Response % | 5% | 3% | 0% | 4% | 5% | 0% | | 5% |

## HOW EASY IS IT TO SEE THE FOLLOWING SERVICES IN THIS PRISON?

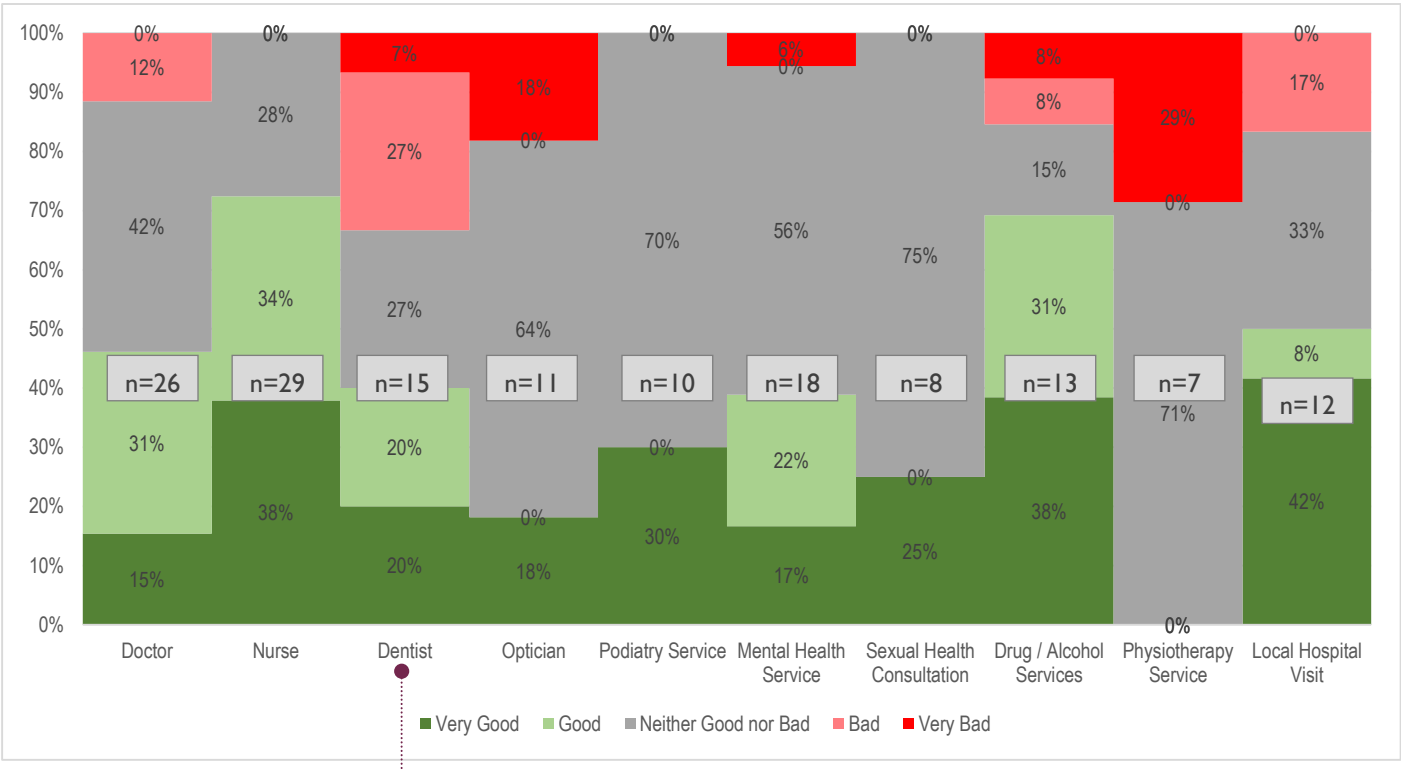
*Below: Figure 2.1.3 - How easy is it to see services?*




57% of respondents said the dentist was difficult/very difficult to see.

74% of respondents said the optician was difficult/ very difficult to see.

## WHAT DO YOU THINK OF THE QUALITY OF HEALTH/ SOCIAL CARE SERVICES IN THIS PRISON?




In addition to being difficult to see, 34% of respondents said that the quality of service was bad/very bad.

*Above: Figure 2.1.4 - Quality of services*

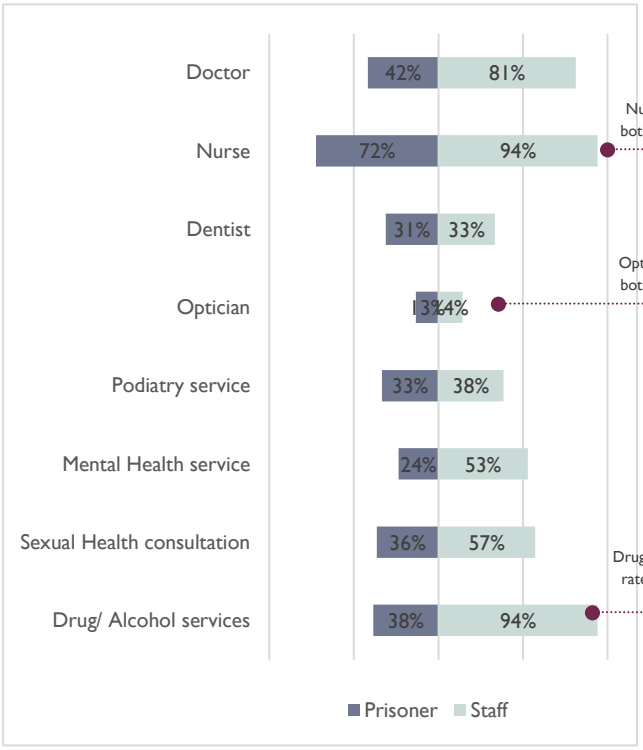
Both the prisoner survey and the staff survey included questions relating to ease of access to services and quality of services.

Figures 2.1.5 and 2.1.6 compare the responses. It is expected that there will be a difference between the views of the prison population and staff members. However, the analysis highlights trends and patterns between the responses.

*Below: Figure 2.1.5 - Staff/prisoner comparison, how easy to see services.*

HOW EASY IS IT TO SEE THE FOLLOWING SERVICES IN THIS PRISON?

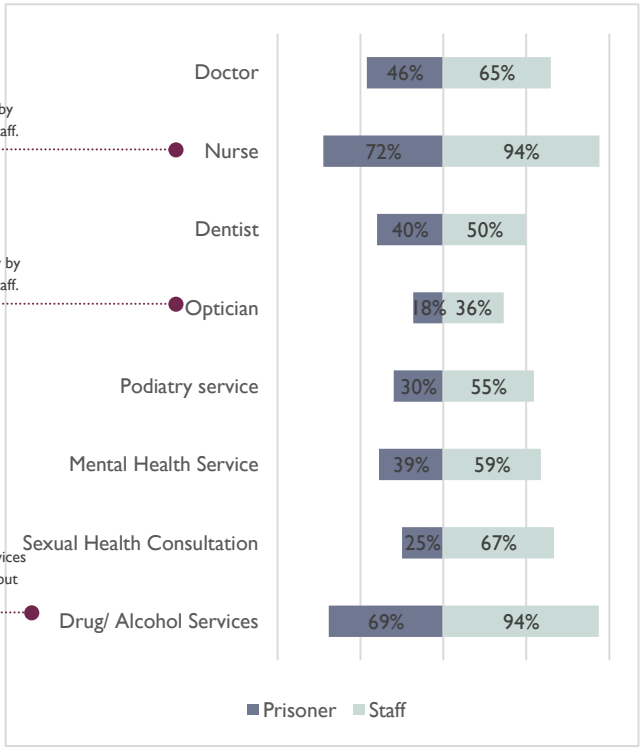
EASY/VERY EASY




*Below: Figure 2.1.6 - Staff/prisoner comparison, quality of services.*

WHAT DO YOU THINK OF THE QUALITY OF SERVICES IN THIS PRISON?

GOOD/VERY GOOD




| Response counts | Prisoner | Staff |
|---|---|---|
| Doctor | 119 | 50 |
| Nurse | 124 | 53 |
| Dentist | 100 | 47 |
| Optician | 94 | 42 |
| Podiatry Service | 56 | 31 |
| Mental Health Service | 68 | 54 |
| Sexual Health Consultation | 29 | 34 |
| Care Services | | 40 |
| Drug / Alcohol Services | 38 | 41 |
| Physiotherapy Service | 44 | 34 |

| Response counts | Prisoner | Staff |
|---|---|---|
| Doctor | 119 | 42 |
| Nurse | 127 | 46 |
| Dentist | 78 | 37 |
| Optician | 82 | 29 |
| Podiatry Service | 44 | 25 |
| Mental Health Service | 57 | 45 |
| Sexual Health Consultation | 20 | 26 |
| Care Services | 27 | 33 |
| Drug / Alcohol Services | | 34 |
| Physiotherapy Service | 33 | 26 |

## GENERAL HEALTH

Prisoners were asked a number of questions about their general health. Prisoners were asked about their mobility, their ability to self-care, and their usual activities, pain, and anxiety/depression.

17% of respondents said that they have problems relating to self-care. This cohort may require a social care assessment.

| Mobility | | | |
|---|---|---|---|
| | I have no problems walking about | I have some problems walking about | I am confined to bed |
| # | 21 | 9 | 0 |
| % | 70% | 30% | 0% |
| **Self-Care** | | | |
| | I have no problems with self-care | I have some problems washing or dressing myself | I am unable to wash or dress myself |
| # | 24 | 5 | 0 |
| % | 83% | 17% | 0% |
| **Usual Activities** | | | |
| | I have no problems with my usual activities | I have some problems with my usual activities | I am unable to perform my usual activities |
| # | 22 | 5 | 3 |
| % | 73% | 17% | 10% |
| **Pain/Discomfort** | | | |
| | I have no pain or discomfort | I have moderate pain or discomfort | I have extreme pain and discomfort |
| # | 12 | 14 | 4 |
| % | 40% | 47% | 13% |
| **Anxiety/Depression** | | | |
| | I am not anxious or depressed | I am moderately anxious or depressed | I am extremely anxious or depressed |
| # | 9 | 11 | 8 |
| % | 32% | 39% | 29% |

*Above: Figure 2.1.7 - Prisoner general health responses*

29% of respondents said they were extremely anxious or depressed.

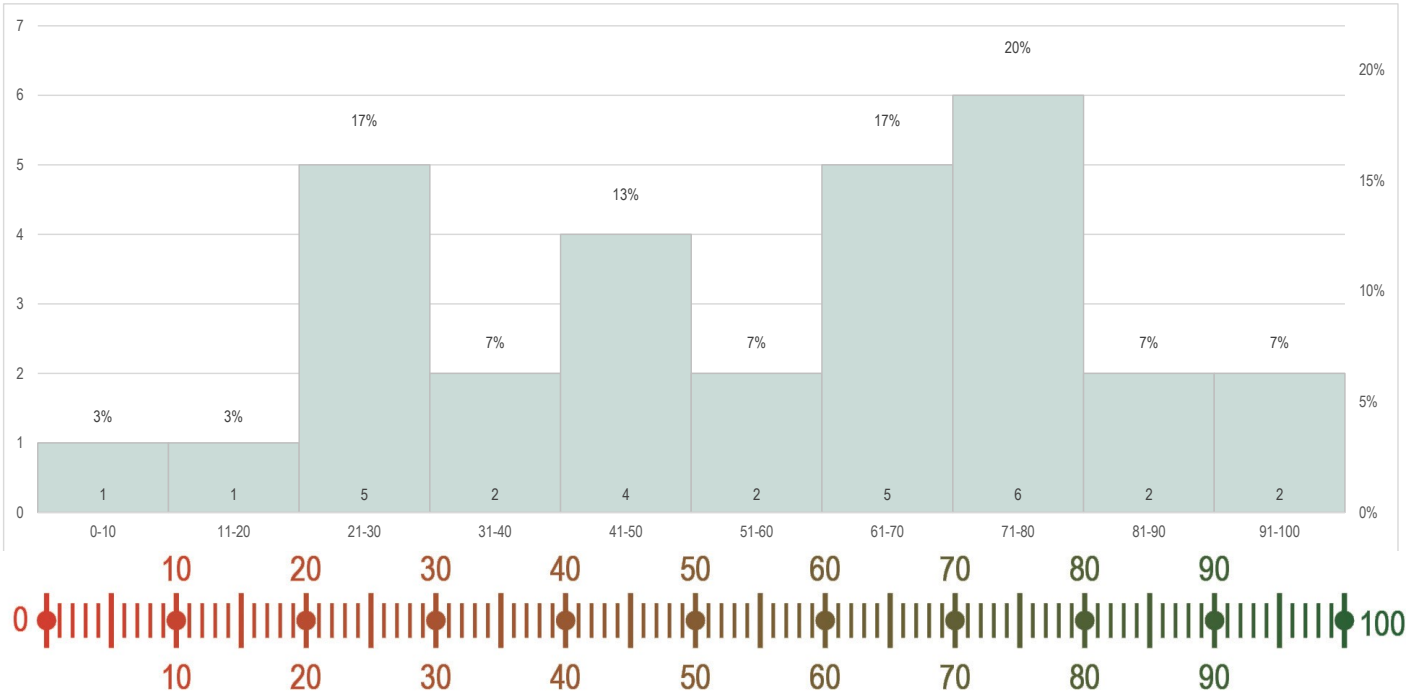
17% of respondents said that they had problems performing usual activities such as work and leisure. The level of impact this may have on their health and social care needs may require further investigation.

## GENERAL HEALTH SCALE

Prisoners were asked how they rated their health state out of 100, where 0 was the worst possible health state, and 100 was the best. Figure 2.1.8 shows the distribution of the results.

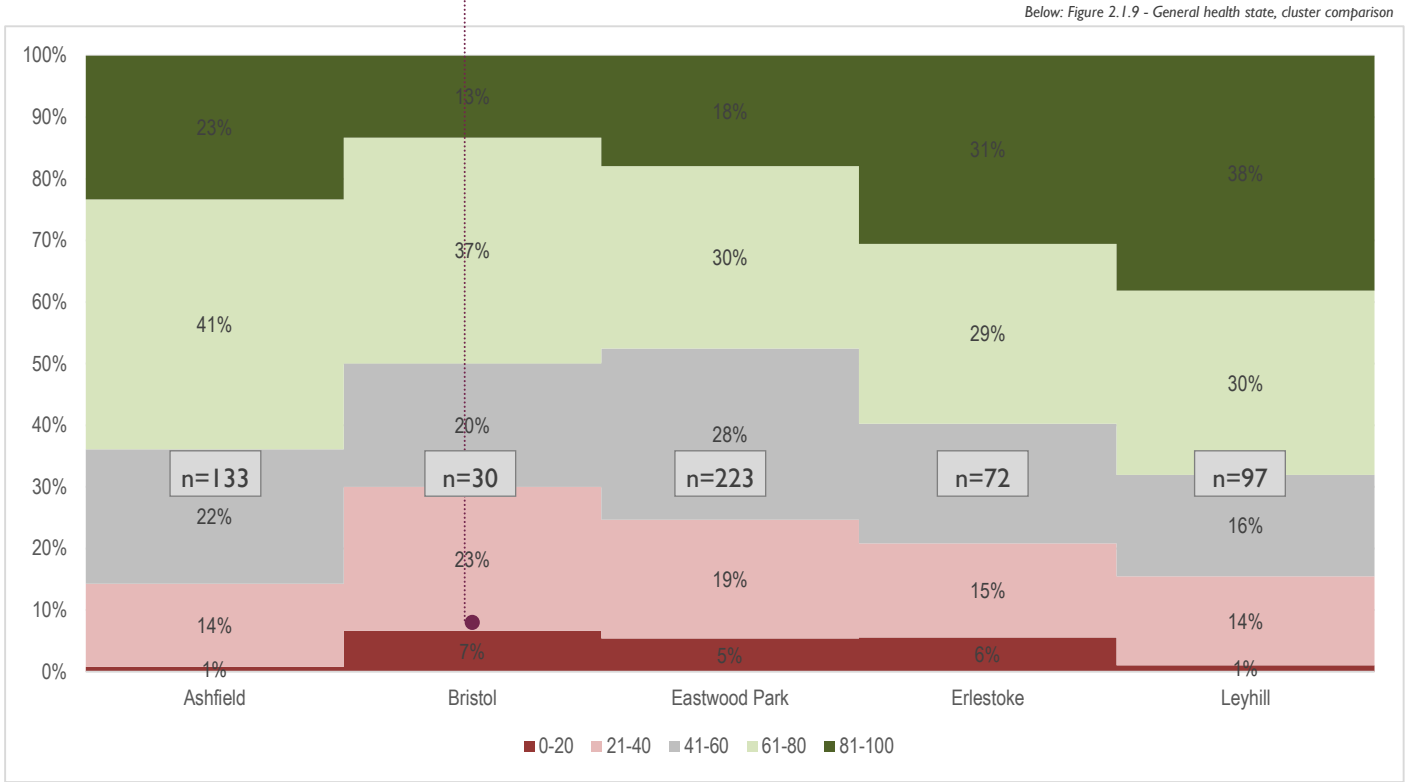
Figure 2.1.9 gives a comparison of the general health scale scores across the five prisons.

*Below: Figure 2.1.8 - General health state of prisoners - self reported*




Respondents from HMP Bristol report relatively high numbers of prisoners rating their health below 40.

*Below: Figure 2.1.9 - General health state, cluster comparison*



## CARE NEEDS

Prisoners were asked whether they needed help with a number of social care related tasks.

A question was also asked about who provided any help they were currently receiving.

Only one prisoner said they receive help from other prisoners.

A number of prisoners said that they are not receiving help, but would like help.

| | Healthcare Staff | Prison Staff | "Buddy" / Prisoner Carer | Other Prisoner | Someone Else | No Help, Would Like Help | I don't Need Help | Not Answered | Total (Answered) | % Requiring Help |
|---|---|---|---|---|---|---|---|---|---|---|
| Eating and Drinking | 0 | 1 | 0 | 0 | 0 | 2 | 27 | 1 | 30 | 10% |
| Personal Hygiene Brushing Hair/Teeth | 0 | 0 | 0 | 0 | 0 | 1 | 29 | 1 | 30 | 3% |
| Bathing | 0 | 0 | 0 | 1 | 0 | 1 | 28 | 1 | 30 | 7% |
| Dressing | 0 | 0 | 0 | 0 | 0 | 1 | 29 | 1 | 30 | 3% |
| Using the Toilet | 0 | 0 | 0 | 0 | 0 | 0 | 30 | 1 | 30 | 0% |
| Incontinence (Faeces) | 0 | 0 | 0 | 0 | 0 | 2 | 27 | 2 | 29 | 7% |
| Incontinence of the Bladder | 0 | 0 | 0 | 0 | 1 | 0 | 29 | 1 | 30 | 3% |
| Moving Around the Prison | 1 | 1 | 0 | 0 | 0 | 1 | 27 | 1 | 30 | 10% |
| Using a Wheelchair | 0 | 1 | 0 | 0 | 0 | 0 | 29 | 1 | 30 | 3% |
| Climbing Steps or Stairs | 2 | 1 | 0 | 0 | 0 | 2 | 25 | 1 | 30 | 17% |
| Getting out of a Chair/Bed | 0 | 0 | 0 | 0 | 0 | 0 | 29 | 2 | 29 | 0% |
| Managing Medication | 0 | 1 | 0 | 0 | 0 | 3 | 25 | 2 | 29 | 14% |
| Help with Night Time Routine | 0 | 1 | 0 | 0 | 0 | 2 | 27 | 1 | 30 | 10% |

*Above: Figure 2.1.10 - Prisoner care needs, self-reported.*

14% of respondents said they required help with managing medication and 10% said they would like help with the night time routine.

# FOCUS GROUPS

## INTRODUCTION

This section summarises the focus group that took place in HMP Bristol. The focus group was carried out to gather the views of prisoners and explore in more detail their opinions about healthcare provision in the prison.

### METHODOLOGY

The focus group was organised by HMP Bristol. Permission was sought prior to the focus group to allow the researchers to bring in an electronic recording device. This meant that the focus group was recorded. Informed consent of participants was sought prior to the group with anonymity and confidentiality assured.

The focus group was semi-structured, with the researchers using a prepared list of questions to guide the discussion. The semi-structured nature allowed the prisoners to discuss any issues that were important to them that were not covered by the question list.

## FINDINGS

### ACCESSIBILITY AND AVAILABILITY

Prisoners said that it was easy to see nursing staff on the substance misuse wing, however on other wings it was more difficult. Another prisoner said that if a prisoner makes an application to see substance misuse or mental health staff, they are normally seen fairly quickly.

Prisoners said that they were not given any indication as to how long they would have to wait for an appointment.

### DENTIST

A prisoner said the dental service was the most difficult service to see in the prison: "you start with one bad tooth, and by the time you see them you've got three or four." A prisoner added that the dentist does not do anything other than extractions.

Another prisoner said that the dentist may see you for an initial appointment, but he knows that by the time the treatment appointment comes up, the prisoner is more than likely going to have moved out of the prison. The prisoner said that this means that prisoners move on to their next prison still experiencing dental pains, and have to re-join the waiting list.

## COMMUNICATION

A prisoner said that there was not much communication between day staff and night staff. He said he was in pain during the night due to an infection in his jaw, but the night duty would not give him access to any paracetamol because it was not in his notes.

## STAFF INTERACTIONS

A prisoner said that he is not informed when his medication is going to be changed: "the first you hear about a change in your medication is when you pick it up." The prisoner said that in order to discuss the changes to his medication, he had to put in another healthcare application.

Another prisoner said that prisoners' detox plans are changed without them knowing, and this can cause frustration on the wings. He added that this gets taken out on the officers.

A prisoner said that when he saw the GP he wanted to talk about more than one issue, but was told that he had to stick to one issue per consultation.

## RECEPTION

All prisoners said that they were given the first night screen, however not all prisoners said that they had received the secondary health screen. A prisoner said that only prisoners that were detoxing from drugs or alcohol would get the secondary health screen.

A prisoner who said that he was an alcoholic reported that he was assessed as not needing an alcohol detoxification on reception. He added that two days later, the nurses decided that he did need to detox from alcohol, but the prisoner said that it was pointless because he had been through the worst part of the detoxification process already.

## SELF-MANAGEMENT OF HEALTH

A prisoner said that the diet was one of the biggest issues in the prison, especially when prisoners are detoxing. The prisoner added that when detoxing he needed a lot of food as he lost a lot of weight.

Regarding exercise, one prisoner said that the biggest problem was the shortage of staff. He said: "if there are not enough staff, then you might not get out to the gym." He added that the staff "do what they can." Another prisoner added that exercise came down to the personal motivation of the prisoner.

## MEDICATION

A prisoner said that the GPs in the prison do not treat prisoners as individuals, and when he makes any request to the GP, it is seen as drug seeking behaviour. Another prisoner said that he needed some cream for a rash and was told to buy it from the canteen. The prisoner said he could not afford the canteen price.

## MAIN FINDINGS

Prisoners said that they were not given any indication as to how long they would have to wait for an appointment.

Prisoners gave negative feedback about the dental service.

A prisoner was not given any paracetamol by night staff.

Prisoners said there was not a lot of communication around medication changes.

A prisoner said that when he saw the GP he wanted to talk about more than one issue, but was told that he had to stick to one issue per consultation.

All prisoners said that they were given the first night screen, however not all prisoners said that they had received the secondary health screen.

## ENGAGEMENT CHECKPOINT AND RECOMMENDATIONS

| ID / Pg | Consideration / Key Finding | Relevance to HMP Bristol | Recommendation |
|---|---|---|---|
| FG1 18 | Of the 598 prisoners, 31 took part in the survey, equating to a response a rate of 5%. | This is a low response rate. | Results of the survey will have a low degree of confidence so should be used as a guide only. |
| FG2 19 | 74% of respondents said the optician was difficult/very difficult to see. | Dental services were also highlighted as bad in the focus group. | Dental providers should review their service to address prisoner dissatis-faction. |

# SPECIALIST PATHWAYS

MENTAL HEALTH PG 28

SELF-HARM & SUICIDE PG 41

LEARNING DISABILITIES PG 46

SUBSTANCE MISUSE PG 53

# MENTAL HEALTH

## INTRODUCTION

Research shows that the prevalence of mental health issues is significantly higher in prisons than in the general population. One of the highest profile reports to have been released in recent years is the Bradley Review[1] published in 2009. The report looked specifically at diverting people with learning disabilities and mental health problems away from the criminal justice system.

The Bradley Review used a number of existing research papers for evidence, including "Too Little Too Late: An Independent Review of Unmet Mental Health Need in Prison,"[2] "Bromley Briefings" fact-file,[3] *No One Knows*,[4] and the Survey for the Office for National Statistics on Psychiatric Morbidity among Prisoners.[5]

Some of the key facts taken from these research papers include:

- Over 90% of prisoners had one or more of the five psychiatric disorders studied (psychosis, neurosis, personality disorder, hazardous drinking, and drug dependence).
- 72% of male and 70% of female sentenced prisoners suffer from two or more mental health disorders.
- At any one time 10% of the prison population has "serious mental health problems."
- 96% of prisoners with mental disorders returned to the community without supported housing, including 80% of those who had committed the most serious offences; more than three quarters had been given no appointment with outside carers.
- There are now more people with mental health problems in prison than ever before.
- Self-harm and suicide rates are significantly higher in the prison population compared to the general population.
- The 2007 Adult Psychiatric Morbidity Survey shows that male remand prisoners are 20 times more likely to suffer psychosis, and 20 times more likely to entertain suicidal thoughts than the general population.
- People from BME communities with mental health problems represent about 10% of the UK population, but in prison, this rises to approximately 20%.
- Remand prisoners had higher rates of mental disorders than sentenced prisoners.
- Certain elements of the prison population with mental health problems are not receiving any treatment at all.

There is conflicting research on the effect of prison on the mental health of prisoners. A paper released by Advances in Psychiatric Treatment[6] argued that imprisonment is detrimental to mental health. However, in 2010 the results of a study by the OHRN[7] indicated that prison does not have a universally detrimental effect on mental health.

In response to Lord Bradley's Review, the DoH published "Improving Health, Supporting Justice."[8]

## HISTORICAL TRENDS

Prisoners are assessed for their mental health needs at the reception screen. Figure 3.1.1 shows the READ codes associated with questions that are common to the reception and transfer screen. Figure 3.1.2 shows questions that are unique to the reception screen. Figure 3.1.3 shows questions that are on the secondary health screen.

The data from the second screen shows that the number of prisoners with a history of depression has increased over the three year period.

| Reception & Transfer Screen | | Year 1 | Year 2 | Year 3 | Under 21 | 21 - 29 | 30 - 39 | 40 - 49 | 50 - 59 | 60+ |
|---|---|---|---|---|---|---|---|---|---|---|
| Screens | # | 3444 | 3500 | 3640 | 223 | 1324 | 1114 | 593 | 276 | 110 |
| (YX020) Prisoner has tried to harm themselves (in prison) | # | 264 | 313 | 327 | 10 | 131 | 94 | 62 | 24 | 6 |
| | % | 8% | 9% | 9% | 4% | 10% | 8% | 10% | 9% | 5% |
| (YX021) Prisoner has tried to harm themselves (outside prison) | # | 643 | 589 | 636 | 32 | 245 | 177 | 125 | 46 | 11 |
| | % | 19% | 17% | 17% | 14% | 19% | 16% | 21% | 17% | 10% |
| (Y0904) Prisoner feels like Self Harming or Suicide | # | 84 | 119 | 103 | 2 | 42 | 33 | 15 | 8 | 3 |
| | % | 2% | 3% | 3% | 1% | 3% | 3% | 3% | 3% | 3% |

*Left: Figure 3.1.1 - Reception and transfer screen, mental health codes.*

*Source - SystmOne*

| Reception Screen | | Year 1 | Year 2 | Year 3 | Under 21 | 21 - 29 | 30 - 39 | 40 - 49 | 50 - 59 | 60+ |
|---|---|---|---|---|---|---|---|---|---|---|
| Screens | # | 2990 | 2788 | 2809 | 172 | 1037 | 861 | 444 | 207 | 88 |
| (YX016) Prisoner has received treatment from a psychiatrist outside prison | # | 211 | 302 | 316 | 14 | 94 | 97 | 69 | 34 | 8 |
| | % | 7% | 11% | 11% | 8% | 9% | 11% | 16% | 16% | 9% |
| (YX017) Prisoner has stayed in a psychiatric hospital | # | 117 | 134 | 152 | 5 | 43 | 42 | 35 | 22 | 5 |
| | % | 4% | 5% | 5% | 3% | 4% | 5% | 8% | 11% | 6% |
| (YX018) Prisoner has a psychiatric nurse or care worker in the community | # | 114 | 98 | 115 | 11 | 38 | 36 | 18 | 9 | 3 |
| | % | 4% | 4% | 4% | 6% | 4% | 4% | 4% | 4% | 3% |
| (YX019) Prisoner has received medication for mental health problems | # | 495 | 475 | 528 | 17 | 177 | 180 | 104 | 41 | 9 |
| | % | 17% | 17% | 19% | 10% | 17% | 21% | 23% | 20% | 10% |

*Left: Figure 3.1.2 - Reception screen, mental health codes.*

*Source - SystmOne*

| Second Screen | | Year 1 | Year 2 | Year 3 | Under 21 | 21 - 29 | 30 - 39 | 40 - 49 | 50 - 59 | 60+ |
|---|---|---|---|---|---|---|---|---|---|---|
| Screens | # | 2340 | 3043 | 3285 | 185 | 1193 | 1021 | 539 | 250 | 97 |
| (X00Sf) Post-traumatic stress disorder | # | 50 | 78 | 85 | 4 | 22 | 28 | 21 | 7 | 3 |
| | % | 2% | 3% | 3% | 2% | 2% | 3% | 5% | 3% | 3% |
| (1465.) H/O: depression | # | 504 | 717 | 791 | 29 | 279 | 240 | 157 | 69 | 17 |
| | % | 17% | 26% | 28% | 17% | 27% | 28% | 35% | 33% | 19% |
| (1466.) H/O: anxiety state | # | 297 | 391 | 437 | 19 | 146 | 156 | 79 | 27 | 10 |
| | % | 10% | 14% | 16% | 11% | 14% | 18% | 18% | 13% | 11% |
| (Y2343) Sleep Problem | # | 88 | 154 | 227 | 10 | 82 | 72 | 41 | 15 | 7 |
| | % | 3% | 6% | 8% | 6% | 8% | 8% | 9% | 7% | 8% |
| (X00S6) Psychotic disorder | # | 97 | 151 | 214 | 9 | 70 | 72 | 42 | 20 | 1 |
| | % | 3% | 5% | 8% | 5% | 7% | 8% | 9% | 10% | 1% |
| (Xa2jW) Depot medication | # | 23 | 13 | 33 | 2 | 10 | 8 | 7 | 5 | 1 |
| | % | 1% | 0% | 1% | 1% | 1% | 1% | 2% | 2% | 1% |

*Left: Figure 3.1.3 - Second screen, mental health codes.*

*Source - SystmOne*

Rates of prisoners with history of depression have been increasing over the last 3 years.

PRISON COMPARISONS - Figure 3.1.4 shows a comparison across the five prisons. The rates of self-harm and mental health issues identified at the reception screen were similar between HMP Ashfield and HMP Bristol.

*Below: Figure 3.1.4 - Self-harm & mental health across the cluster. Source—SystmOne*

| SELF-HARM | | | | |
|---|---|---|---|---|
| ASHFIELD | BRISTOL | EASTWOOD PARK | ERLESTOKE | LEYHILL |
| Number of Screens | | | | |
| 196 | 3942 | 1626 | 531 | 648 |
| (YX020) Prisoner has tried to harm themselves (in prison) | | | | |
| 13% | 9% | 14% | - | 8% |
| (YX021) Prisoner has tried to harm themselves (outside prison) | | | | |
| 17% | 17% | 41% | | |
| (146A.) H/O: attempted suicide | | | | |
| | | | | 8% |
| (Y0904) Prisoner feels like self-harming or suicide | | | | |
| 3% | 3% | 6% | | |

| MENTAL HEALTH | | | | |
|---|---|---|---|---|
| ASHFIELD | BRISTOL | EASTWOOD PARK | ERLESTOKE | LEYHILL |
| Number of Screens | | | | |
| 196 | 3111 | 1626 | 531 | 648 |
| (YX019) Prisoner has received medication for mental health problems | | | | |
| 20% | 17% | 40% | - | 16% |
| (YX018) Prisoner has a psychiatric nurse or care worker in the community | | | | |
| 7% | 4% | 13% | | 3% |
| (YX016) Prisoner has received treatment from a psychiatrist outside prison | | | | |
| 7% | 10% | 31% | 12% | 7% |
| (YX017) Prisoner has stayed in a psychiatric hospital | | | | |
| 3% | 5% | 14% | 2% | 3% |

## PREVALENCE

The table below shows the expected prevalence of mental health disorders taken from the PHE toolkit. The table is also populated by available data from HMP Bristol.

*Below: Figure 3.1.5 - Expected prevalence compared against local prevalence.*

*Source - PHE Toolkit; SystmOne.*

| MENTAL HEALTH DISORDER | ENGLAND | REMAND PRISONERS | SENTENCED PRISONERS | RECEPTION SCREEN | READ CODE |
|---|---|---|---|---|---|
| SEVERE MENTAL DISORDERS | | | | | |
| Functional psychoses (prison populations) psychotic disorders (general) | 0.3% | 10.0% | 7.0% | | Psychotic disorder (49; 8.3%) |
| Personality disorders | - | 78.0% | 64.0% | | Personality disorder (1; 0.2%) |
| PREVALENCE OF COMMON MENTAL DISORDER IN PAST WEEK | 12.5% | 59.0% | 40.0% | | |
| Mixed anxiety and depression | 6.9% | 26.0% | 19.0% | | H/O depression (179; 30.4%)<br><br>Depressed mood (135; 22.9%)<br><br>Depressive disorder (12; 2.0%)<br><br>Mixed anxiety and depressive disorder (15; 2.8%) |
| Generalised anxiety disorder | 3.4% | 11.0% | 8.0% | | (Anxiety disorder (10; 1.7%)<br><br>H/O: Anxiety state (105; 17.8%) |
| Depressive episode | 1.9% | 17.0% | 8.0% | | |
| Phobias | 0.8% | 10.0% | 6.0% | | |
| Obsessive compulsive disorder | 0.9% | 10.0% | 7.0% | | |
| Panic disorder | 1.0% | 6.0% | 3.0% | | Panic attack (1; 0.2%)<br><br>Panic disorder (2; 0.3%) |
| SELF-HARM AND SUICIDE | | | | | |
| Suicide attempts (past week) | 0.0% | 2.0% | 0.0% | | |
| Suicidal thoughts (past week) | 0.6% | 12.0% | 4.0% | Prisoner feels like self-harming or suicide (103; 2.8%) | Prisoner feels like self-harming or suicide (45; 7.6%) |
| Non suicidal self-harm | 3.4% | 5.0% | 7.0% | Prisoner has tried to harm themselves (in prison) (327; 9.0%)<br><br>Prisoner has tried to harm themselves (outside prison) (636; 17.5%) | Prisoner has tried to harm themselves (in prison) (70; 11.9)<br><br>Prisoner has tried to harm themselves (outside prison) (145; 24.6%) |

## READ CODES

Figure 3.1.6 shows a count of mental health related READ codes for the five different prison populations, as at September 2014.

HMP Bristol reports high rates of prisoners receiving medication for mental health issues, treatment from a psychiatrist, and self-harming.

*Below: Figure 3.1.6 - Mental health READ codes.*
*Source - SystmOne*

| ESTABLISHMENT | Ashfield | | Bristol | | Eastwood Park | | Erlestoke | | Leyhill | |
|---|---|---|---|---|---|---|---|---|---|---|
| POPULATION | 386 | | 589 | | 332 | | 525 | | 459 | |
| READ CODE | # | % | # | % | # | % | # | % | # | % |
| (X00S6) Psychotic disorder | 5 | 1% | 49 | 8% | 0 | 0% | | 0% | 4 | 1% |
| (XE2b6) Personality disorder | 5 | 1% | 1 | 0% | 2 | 1% | | 0% | 12 | 3% |
| (1465.) H/O: depression | 59 | 15% | 179 | 30% | 15 | 5% | | 0% | 181 | 39% |
| (XE0re) Depressed mood | 109 | 28% | 135 | 23% | 66 | 20% | | 0% | 53 | 12% |
| (XaB9J) Depression NOS | 53 | 14% | 8 | 1% | 49 | 15% | | 0% | 33 | 7% |
| (X00SO) Depressive disorder | 51 | 13% | 12 | 2% | 10 | 3% | | 0% | 49 | 11% |
| (X00Sb) Mixed anxiety and depressive disorder | 15 | 4% | 15 | 3% | 46 | 14% | | 0% | 26 | 6% |
| (1466.) H/O: anxiety state | 26 | 7% | 105 | 18% | 3 | 1% | | 0% | 34 | 7% |
| (E200.) Anxiety disorder | 13 | 3% | 10 | 2% | 13 | 4% | | 0% | 27 | 6% |
| (YA741) H/O: mental health problem | 77 | 20% | 17 | 3% | 5 | 2% | | 0% | 52 | 11% |
| (E....) Mental health disorder | 35 | 9% | 19 | 3% | 103 | 31% | | 0% | 55 | 12% |
| (YX019) Prisoner has received medication for mental health problems | 176 | 46% | 135 | 23% | 186 | 56% | | 0% | 189 | 41% |
| (XaJr3) Mental health medication review | 75 | 19% | 32 | 5% | 26 | 8% | | 0% | 46 | 10% |
| (YX018) Prisoner has a psychiatric nurse or care worker in the community | 88 | 23% | 34 | 6% | 74 | 22% | | 0% | 94 | 20% |
| (YX016) Prisoner has received treatment from a psychiatrist outside prison | 125 | 32% | 82 | 14% | 133 | 40% | | 0% | 138 | 30% |
| (YX017) Prisoner has stayed in a psychiatric hospital | 79 | 20% | 41 | 7% | 70 | 21% | | 0% | 108 | 24% |
| (YX020) Prisoner has tried to harm themselves (in prison) | 123 | 32% | 70 | 12% | 66 | 20% | | 0% | 122 | 27% |
| (YX021) Prisoner has tried to harm themselves (outside prison) | 155 | 40% | 145 | 25% | 174 | 52% | | 0% | 158 | 34% |
| (Y0904) Prisoner feels like Self Harming or Suicide | 36 | 9% | 45 | 8% | 44 | 13% | | 0% | 10 | 2% |

# CURRENT SERVICE KEY STATISTICS

## AVERAGE WAITING TIME BETWEEN REFERRAL AND INITIAL CONSULTATION

ROUTINE: 8-10 DAYS

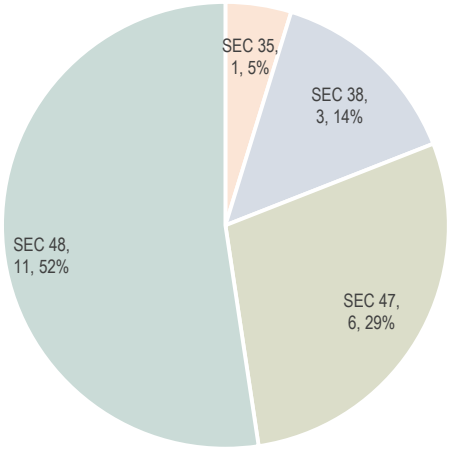
URGENT: DAILY

## AVERAGE NUMBER OF REFERRALS PER MONTH

68

(11% OF THE POPULATION)

## 21 MH HOSPITAL TRANSFERS IN 2014




## WAITING TIMES

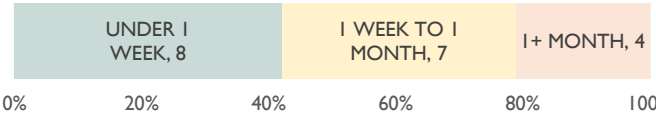



*Figure 3.1.7 - Local mental health service data*

*Source - Local data*

## TYPICAL CASELOAD

PRIMARY = 35

SECONDARY = 35

## WAITING LIST

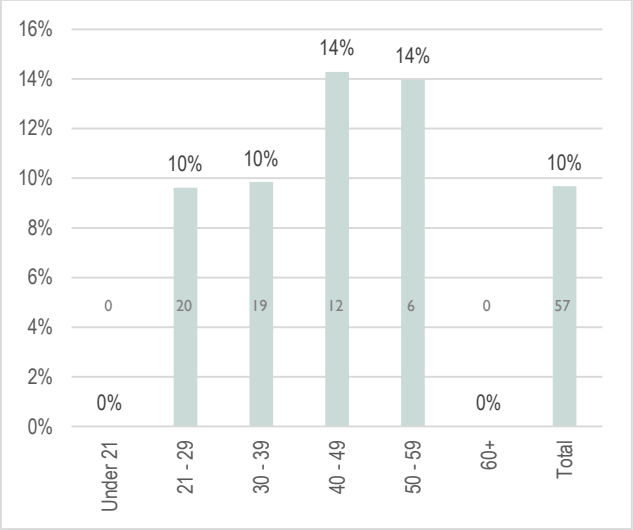
GENERALLY AROUND 17 AT ANY TIME

EXTRA CLINICS ARE SCHEDULED WHEN WAITING TIME ANTICIPATED AS OVER 2 WEEKS

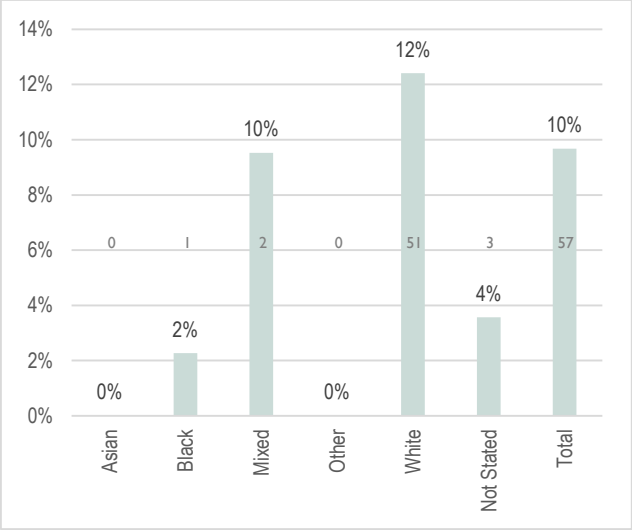
As part of the QOF indicators relating to mental health, MH001 requires the contractor to establish and maintain a register of patients with schizophrenia, bipolar affective disorder and other psychoses, and other patients on lithium therapy.

As at the end of September 2014, there were 59 prisoners on the register, equating to 9.5% of the prison population of HMP Bristol.

HMP Bristol scores 12 out of a potential 18 points. The QOF score shows that only one out of the 40 comprehensive care plans were in place. The researchers were informed that the care plans are recorded on the RIO system, and therefore did not translate over to SystmOne.




*Above: Figure 3.1.8 - Mental health QOF by age.*
*Source - SystmOne*



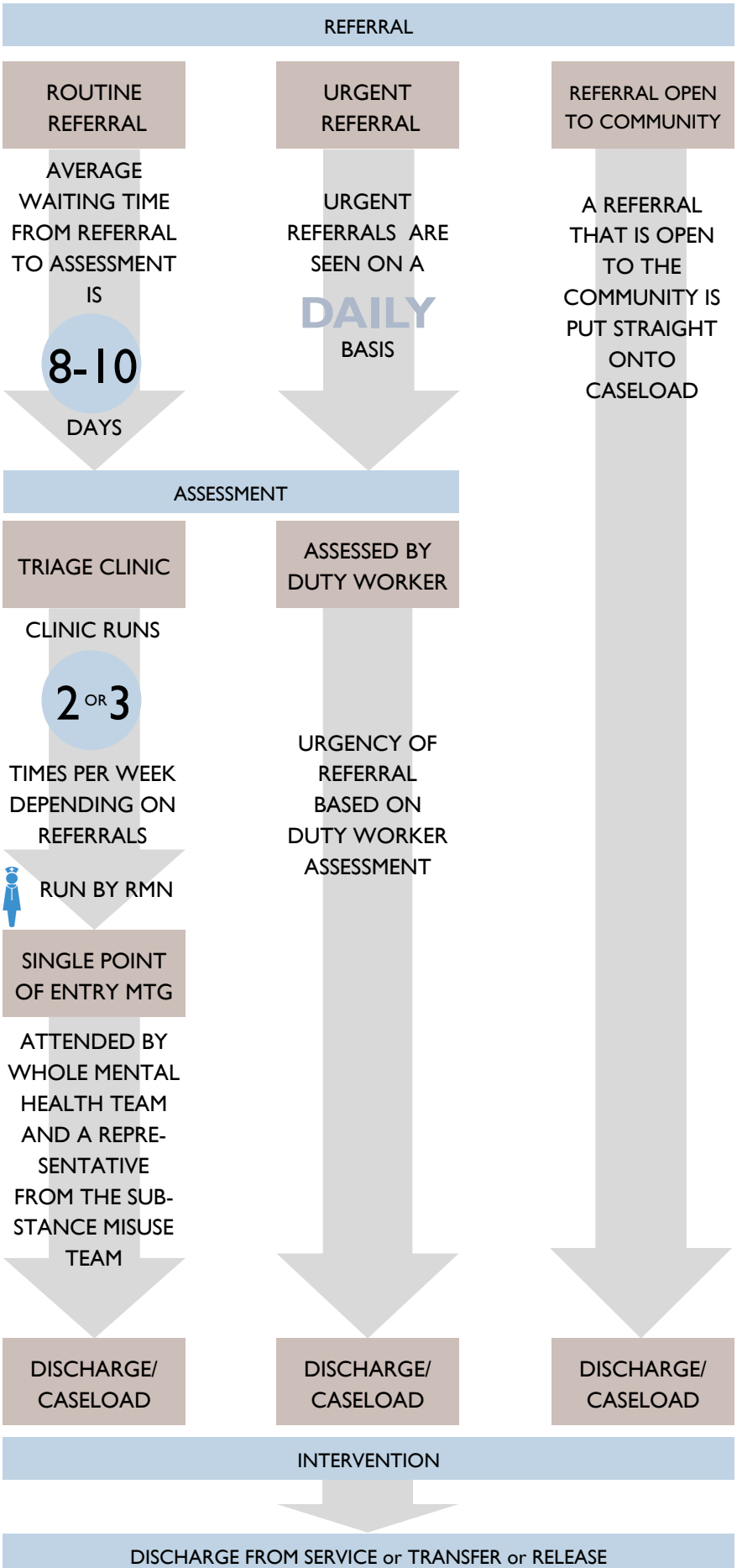

*Above: Figure 3.1.9 - Mental health QOF by ethnicity.*
*Source - SystmOne*

*Below: Figure 3.1.10 - Mental health QOF performance as at September 2014.*

*Source - Local QOF reporting.*

| Measure | Count | Min % | Target % | Actual % | Points |
|---|---|---|---|---|---|
| MH001 - Register | 59 | - | - | 9.5% | 4 / 4 |
| MH002 - Comprehensive care plan | 1 / 40 | 40 % | 90 % | 2.5 % | 0 / 6 |
| MH003 - Psychoses patients with record of blood pressure | 57 / 58 | 50 % | 90 % | 98.2 % | 4 / 4 |
| MH007 - Alcohol consumption in the preceding 12 months | 44 / 49 | 50 % | 90 % | 89.7 % | 4.0 / 4 |
| MH008 - Cervical screening within the last 5 years | 0 / 0 | 45 % | 93.3% | 0.0 % | 0 / 5 |
| MH009 - Lithium therapy, serum creatinine and TSH | 0 / 0 | 50 % | 90 % | 0.0 % | 0 / 1 |
| MH010 - Lithium levels in therapeutic range | 0 / 0 | 50 % | 90 % | 0.0 % | 0 / 2 |
| **Mental Health Total** | | | | | **12 / 18** |

## PRISONER PATHWAY




*Above: Figure 3.1.11 - Mental health prisoner pathway.*

*Source - Local information*

### INTERVENTION

GROUP WORK: Group work takes place on the Brunel Unit, the Mental Health Interventions Unit. Currently, groups have not been running due to a lack of discipline staff available for supervision.

PRIMARY CARE CASELOAD: Band 5 RMNs hold a primary care caseload. The nurses offer support and self-help materials to prisoners located on the wings.

Prisoners have given positive feedback about the in-cell materials at the mental health prisoner forum.

SECONDARY CARE CASELOAD: These are prisoners that require more in-depth mental health work. They may have possible psychiatrist input.

### RELEASE

PRISONERS ON CPA: There is normally a hand-over with the community team for prisoners on a CPA.

CHANGES TO PRISON ROLL: Staff were worried that there would be less time around how long they would have to set up a prisoner's package of care in the community, before they were released.

*"It has been my experience that a prisoner has been moved back to HMP Bristol and nothing has been set up for them. It has meant we have been doing mental health assessments at the gate."*

The mental health provision in HMP Bristol is delivered by the Wellbeing Team, who also provide substance misuse and learning disability services.

## STAFFING

Figure 3.1.12 shows the staffing to prisoner ratios of HMP Ashfield, HMP Bristol, HMP Eastwood Park, HMP Erlestoke, and HMP Leyhill. The table includes positions that are currently vacant or on maternity leave. The table also shows a comparison for the number of psychiatrist sessions per week.

Figure 3.1.13 shows the staffing ratios of Band 5 and Band 6 Registered Mental Health Nurse (RMNs) to prisoners. Figures for HMP Ashfield include staffing levels for the whole Wellbeing Team who provide mental health, substance misuse, and learning disability interventions.

In HMP Bristol there is one RMN per 69 prisoners. This is comparable to the levels seen in HMP Ashfield where there is approximatelyone nurse for every 80 prisoners, and HMP Eastwood Park where there is approximately one nurse for every 74 prisoners. HMP Erlestoke and HMP Leyhill have more prisoners per RMN, with one nurse per 436 prisoners in HMP Erlestoke, and one nurse per 251 prisoners in HMP Leyhill.

* HMP Ashfield's figures include staff numbers for whole Wellbeing Team. HMP Bristol's figures include staff working on the Brunel Unit. HMP Erlestoke's staffing number is provisional.


*Above: Figure 3.1.13 - Band 5&6 RMN staffing to prisoner ratios.*

*Source: Interviews.*

| | Ashfield | Bristol | Eastwood Park | Erlestoke | Leyhill |
|---|---|---|---|---|---|
| Population Size | 400 | 610 | 318 | 524 | 502 |
| Number of RMNs (Ratio to Prisoner) | 5 (1:80)* | 8.9 (1:69) | 4.3 (1:74) | 1.2 (1:436) | 2 (1:251) |
| Psychiatrist Sessions per Week | 0.5 | 5 | 2.5 | 0.5 | 0.5 |

*Left: Figure 3.1.12 - Staffing to prisoner ratios.*

*Source - Interviews.*

Figure 3.1.14 shows the staffing composition of the Mental Health Team in HMP Bristol. As at January 2015, there were no vacancies in the Mental Health Team.

There is a consultant psychiatrist, and junior psychiatrists offer regular clinics. At the time of this H&SCNA, there were two junior psychiatrists and five psychiatry sessions per week.

There is no specific counselling service in HMP Bristol.

*Below: Figure 3.1.14 - Staffing composition of the Mental Health Team. Source - Interviews; SystmOne.*

| Community Mental Health Team | |
|---|---|
| Number of staff | Role |
| 1 | Team Leader |
| 3 | Band 6 RMNs |
| 1 | Band 6 LD Practitioner |
| 3 | Band 5 RMNs |
| 1 | Nurse Therapist |
| Brunel Unit | |
| 1 | Band 6 RMN |
| 1.9 | Band 5 RMNs |
| 3 | Band 3 HCAs |
| 0.2 | Nurse Prescriber |
| Psychiatry | |
| 5 | Psychiatry sessions per week |

## REFERRAL

Referrals come from a number of sources. A number come from healthcare staff, but referrals also come from prison staff and prisoners themselves.

A referral to the Mental Health Team could result in a number of outcomes. If a referral is urgent it would be seen by the duty worker, who would use their professional judgement to decide on the urgency of the referral.

If the referral is already open to the community team then the client would go straight onto the caseload of one of the RMNs.

If the referral is routine, it would be placed on the waiting list for the triage clinic. Triage clinics run two or three times per week, depending on the number of referrals. The clinics are run by an RMN.

The new referrals are discussed by the Mental Health Team at single point of entry meetings that are held once a week. The team then decide whether the prisoner is discharged or allocated.

## PRIMARY CARE

The Band 5 RMNs hold a primary care caseload. The nurses offer support and self-help materials to prisoners located on the wings. The Band 3 HCAs from the Brunel Unit carry out outreach work on the wings, through cell visits with prisoners. There could be a number of reasons for patients being allocated to the primary mental health case load, such as group work, medication review, or assessment by an outside agency.

## BRUNEL UNIT

The Brunel Unit, the prison's mental health treatment unit, opened in 2013. The unit has two safer custody cells, six mental health cells, and two social care cells that are in regular use. At the time of the assessment there were two prisoners with learning disabilities on the unit. The six mental health beds are usually full.

Prisoners with mental health problems in the unit have their situation reviewed at least weekly. Prisoners in the unit also have access to the gym.

There is an option to increase the number of prisoners on the unit if required. There are a total of 18 cells in the unit.

## GROUPS

The following groups are offered to prisoners with mental health problems in HMP Bristol:

- Anxiety management
- Low mood group
- Managing emotions group
- Mental wellbeing
- Relaxation
- Games and social
- Current affairs
- Arts and crafts
- Cooking

Staff said that a high number of groups were cancelled on the Brunel Unit currently due to lack of discipline staff available to facilitate. Staff said that there should be two prison staff for the groups to take place.

## DUAL DIAGNOSIS

The Substance Misuse Service attend the mental health single point of entry meetings on a weekly basis. A member of the Mental Health Team also attends the Substance Misuse Team meetings.

Normally the Mental Health Team would request RMNs are being trained to deliver groups following the deletion of the nurse therapist post.

that a prisoner complete any detoxification treatment before they engage with the Mental Health Team, unless more urgent concerns are raised beyond normal detox.

## MENTAL HEALTH PRISONER FORUM

There is a fortnightly mental health prisoner forum. All prisoners on the primary or secondary caseload are invited to the forum, which is usually attended by ten prisoners.

The meeting is minuted, and the minutes are provided to prisoners in an easy-read version. The minutes are reviewed and actioned in the Mental Health Team Meetings.

Occasionally, prison officers attend the forum to answer questions on security and the prison regime.

## MENTAL HEALTH TRAINING

The Mental Health Team have given mental health training to prison and healthcare staff in the past. This training was well received. The provision of training was raised again at the heads of department meetings, as it was noted that there was a gap in prison training.

### POPULATION

Staff said that they are completing a lot more assessments now than in previous years. Staff said that in the past they had a lot more time to work with people: "there are a lot more assessments now, compared to caseload management."

### RELEASES

Staff in the Mental Health Team were unsure how the changes to the prison roll would affect their work. There was a worry around how long they would have to set up a prisoner's package of care in the community, before they were released. Release planning would be made easier if the process had been started before the prisoner is moved to HMP Bristol.

Mental health teams in the community have come into HMP Bristol to meet prisoners before they are released. This normally happens for those prisoners on the Care Programme Approach (CPA). The Mental Health Team work closely with community teams to ensure that follow-up appointments are made.

## INSPECTION REPORT

The HMIP Inspection report in 2013 included some recommendations about mental health services. Below are some of the key findings and progress against them.

| Inspection Report Finding | Progress |
|---|---|
| Prisoners with personality disorder | There is no specific personality disorder treatment in HMP Bristol. It was felt that prisoners were not in the prison for long enough to address personality disorders.<br>If appropriate, the Mental Health Service will refer prisoners to the Pathfinder Service in the Community. Pathfinders is a specialist personality disorder service.<br>Certain personality disorders has been covered by interventions carried out by the nurse therapist. The nurse therapist post has now been deleted, with RMN's being skilled to deliver group interventions. |
| Self-help material | There is a group run in the Brunel Unit for Mental Health and Wellbeing. Self-help material is offered to prisoners following a triage assessment from the RMN, if appropriate. |
| Mental health transfers | In the year previous to this H&SCNA, there had not been a breach of the 14-28 day time limit for a transfer. However at the time of the assessment there was one prisoner that was likely to breach due to the level of security needed for the prisoner. |
| Offender Assessment System (OASys) access | There is limited access to the prison IT system needed to access OASys data. It was also felt that there was not always the time to search new referrals against OASys to check for any risk information. |

## MENTAL HEALTH CHECKPOINT AND RECOMMENDATIONS

| ID / Pg | Consideration / Key Finding | Relevance to HMP Bristol | Recommendation |
|---|---|---|---|
| MH1 38 | Staff said that a high number of groups are cancelled on the Brunel Unit due to lack of discipline staff available to facilitate. | The lack of groups means patients are missing out on an important therapeutic treatment, and reduces the ability of staff to fully assess prisoners' socialisation. | Groups should be able to take place as scheduled on the Brunel Unit. |
| MH2 39 | There is limited access to the prison IT system needed to access OASys data. | Mental health staff may not be accessing relevant information that may assist with the risk assessing and care planning for prisoners. | The Mental Health Team should be provided with access to the OASys as required. |
| MH3 39 | Staff said that they are completing a lot more assessments now than in previous years. | The increase in the number of assessments means that there is less time to case manage patients that need mental health interventions. | The less time available to case manage prisoners, combined with the reduction in the number of groups, may have a detrimental effect on the mental health condition of prisoners.<br>The appropriateness of the self-help material should be reviewed. Feedback on the material from patients should be gathered. |
| MH4 38 | The provision of training was raised again at the heads of department meetings, as it was noted that there was a gap in prison training. | Prison staff may not be aware of up to date mental health practice, and how mental health services work in HMP Bristol. | A training timetable for prison staff should be produced. |
| MH5 39 | Staff in the Mental Health Team were unsure how the changes to the prison roll would affect their work. | In the past some prisoners have been transferred to HMP Bristol with a short amount of time left on their sentence, meaning that a less than adequate amount of release planning can be done. | Work should be done with the main prisons that transfer to HMP Bristol, to encourage a certain amount of pre-release work to be started prior to transfer. |
| MH6 39 | Mental health teams in the community have come into HMP Bristol to meet prisoners before they have been released. | Community teams visiting prisoners prior to their release strengthens relationships between the patient and case worker. | Links should be strengthened with those community mental health teams that have the most contact with patients in HMP Bristol. |

# SELF-HARM & SUICIDE

## INTRODUCTION

In December 2013, the results of the largest ever study of self-harm and suicide in prisons was published by the medical journal The Lancet.[9] The report found that in England and Wales, standardised mortality ratios for suicide are five times higher in male prisoners than in the general population.

Another key finding from the report is that about 50% of people who die by suicide in prison have a history of self-harm, which increases the odds of suicide in custody by between 6 and 11 times.

There are a number of possible reasons why the rates of self-harm are higher in the prison population than in the general population:

- Self-harm is sometimes used as a coping mechanism in a difficult situation, which prison can be.
- Prison contains a disproportionate number of distressed and vulnerable people. This cohort is associated with self-harm.
- Self-harm can be a way of communicating for those that are unable to express their feelings.
- Substance misusers are more likely to self-harm.
- It is harder to hide self-harm in prisons.

Reducing and managing self-harm is a priority across the prison system. The "Safer Custody" Prison Service Instruction (PSI) 64/2011 came into force from the 1st of April 2012 and is effective until the 31st of January 2016.

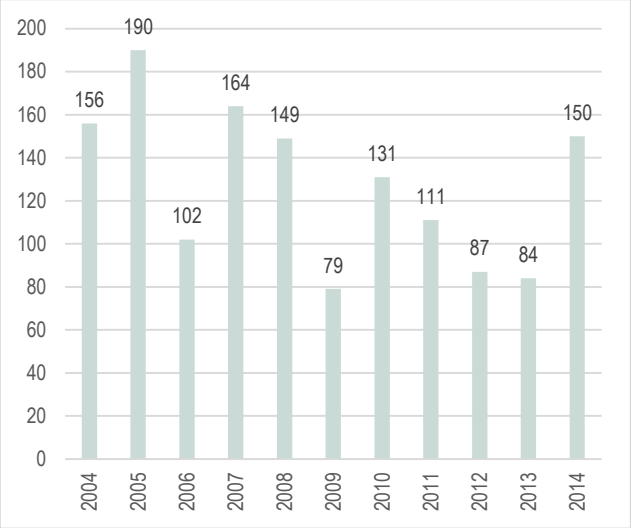
The PSI replaced several Prison Service Orders (PSO) including PSO 2700 (Suicide and Self-Harm), PSO 2750 (Violence Reduction), and PSO 2710 (Follow up to Deaths in Custody).

A significant development as part of the new PSI 64/2011 is the requirement of the ACCT. Meeting the requirements of the ACCT will ensure the best possible management of individuals at risk of self-harm and suicide.

The PSI 64/2011 states that "any prisoner identified as at risk of suicide or self-harm must be managed using the Assessment, Care in Custody and Teamwork (ACCT) procedures."

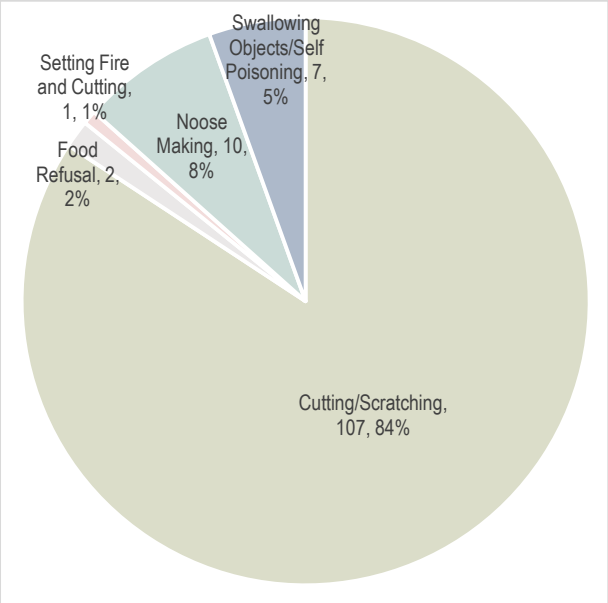
The ACCT framework involves a number of elements including identifying those at risk, opening an ACCT, Assessment, Review, completing the Care Map, management of the ACCT plan, and closing the ACCT.

Staff said that the number of violent incidents within HMP Bristol was increasing. This increase was due to better reporting. Staff also said that there was a increase nationally in the number of violent incidents in prisons.




*Above: Figure 3.2.1 - Long-term self-harm incidents.*

*Source: Local data.*

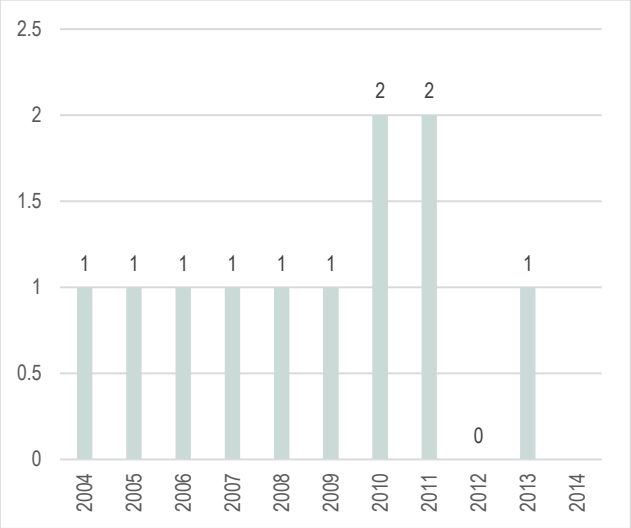



*Above: Figure 3.2.2 - Reasons for self harm.*

*Source - Local data*

## SELF-INFLICTED DEATHS

Figure 3.2.3 shows the number of self-inflicted deaths in HMP Bristol since 2004.




*Right Figure 3.2.3 - Number of self-inflicted deaths.*

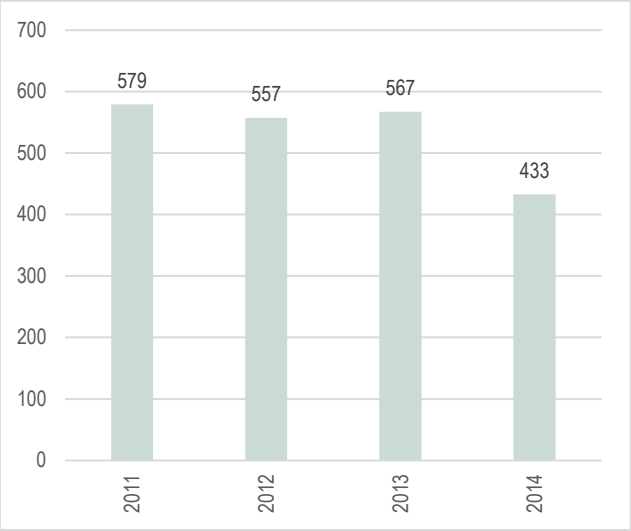
*Source - Local data*

## ACCT

Staff felt that the figures for ACCTs were fairly consistent. Staff from the Safer Custody Team said that they had done work addressing the quality of the ACCT documents.

Staff said that most of the ACCT documents were opened on reception and the residential wings: "at this moment in time there is probably an ACCT open on every wing. Brunel would usually have two or three as well. The higher population [on ACCTs] is usually around A wing." The ACCT case manager arranges reviews and invites relevant attendees. If healthcare or mental health staff cannot attend an ACCT review, they would be asked to give their input on the prisoners care via a phone call. This information can then be added to the ACCT document by the case manager.

Staff said that in the past there have been ACCT reviews where only the senior officer and the prisoner have been in attendance. There has been work carried out to address this issue, which will now happen very rarely.




*Above: Figure 3.2.4 - ACCT numbers.*

*Source - Local data*

Where possible, there are processes in place to provide continuity of care for prisoners being released with open ACCT documents. If a prisoner is being released to an approved premises, a hostel, or a secure hospital, then prison staff would routinely contact these premises and inform them that a prisoner is being discharged into their care with issues of self-harm, and provide them with a risk assessment. There are also processes in place for transferring a prisoner to another prison on an open ACCT.

## CONSTANT SUPERVISION

Constant supervisions were described as being fairly regular. It was thought that there were between two and four each month, however this is often for a very short period of time.

Prisoners that need to be placed on constant supervision are usually flagged up at reception by nurses or officers, who judge if the prisoner is a high risk of suicide, or place a flag on the Prisoner Escort Record. "We often are told in advance by the CARS team at the court, who will notify Mental Health; they in turn inform reception and normally the Duty Governor before they arrive at the prison."

Constant Supervisions are required to be authorised by either a GP or the duty governor, but ideally both. Prisoners that are placed on constant supervision on their first night in prison have a full disciplinary review the following day. The review includes attendance from the Mental Health Team, healthcare staff, the duty governor, and any other relevant parties. Prison staff said that the meetings are normally well attended by mental health staff. Healthcare staff attend if needed.

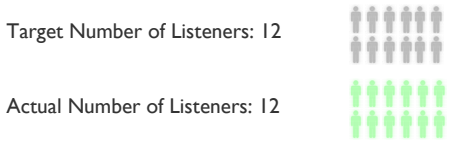
## LISTENERS

Nationally, the Listener Scheme aims to have one Listener for every 50 prisoners. With a population of 592, there should be at least 12 Listeners in HMP Bristol.

Currently there are 12 Listeners in post in HMP Bristol. Staff said that due to the high turnover of prisoners, staff "try to keep on top of Listener numbers." Listeners are given training by the Samaritans.

Listeners are available to prisoners in all parts of the prison. The only restrictions on access to Listeners is in the Brunel Unit and in the Segregation Unit, where a risk assessment must be completed before a prisoner can access a Listener. If it is not appropriate for a Listener to go into a cell with a prisoner, the Listener will try to talk to the prisoner through the door. The prison are receiving an order of phones that will allow prisoners to contact the Samaritans directly.

Listeners are on call for 24 hours. There are three Listener suites in the prison: on A wing, C wing, and D wing.




*Above: Figure 3.2.5 - Target and actual number of Listeners.*

*Source - Local Data.*

## PRISONER PHONE LINE

There is a dedicated phone line, which family members can call if they are concerned about a prisoner in HMP Bristol. Prisoners can also call this phone. Callers can leave a message on an answerphone that is checked twice daily, or if it is urgent a phone message instructs them on how to contact the duty governor.

## INSPECTION REPORT

The HMIP Inspection Report of 2013 included some findings around self harm. Below are the main findings and an update of progress against them.

| Inspection Report Finding | Progress |
|---|---|
| No specific local suicide or self-harm policy in HMP Bristol. | This is still the case, however the prison do adhere to Prison Service Instruction 64/2011 regarding Safer Custody. |
| Case managers have little contact with prisoners between reviews. | Staff said that the case manager reviews the case, and it is the wing staff who would have regular interactions with the prisoner. Staff said that case managers do visit prisoners periodically, and this information is now recorded. |
| Two of the Listener Suites were not fit for use. | The suites have been updated and are useable now. |
| Interpreting service. | The interpreting service is available to be used all over the prison. |

## CHECKPOINT AND RECOMMENDATIONS

| ID / Pg | Consideration / Key Finding | Relevance to HMP Bristol | Recommendation |
|---|---|---|---|
| SH1 42 | The number of violent incidents within HMP Bristol was increasing, and this was related to incidents of self-harm. | More prisoners than at comparator prisons felt unsafe (from HMIP Inspection, 2013). | A formal strategy for the management of young adults should be developed, including an assessment of their vulnerabilities and risks from other prisoners (from HMIP Inspection, 2013). |
| SH2 43 | A wing has the highest proportion of ACCT reviews. | Staff on A wing will deal with more prisoners at risk of self-harm than in other areas of the prison. | All staff on A wing should be trained in ACCTs, and their training be up to date. |
| SH3 43 | If healthcare or mental health staff cannot attend an ACCT review, they would be asked to give their input on the prisoners care via a phone call. This information can then be added to the ACCT document by the case manager. | This process ensures that the relevant staff have input into a prisoners Care Plan. | Where possible, healthcare and mental health staff should attend the ACCT reviews they have been invited to, however when this is not possible, their views should be given via phone or a written submission. |

# LEARNING DISABILITIES AND LEARNING DIFFICULTIES

## INTRODUCTION

Learning Disabilities or Learning Difficulties?

The World Health Organisation (WHO) defines learning disabilities as a state of arrested or incomplete development of mind. Somebody with a general learning disability is said to have a significant impairment of intellectual, adaptive, and social functioning. A learning disability is not acquired in adulthood and is evident from childhood.

The Foundation for People with Learning Disabilities defines learning difficulties as "unlike a learning disability, a learning difficulty does not affect general intelligence (IQ). An individual may often have more than one specific learning difficulty (for example, dyslexia and dyspraxia are often encountered together), and other conditions may also be experienced alongside each other."

The *No One Knows*[10] report recommends that no strict classification is adopted. Instead, the focus should be on those who have difficulties with certain activities that involve thinking and understanding and who need additional help and support in their everyday living.

There have been a number of national research papers and reports that have investigated how those with learning disabilities interact with the criminal justice system and the prison environment.

Recent reports include the Bradley Report[11] and the *No One Knows* report. Both reports highlighted the need to identify and support the prison population with learning disabilities and learning difficulties.

Some of the key findings include:

- This cohort will need additional support during their time in prison. For example, support for daily living such as filling in forms, communicating with prison staff, and reading prison information.
- The *No One Knows* report also highlighted that prisoners with learning disabilities experience higher levels of anxiety, depression, victimisation, and bullying.
- Prisons have a lack of resources and inadequately trained staff to deal with prisoners with learning disabilities.
- Children with learning disabilities and other impairments are more likely to go to prison than other young people because the youth justice system is failing to recognise their needs, according to a major survey of youth offending team (YOT) staff.
- This group of offenders are at risk of re-offending because of unidentified needs and consequent lack of support and services.
- This group of offenders are targeted by other prisoners when in custody.
- This group of offenders present numerous difficulties for the staff who work with them, especially when these staff lack specialist training, or are unfamiliar with the challenges of working with this group of people.
- The provision of support for people in the criminal justice system who have learning disabilities or learning difficulties depends on accurate and timely identification.

## PROVISION

There is a learning disabilities (LD) nurse within the Mental Health Team. The nurse left her post as of 14/11/2014. This post has now been recruited into.

Once there is a referral to the LD team, the LD nurse carries out a full assessment of the prisoner. The nurse uses various techniques in order to gather as much information about the prisoner's previous contact with services as possible.

## LD NURSE

The role of the LD nurse has developed over time, and the duties of the role include:

- Providing emotional support.
- Assessment of physical and mental health needs.
- Care co-ordination and all the CPA key working responsibilities this entails.
- Facilitating health appointments as a supportive advocate.
- Providing easy-read information and creating documents as necessary.
- Helping prisoners understand the situation they are in.
- Linking prisoners in with other services.
- Making sure prisoners are safe.
- Acting as an interpreter between the prisoner and wing staff.
- Running groups.
- Liaison with solicitors and legal teams.

## REFERRALS

Referrals for the LD service come from a number of sources. It is an open referral process as referrals can come from the community learning disability team, Court Assessment and Referral Service, reception screen, and secondary health screen, self-referral, and prison officers on wings.

## WAITING LIST

The LD nurse's capacity fluctuates depending on the complexities of the prisoners that they are working with.

The LD nurse sees prisoners regardless whether they have a diagnosis of LD or not.

## SCREENING QUESTIONS

Learning disabilities is covered in the reception screen, and again on the secondary reception screen. The LD nurse has said that some prisoners that have learning disabilities will sometimes not disclose this at the initial health screens.

"In my experience, prisoners with a learning disability do not want to put their hands up. It makes them very vulnerable. They are more inclined to do that in the court or police station."

## COURT ASSESSMENT AND REFERRAL SERVICE (CARS)

The Court Assessment and Referral Service work in the courts to try and identify and divert vulnerable prisoners away from prison. CARS is run by the Avon and Wiltshire Mental Health Partnership (AWP), and they do not have access to the records of prisoners from other local authorities. This means that sometimes the most vulnerable prisoners are not picked up.

## LD SECURE UNIT

The LD nurse cannot make direct referrals to the LD secure unit. When necessary the LD nurse contacts the community team who gate keep the referrals to the LD secure units.

"The route to get a prisoner with learning disabilities out of prison is very difficult."

## EDUCATION

There are no courses in HMP Bristol aimed specifically at prisoners with a learning disability. There is an education outreach service that prisoners with learning disabilities can be referred to.

## STAFF TRAINING

There is no formal staff training around learning disabilities. The LD nurse has carried out ad hoc training at team meetings, as well as inviting external providers to come in and give talks.

"I carry out a little bit of ad hoc training. I also ask the Bristol Autistic Service to come into the prison to do talks."

## TOE BY TOE

There is a Toe by Toe service. It was described as being helpful for the prisoners with learning disabilities.

"I have had a couple of service users that have found the Toe by Toe mentors really helpful."

## LD POLICY

There is no LD policy in the prison.

## COMMUNICATION WITH OTHER PRISONERS

The LD nurse has good links with all prisons in the south west. Alongside the LD practitioner at HMP Eastwood Park, the LD nurse at HMP Bristol used to carry out assessments in HMP Ashfield.

## CONTINUITY OF CARE

It was highlighted that it was hard to get the community teams to engage with prisoners. Community teams were reluctant to visit the prison to carry out assessments on prisoners. This was having a detrimental effect on continuity of care.

## ANNUAL HEALTH CHECKS

There have been attempts to introduce health checks for prisoners with LD, but the time that prisoners were in the prison was felt to be too short.

"We have tried to implement annual health checks for people with LD, but that has proved problematic. In the community people with learning disabilities should have an annual health check with their GP."

## RECEPTION SCREEN

Questions relating to learning disabilities and learning difficulties are asked in the first reception screen, transfer screen, and second screen.

Figures 3.3.1 outlines the questions asked at the first reception screen, with figure 3.3.2 showing the transfer screen.

The transfer screen would usually include the same questions as the first reception screen, however this is not the case for the learning disabilities.

A question asking specifically if the prisoner has a learning disability was introduced in January 2014. Since the implementation of this question, 136 prisoners were recorded positive, equating to 7% of the screens.

The number of referrals to the LD nurse from the first reception screen has increased over the last three years, with 3% of screens being referred.

Around 10% of reception screens have issues relating to their ability to write. This rate is lower for the transfer screen.

*Below: Figure 3.3.1 - Reception screen data.*
*Source - SystmOne*

| FIRST RECEPTION SCREEN | | Sep-12 | Sep-13 | Sep-14 |
|---|---|---|---|---|
| NUMBER OF SCREENS | # | 2990 | 2788 | 2809 |
| **DOES PRISONER HAVE A LEARNING DISABILITY?** | | | | |
| (XaKYb) On learning disability register | # | 0 | 0 | 136 |
| | % | 0 | 0 | 7% |
| **HAS REFERRAL BEEN MADE TO LD NURSE?** | | | | |
| (XaJmc) Referral to learning disability team | # | 4 | 29 | 73 |
| | % | 0% | 1% | 3% |
| **ABILITY TO WRITE** | | | | |
| (XaAzP) Unable to write | # | 107 | 91 | 80 |
| | % | 4% | 3% | 3% |
| (XaAzQ) Difficulty writing | # | 159 | 190 | 196 |
| | % | 5% | 7% | 7% |
| (XaQGD) Illegible writing | # | 36 | 25 | 16 |
| | % | 1% | 1% | 1% |

This question was implemented in January 2014. The 7% rate is as of the 2401 screens in the same period.

Why are the proportions of referrals ower than the 7% on the LD register.

| TRANSFER SCREEN | | Sep-12 | Sep-13 | Sep-14 |
|---|---|---|---|---|
| NUMBER OF SCREENS | # | 454 | 712 | 831 |
| **ABILITY TO WRITE** | | | | |
| (XaAzP) Unable to write | # | 11 | 15 | 9 |
| | % | 2% | 2% | 1% |
| (XaAzQ) Difficulty writing | # | 19 | 21 | 29 |
| | % | 4% | 3% | 3% |
| (XaQGD) Illegible writing | # | 4 | 8 | 0 |
| | % | 1% | 1% | 0% |

*Left: Figure 3.3.2 - Transfer screen data.*
*Source - SystmOne*

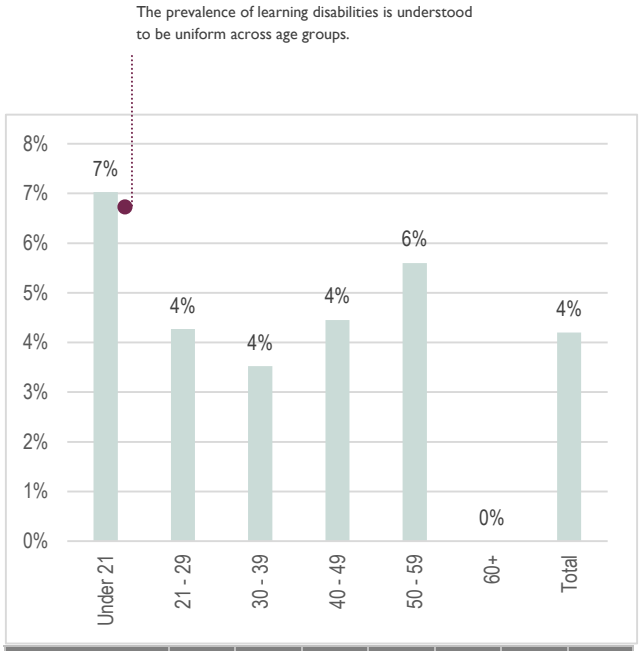
## SECONDARY SCREEN

The secondary screen includes a brief assessment to indicate possibility of learning disabilities. A score of three or above triggers a referral to the LD nurse. Figure 3.3.3 shows the scores over two years from September 2012 to September 2014. In the year to September 2014, 4% of screens triggered a referral to the LD nurse.

| SECONDARY SCREEN - LD | Sep-13 | Sep-14 |
|---|---|---|
| Number of Screens | 3043 | 3285 |
| LD SCREEN SCORE | Sep-13 | Sep-14 |
| 0 | 2657 | 2811 |
| 1 | 174 | 235 |
| 2 | 70 | 104 |
| 3 | 55 | 65 |
| 4 | 40 | 41 |
| 5 | 22 | 32 |
| 6 | 17 | 0 |
| 7 | 13 | 0 |
| Total | 3048 | 3288 |
| >=3 | 5% | 4% |

*Above: Figure 3.3.3 - Secondary screen figures*

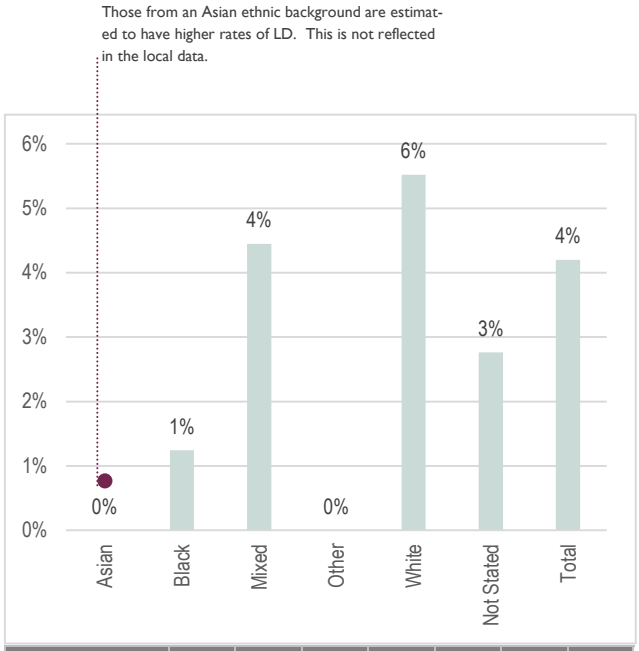
*Source - SystmOne*




| Age Group | Under 21 | 21 - 29 | 30 - 39 | 40 - 49 | 50 - 59 | 60+ | Total |
|---|---|---|---|---|---|---|---|
| Screens | 185 | 1195 | 1022 | 539 | 250 | 97 | 3288 |
| >=3 | 13 | 51 | 36 | 24 | 14 | 0 | 138 |

*Above: Figure 3.3.4 - LD prevalence by age from the second reception screen..*

*Source - SystmOne*

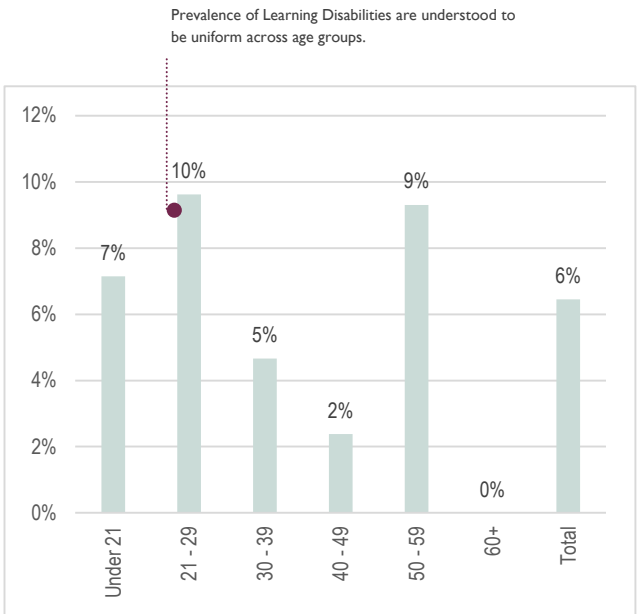



| Ethnic Group | Asian | Black | Mixed | Other | White | Not Stated | Total |
|---|---|---|---|---|---|---|---|
| Screens | 63 | 161 | 90 | 58 | 1866 | 1050 | 3288 |
| >=3 | 0 | 2 | 4 | 0 | 103 | 29 | 138 |

*Above: Figure 3.3.5 - LD prevalence by ethnicity from the second reception screen.*

*Source - SystmOne*

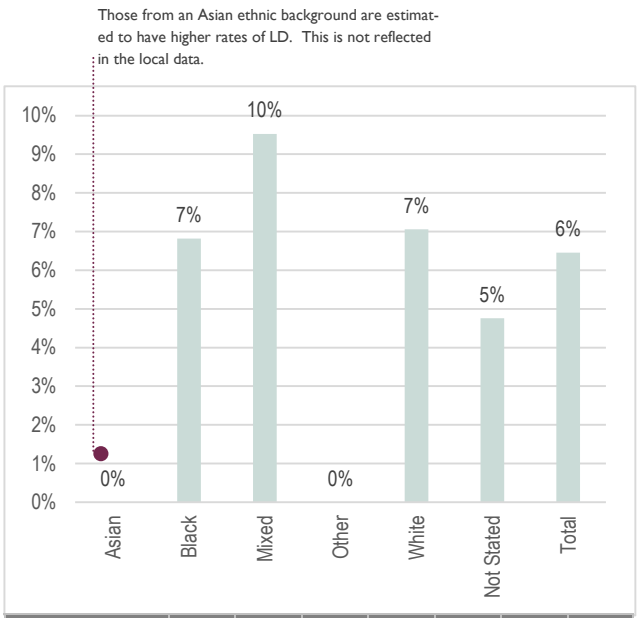
Figures 3.3.6 and 3.3.7 show the demographic breakdowns of those prisoners with learning disabilities from the QOF register.




| Bristol | Under 21 | 21 - 29 | 30 - 39 | 40 - 49 | 50 - 59 | 60+ | Total |
|---|---|---|---|---|---|---|---|
| Population | 42 | 208 | 193 | 84 | 43 | 19 | 589 |
| LD Register | 3 | 20 | 9 | 2 | 4 | 0 | 38 |

*Above: Figure 3.3.6 - LD prevalence by age from the QOF register.*

*Source - SystmOne*




| Ethnic Group | Asian | Black | Mixed | Other | White | Not Stated | Total |
|---|---|---|---|---|---|---|---|
| Population | 15 | 44 | 21 | 14 | 411 | 84 | 589 |
| LD Register | 0 | 3 | 2 | 0 | 29 | 4 | 38 |

*Above: Figure 3.3.7 - LD prevalence by ethnicity from the QOF register.*

*Source - SystmOne*

## LEARNING DISAILITIES CHECKPOINT AND RECOMMENDATIONS

| ID / Pg | Consideration / Key Finding | Relevance to HMP Bristol | Recommendation |
|---|---|---|---|
| LD1<br>47 | The LD nurse sees prisoners regardless whether they have a diagnosis of LD or not.<br>This is in line with *No One Knows* which states that rather than focusing on diagnoses, the focus should be on those that have difficulties with certain activities that involve thinking and understanding, and who need additional help and support in their everyday living. | This allows a higher number of prisoners to benefit from the input of the LD nurse. | The LD nurse should continue to see prisoners regardless of whether they have a diagnosis or not. |
| LD2<br>47 | Some prisoners that have learning disabilities will sometimes not disclose this at the initial health screens. | This may mean that those with learning disabilities are not identified at reception. | Nurses on reception should be given refresher training around identifying prisoners that would benefit from the input of the LD nurse. |
| LD3<br>47 | CARS is run by AWP, and they do not have access to the records of prisoners from other local authorities. | This means that sometimes the most vulnerable prisoners are not picked up. | |
| LD4<br>48 | There is no formal staff training around learning disabilities. The LD nurse has carried out ad hoc training at team meetings, as well as inviting external providers to come in and give talks. | Healthcare and prison staff are not up to date on learning disabilities and associated issues. | The possibility of delivering a learning disability training course should be explored. |
| LD5<br>48 | The route to get a prisoner with learning disabilities to an LD secure unit was described as very difficult. | This can cause delays in the treatment of vulnerable prisoners. | The pathway from prison to an LD secure unit should be evaluated. |
| LD6<br>48 | There is an education outreach service that prisoners with learning disabilities can be referred to. | This allows prisoners with learning disabilities to receive an education. | No recommendation. |
| LD7<br>48 | It was hard to get the community teams to engage with prisoners. Community teams were reluctant to visit the prison to carry out assessments on prisoners. | This was having a detrimental effect on continuity of care. | Links should be strengthened with the community teams that have the most contact with learning disability clients in HMP Bristol. |
| LD8<br>48 | There have been attempts to introduce health checks for prisoners with learning disabilities, but the time that prisoners were in the prison was felt to be too short. | People with learning disabilities have worse health outcomes than those without. Their needs are less likely to be identified without a specific health check. | Where possible, prisoners with learning disabilities should receive a health check. |

# SUBSTANCE MISUSE

## INTRODUCTION

From April 2013, NHS England took over responsibility for commissioning drug and alcohol treatment in prisons.

Current government policy objectives include: integrating prison, probation, and youth justice agencies with other local health and community services to address the needs of offenders; identifying non-custodial options for drug dependent offenders to tackle dependence; and creating drug-free environments in prisons by piloting Drug Free Wings and Drug Recovery Wings.

The Government also want the promotion of integrated recovery pathways that capitalise on the potential for a prison to be a relatively safe and supportive environment, where offenders take their first strides towards recovery.

In line with the vision set out in the National Drug Strategy (2010),[12] the Government's Alcohol Strategy (2012),[13] and the Patel Report (2010),[14] all commissioned services should be fully integrated, recovery orientated, and outcome focussed.

Current evidence points towards clinical treatment being accompanied by psychosocial services, including life skills work, mutual aid, and couples and families work.

Drug treatment in secure settings has to manage risks such as: suicide and self-harm following reception related to uncontained drug withdrawal; post-release fatal overdose due to loss of opioid tolerance; and possibility of simultaneous access to illicit medication, both prescribed and non-prescribed.

## SUBSTANCE MISUSE IN PRISON

Substance misuse is a big issue amongst the prison population. Drug users report engaging in much higher levels of criminal activity than non drug users, and several studies have found that drug use appears to intensify, motivate, and perpetuate offending behaviour.[15]

The Surveying Prisoners Crime Reduction Survey (SPCR) from 2005 and 2006 found that 81% of prisoners had taken illegal drugs at some point in their lives. Cannabis was the most frequently reported drug used, with 71% of SPCR respondents reporting to have used it. This was followed by cocaine (45%) and crack cocaine (43%).[16]

Compared to the wider prison population, problem drug-using offenders are a group with particularly complex and intractable problems, which means they will be more challenging to treat, rehabilitate, and reintegrate into society.[17] The 2005/06 Arrestee Survey[18] found that among arrestees who used heroin and crack at least once a week:

- almost a quarter had slept rough in the past month (compared with less than one-tenth of other arrestees);
- half (50%) said they had left school before they were 16, 58% said they had been temporarily excluded at some time, and 36% hsd been permanently excluded (the equivalent figures for other arrestees are 32%, 39%, and 21%);
- only 1 in 10 were in employment (compared with almost half of other arrestees);
- and 29% had been in local authority care at some time (compared with 15% of other arrestees).

The Psychosocial Service is provided by the Avon and Wiltshire Mental Health Partnership NHS Trust (AWP). The Clinical Substance Misuse Service is provided by Bristol Community Health (BCH).

## STAFFING

Figure 3.4.1 shows the ratio of psychosocial support workers to prisoners (displayed by applying the percentage of new receptions starting a substance misuse treatment episode to the latest prison population figure). All prisons apart from HMP Ashfield have similar staffing levels. HMP Ashfield does not have any specific substance misuse psychosocial staff.

Figure 3.4.2 shows this information in table form, and includes the ratios for clinical substance misuse staff.

Figure 3.4.3 overleaf shows the staffing make up of the Psychosocial Team and the Clinical Team in HMP Bristol.


*Above: Figure 3.4.1 - Ratio of psychosocial support workers to prisoners (% of new receptions starting a substance misuse treatment episode).*

*Source: Interviews and local data.*

*Below: Figure 3.4.2 - Staffing ratios across the cluster.*
*Source - Interviews and local data*

| | Ashfield | Bristol | Eastwood Park | Erlestoke | Leyhill |
|---|---|---|---|---|---|
| Population Size | 400 | 610 | 318 | 524 | 502 |
| New receptions starting a substance misuse treatment episode (%) | * | 220 (36%) | 188 (59%) | 173 (33%) | 50 (10%) |
| Clinical - Band 5 RGNs (ratio to prisoners) | * | 10.6 (1:21) | 9.8 (1:19) | 5 (1:35) | Covered by primary care staff |
| Psychosocial - Support Workers (rtp) | * | 9 (1:24) | 5 (1:38) | 4 (1:43) | 2 (1:25) |

Figure 3.4.3 shows the staffing make up of the Psychosocial and Clinical Team in HMP Bristol. At the time of this H&SCNA there was one Band 5 and one Band 4 vacancy.

The clinical staff have a special interest in substance misuse, however if needed they are able to work on one of the general wings.

| Psychosocial Team | |
|---|---|
| Number of staff | Role |
| 1 | Band 7 |
| 1 | Band 6 Advanced Drug and Alcohol |
| 2 | Band 5 Drug and Alcohol Practition- |
| 8 | Band 4 Recovery Support Workers |
| Clinical Team | |
| 1 | Clinical Nurse Manager |
| 1 | Band 6 Clinical Team Leader |
| 10.6 | Band 5 RGNs |
| 9 | Band 3 Healthcare Assistant |

*Above: Figure 3.4.3 - Substance misuse staffing list..*

*Source - Local data*

## LOCATION

Staff said that C wing should hold substance misuse patients only, however due to a lack of space in the prison, non-substance misusing prisoners get housed on C wing. These prisoners could include those that have completed their substance misuse treatment and have ceased taking opiate substitute medication, but who are stable on C wing as they have a job.

Prisoners that access the Psychosocial Service can be based all over the prison. Prisoners with any substance misuse issue, regardless of how serious it is, can access Psychosocial Services.

## STABILISATION UNIT

The top landing of C wing is for prisoners that are being stabilised on opiate substitute medications. In addition to substance misusers, there are also prisoners in the unit that do not have substance misuse problems, but are kept in the unit due to a lack of space in the rest of the prison.

The substance misuse clinical staff have to ensure there is enough space in the stabilisation unit for patients that are detoxing from opiates and alcohol. This can be a time consuming task and can divert the nurses away from their primary role.

## ALCOHOLICS/NARCOTICS ANONYMOUS (AA/NA)

There are AA and NA services that come into the prison on a weekly basis.

## DRUG FREE WING

B wing holds prisoners that are not being prescribed opiate based medications. Previously, B wing was the drug free wing in the prison, and prisoners were transferred there when they became stable and ceased being prescribed opiate based medication. Staff felt that B wing did not function as a drug free wing anymore, due to the availability of illicit drugs on the wing.

"I don't think we have a drug free wing now, because the drugs are everywhere and hard to control. The status of B wing is not clear; it now holds prisoners that have employment."

## RESETTLEMENT PRISON

The Clinical Team were worried that changing HMP Bristol into a resettlement prison would mean they would have less time with prisoners in order to get them stable before release.

## CASE REVIEWS

The Clinical Team carry out joint medication reviews with the Psychosocial Team.

## N-ALIVE STUDY

This study is looking at prisoners with a history of opiate injecting. It is exploring whether giving prisoners a single rescue injection of Naloxone to take with them when released will reduce the death rate from overdose. The study is still at the pilot stage. It is running in 16 prisons in England.

## MEDICATION

A member of the Psychosocial Team attends medication reviews for prisoners on the stabilisation unit. Psychosocial Team staff attend daily on a rota basis. This review takes place with a member of the Clinical Team.

## NEW PSYCHOACTIVE SUBSTANCES (NPS)

There are no specific courses covering NPS. Psychosocial staff are able to access relevant training around NPS. Training has been delivered by the Avon and Wiltshire Police. Staff said: "We are aware that drugs like Spice are an issue in the prison."

## DUAL DIAGNOSIS

The Psychosocial Team attend the weekly mental health single point of entry meeting. Joint cases are discussed in these meetings, and the appropriateness of substance misuse treatment commencement is discussed. The Mental Health Team would initially assess clients to ascertain if a mental health intervention was appropriate. Staff said: "There is a lot of communication between mental health and substance misuse services."

## SERVICE USER FEEDBACK

Service user feedback is captured using evaluation forms at the end of every group, and the "Friends and Family Test."

There has not been any formal feedback from the Recovery Champions on their experiences.

"It would be a development of the service to have more of a service user forum."

## DRUG AND ALCOHOL STRATEGY

There is currently a Drug and Alcohol Strategy. A new Drug Strategy was produced in Autumn 2014.

## RELAPSE INTERVENTION SERVICE

The Relapse Intervention Service is led by a Band 5 nurse and a Band 5 drug and alcohol practitioner. The service provides psychosocial support and clinical interventions with a doctor to patients that have relapsed within the prison. The service are planning to run some group work sessions providing information and support to prisoners around relapse.

There used to be a relapse officer funded by the prison, but this post is no longer funded. Clinical staff said this role was useful, as it provided supervision for the nurses when they were carrying out tasks such as urine tests, and reducing or stopping prescriptions. Staff also found the relapse officer useful when prisoners who wanted to use the relapse intervention service disclosed that they had illicit drugs, or drug paraphernalia, in the prison.

At the time of this H&SCNA, there were 20 active clients on the Relapse Intervention Service caseload, and prisoners were being referred to the service on a daily basis.

## INSPECTION REPORT

There was a HMIP Inspection in HMP Bristol while this H&SCNA was being undertaken. The report was not published in time for this report. Below are findings from the previous HMIP Inspection in May 2013, and an update on progress.

| Finding | Progress |
|---|---|
| The report highlighted that there were too many non-substance misusing prisoners on C-wing for it to function as a recovery unit. | Staff said that this was still an issue: "It would be better if the wing was only for substance misusing prisoners." |
| The report highlighted that higher numbers of prisoners reported that they could access illicit drugs in the prison, compared to comparator prisons. | At the time of this H&SCNA, there were 20 active clients on the Relapse Intervention Service caseload, and prisoners were being referred to the service on a daily basis. The majority of prisoners were said to be misusing buprenorphine.<br>"Prisoners do disclose that they have relapsed and that they have been using drugs." |

## ALCOHOL

Prisoners with alcohol only problems can access the Psychosocial Service in the same way as users of other substances. Prisoners with any level of drinking can access psychosocial services.

Alcohol users can access all of the interventions run by AWP. To access Inside Recovery, an alcohol user has to have medium to high levels of dependency.

### COURSES

A specific alcohol course which lasted for five days used to be run in HMP Bristol. The possibility of restarting it as a condensed one-day course is being considered, and is on the Substance Misuse Team's action plan.

### ALCOHOL USERS

Clinical substance misuse staff said there were not many services for alcohol dependent patients. Staff said that there was a need for a dedicated alcohol worker to provide information and support to prisoners with alcohol problems. Clinical staff felt that there was not much in place for prisoners that did not need any clinical interventions for alcohol use.

There have been occasions where prisoners have not been honest at reception about their alcohol use, and initially have not received any stabilisation interventions. These prisoners had re-presented again a few days later when they were feeling unwell, due to stabilising without any clinical support.

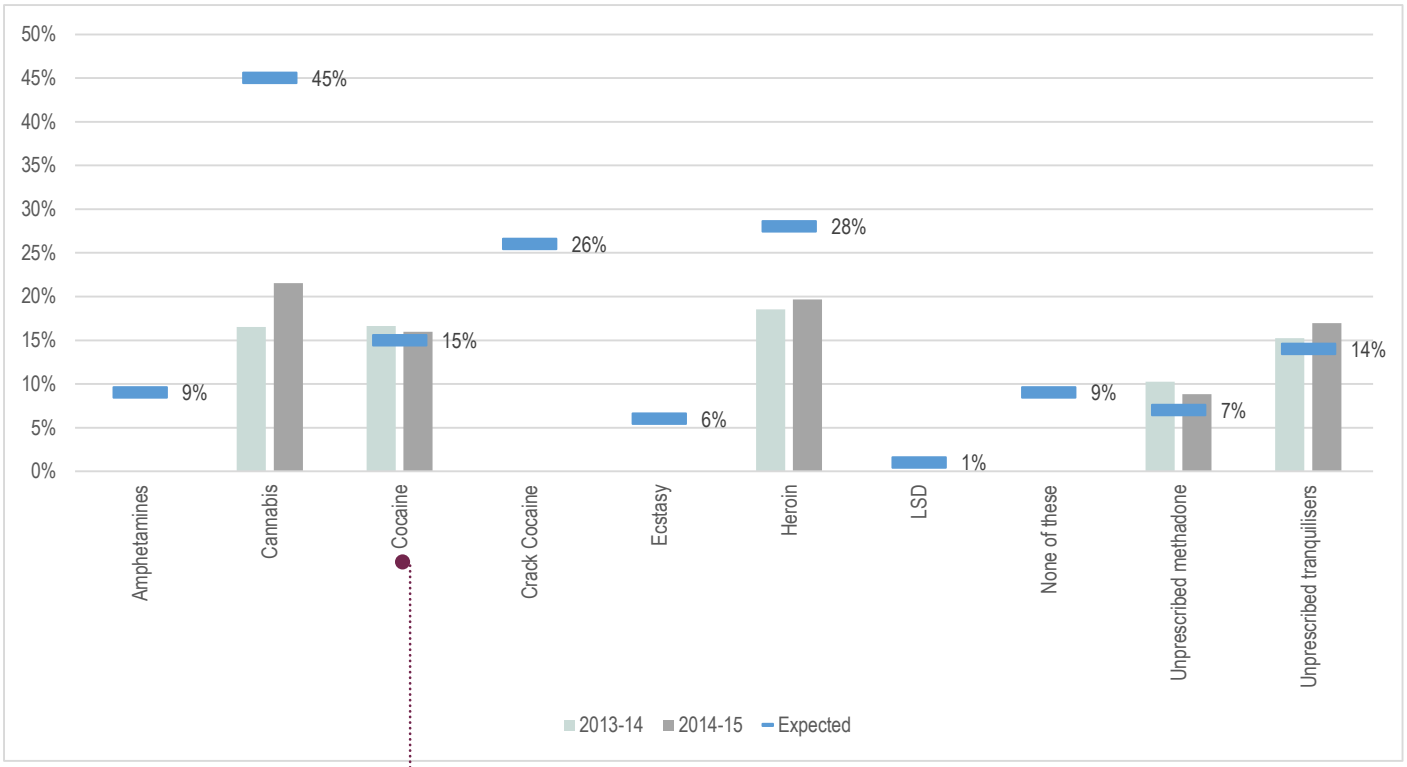
## RECEPTION

Table 3.4.4 shows the expected prevalence at reception based on the results from the Surveying Prisoner Crime Reduction Survey (SPCR), and the results of the urine screen at the reception screen.

For example, it is expected that 28% of reception have used heroin within the four weeks prior to custody. The urine screen picks up a rate of around 20%.

| Average a Month | Expected | Apr 2013 - Mar 2014 Monthly Average | | Apr - Jun 2014 Monthly Average | |
|---|---|---|---|---|---|
| Drug Type | % | # | % | # | % |
| Amphetamines | 9% | - | - | - | - |
| Cannabis | 45% | 39 | 17% | 50 | 22% |
| Cocaine | 15% | 39 | 17% | 37 | 16% |
| Crack Cocaine | 26% | - | - | - | |
| Ecstasy | 6% | - | - | - | - |
| Heroin | 28% | 44 | 19% | 46 | 20% |
| LSD | 1% | - | - | - | - |
| None of these | 9% | - | - | - | - |
| Unprescribed methadone | 7% | 24 | 10% | 21 | 9% |
| Unprescribed tranquilisers | 14% | 36 | 15% | 40 | 17% |

*Right: Figure 3.4.4 - Positive urine tests at reception with expected prevalence rates.*
*Source: SCPR and Systmone*



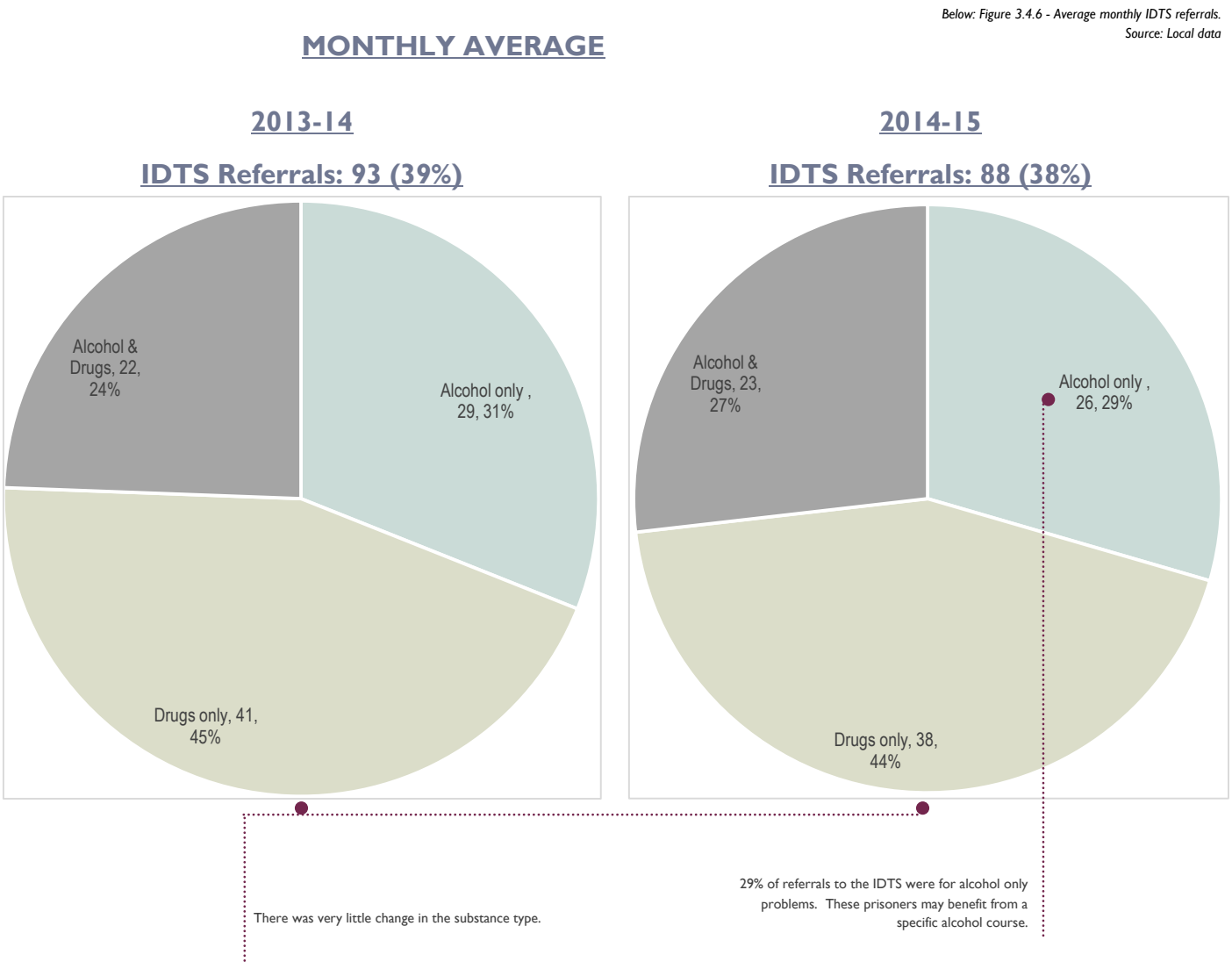

16% of prisoners test positive for cocaine. Generally cocaine stays in the blood for 2-4 days, so this indicates relatively recent use.

*Right: Figure 3.4.5 - Positive urine tests at reception with expected prevalence rates.*
*Source: SCPR and Systmone*

## OUTCOMES

Figure 3.4.6 shows the average monthly referrals from the outcomes of the secondary screen, broken down by substance type (alcohol/drugs, or alcohol and drugs). There are only slight differences in the types of Integrated Drug Treatment Service (IDTS) referrals between 2014/15 and 2013/14.

*Below: Figure 3.4.6 - Average monthly IDTS referrals.*
*Source: Local data*



## REFERRAL

Prisoners are screened for substance misuse issues at the reception screen. If a prisoner identifies as having a substance misuse problem, then they are referred to the Psychosocial Team. These prisoners are seen by the Psychosocial service and assessed.

Psychosocial staff also pick up prisoners via the morning meeting held on C wing (stabilisation unit). Prisoners can also self-refer to the Substance Misuse Service. Referrals are also taken from the offender management unit. These would be prisoners that have to work with the Substance Misuse Team as part of their sentence plan. Referrals also come from community agencies. Staff said "prisoners on C wing are our priority, they are our most risky clients, our most chaotic."


| | Bristol 2013-14 | Bristol 2014-15 YTD Qtr-2 |
|---|---|---|
| Number of new receptions | 3679 | 1587 |
| Number of new receptions beginning drug treatment episodes | 1366 | 576 |
| % of new receptions beginning drug treatment episodes | 37% | 36% |

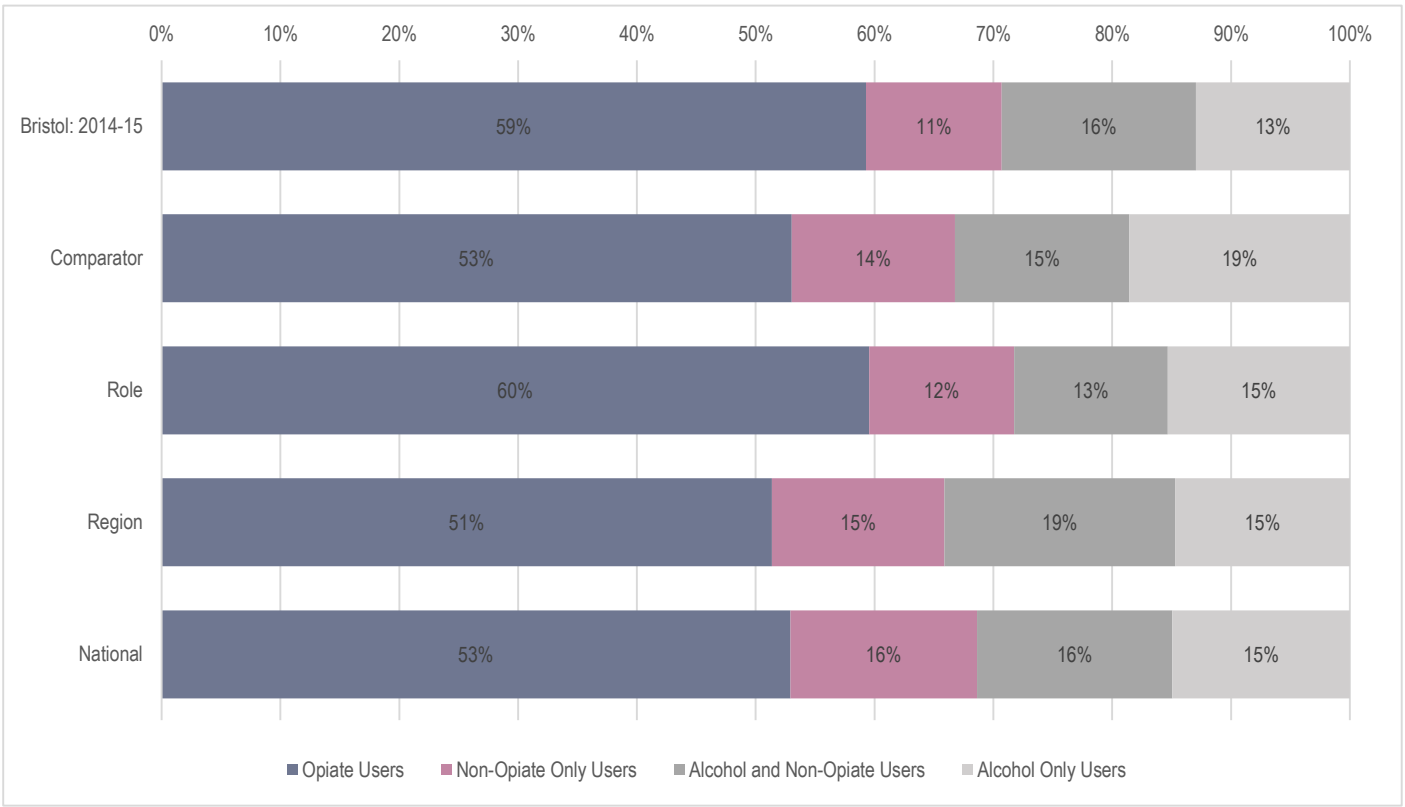
Rates of new receptions starting drug treatment episodes in HMP Bristol are lower than in comparator prisons.

*Above: Figure 3.4.7 - New receptions beginning a drug treatment episode.*

*Source: NDTMS.*

*Below: Figure 3.4.8 - Treatment episode broken down by drug type.*

*Source: NDTMS.*



## SERVICE WITHDRAWALS

Prisoners that decline to commence treatment with substance misuse services are followed up after 10 days, when they are invited again to start treatment.

"When someone has just come into prison they are not in the right frame of mind to think about what they want to do."

"We always make it very clear to them that at any point they can self-refer if they change their mind."

Relatively high numbers of non-opiate using prisoners are picked up after 3 weeks in prison. With the high turnover of prisoners, this may leave less time for interventions.

| 2013-14 Full Year | Total New | | Opiate Users | | Non-Opiate Users | | Primary Alcohol Clients | |
|---|---|---|---|---|---|---|---|---|
| | # | % | # | % | # | % | # | % |
| Taken directly into custody and starting treatment within 3 weeks | 893 | 76% | 441 | 82% | 144 | 60% | 308 | 79% |
| Transferred from another prison and starting treatment within 3 weeks | 183 | 16% | 91 | 17% | 47 | 20% | 45 | 12% |
| Existing prisoners starting a new treatment episode after 3 weeks in prison | 93 | 8% | 8 | 1% | 48 | 20% | 37 | 9% |
| Total | 1169 | - | 540 | - | 239 | - | 390 | - |

| 2014-15 YT Qtr-2 | Total New | | Opiate Users | | Non-Opiate Only Users | | Alcohol and Non Opiate Users | | Alcohol Only Users | |
|---|---|---|---|---|---|---|---|---|---|---|
| | # | % | # | % | # | % | # | % | # | % |
| Taken directly into custody and starting treatment within 3 weeks | 487 | 83% | 305 | 88% | 42 | 63% | 74 | 77% | 66 | 87% |
| Transferred from another prison and starting treatment within 3 weeks | 57 | 10% | 32 | 9% | 12 | 18% | 9 | 9% | 4 | 5% |
| Existing prisoners starting a new treatment episode after 3 weeks in prison | 43 | 7% | 11 | 3% | 13 | 19% | 13 | 14% | 6 | 8% |
| Total | 587 | - | 348 | - | 67 | - | 96 | | 76 | |

*Above: Figure 3.4.9 - Time between entry to HMP Bristol and treatment start.*

*Source: NDTMS.*

## MODALITIES

Figure 3.4.10 shows a breakdown of modalities that were started in the first two quarters of the 2014-15 financial year.

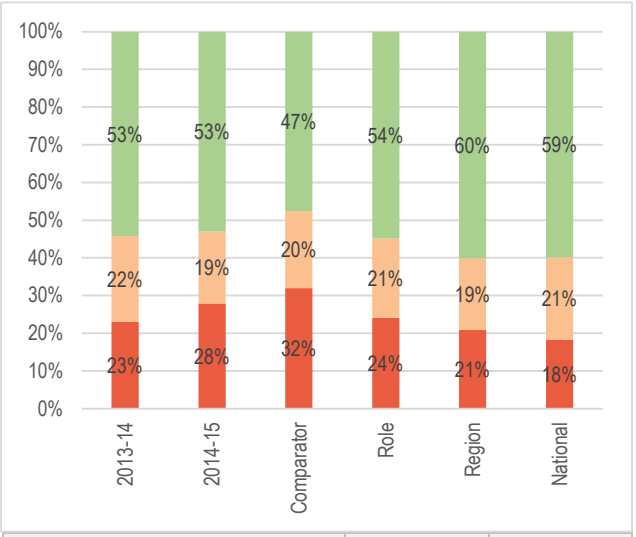
| OPIATE | NON-OPIATE | ALCOHOL AND NON-OPIATE USERS | ALCOHOL ONLY |
|---|---|---|---|
| 657 | 71 | 137 | 138 |
| Other Structured Intervention | Other Structured Intervention | Alcohol - Other Structured Treatment | Alcohol - Other Structured Treatment |
| 325 (49%) | 64 (90%) | 50 (36%) | 72 (62%) |
| Opioid Maintenance | Opioid Maintenance | Other Structured Intervention | Alcohol - Prescribing |
| 243 (37%) | 3 (4%) | 47 (34%) | 38 (32%) |
| Opioid Reduction | Other Clinical Intervention | Alcohol - Prescribing | Other Structured Intervention |
| 24 (4%) | 2 (3%) | 27 (20%) | 4 (3%) |
| Alcohol - Other Structured Treatment | Other Formal Psychosocial Therapy | Alcohol - Structured Psychosocial Intervention | Alcohol - Structured Psychosocial Intervention |
| 20 (3%) | 2 (3%) | 9 (7%) | 2 (2%) |
| Other Modality | | Other Modality | Opioid Maintenance |
| 45 (7%) | | 4 (3%) | 1 (1%) |

*Above: Figure 3.4.10 - Modalities started.*

*Source: NDTMS.*

## INJECTING STATUS

Figure 3.4.11 shows the injecting status of new treatment entrants. For the first two quarters of 2014-15, 28% were recorded as "Currently Injecting (in 28 Days Prior to Custody)." This is higher than the previous year, and higher than other local prisons.




| | Bristol 2013-14 | Bristol 2014-15 YTD Qtr-2 |
|---|---|---|
| Never Injected | 252 | 152 |
| Previously Injecting | 180 | 109 |
| Currently Injecting | 329 | 216 |

*Right: Figure 3.4.11 - Injecting status of those beginning treatment.*

*Source: NDTMS.*

## IN TREATMENT

The following section looks at prisoners that were in treatment during the specified period.

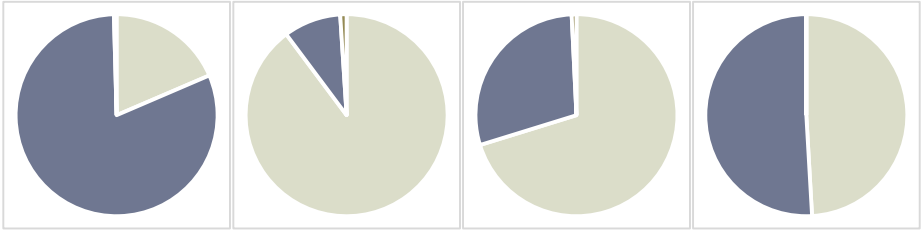
### TREATMENT INTERVENTIONS RECEIVED

The table below shows the treatment interventions received for those in treatment for the period.

| 2014-15 FYTD Qtr-2 | Opiate Users | | Non-Opiate Users | | Alcohol and Non-Opiate Users | | Alcohol Only Users | |
|---|---|---|---|---|---|---|---|---|
| | # | % | # | % | # | % | # | % |
| Clinical Interventions Only | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% |
| Non-Clinical Structured Interventions | 87 | 19% | 88 | 90% | 92 | 70% | 54 | 49% |
| Clinical and Non-Clinical Structured Interventions | 380 | 81% | 9 | 9% | 38 | 29% | 56 | 51% |
| No Structured Modality Started/Recorded | 2 | 0% | 1 | 1% | 1 | 1% | 0 | 0% |
| Total | 469 | - | 98 | - | 131 | - | 110 | - |

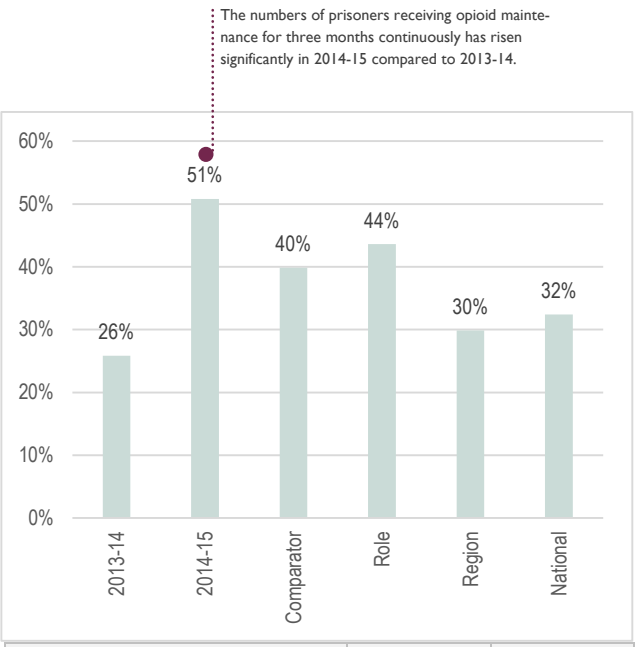
*Above: Figure 3.4.12 - Treatment interventions received.*

*Source: NDTMS.*



## OPIOID MAINTENANCE

Figure 3.4.13 shows the number of opiate users in custody for more than three months, and the number receiving opioid maintenance for three months continuously.




| | Bristol 2013-14 | Bristol 2014-15 YTD Qtr-2 |
|---|---|---|
| In Custody 3+ Months | 178 | 124 |
| Receiving Maintenance for 3+ Months Continuously | 46 | 63 |

*Above: Figure 3.4.13 - Opioid maintenance for 3+ months continuously.*

*Source: NDTMS.*

## AGE / ETHNICITY

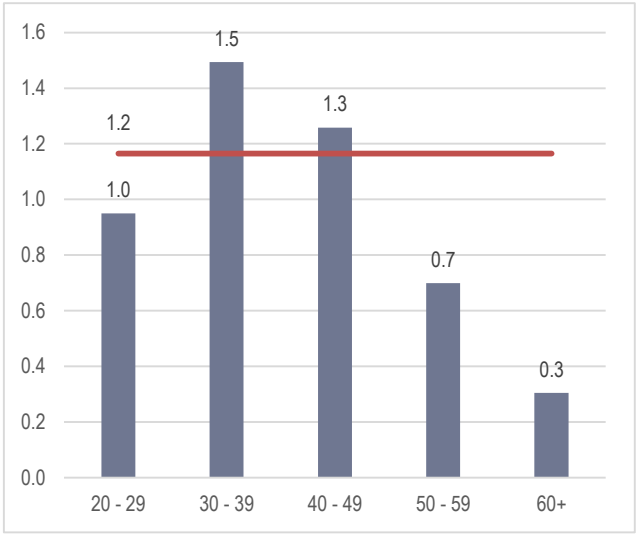
Figures 3.4.14 and 3.4.15 show how those in treatment during the first two quarters of 2014-15 are proportioned to the prison population.

For example, the 30-39 age group accounts for a high percentage of those that have been in treatment. This age group also accounts for a high rate when proportioned against a snapshot of the prison population.

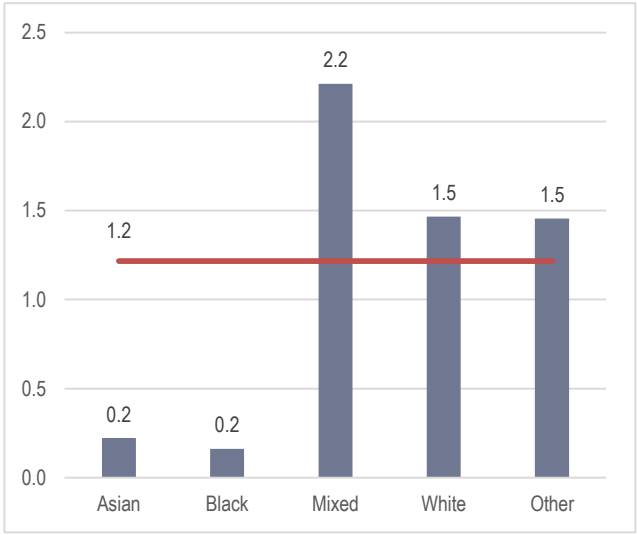
In terms of ethnicity, the data suggests that those of Mixed ethnicity are overrepresented, whereas those from an Asian or Black ethnic background are underrepresented.

*Below: Figures 3.4.14 & 3.4.15 - In treatment population by age and ethnicity.*

*Source: NDTMS.*



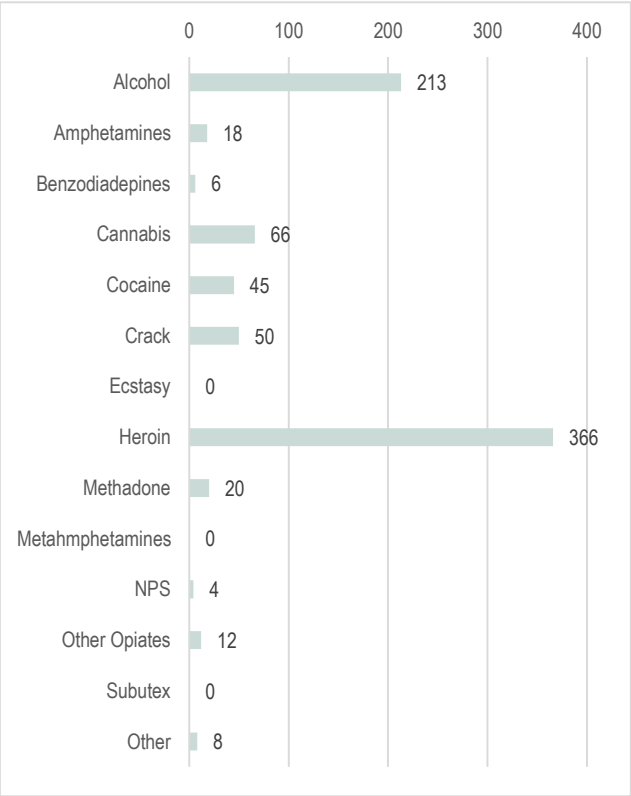

| Age | In Treatment # | In Treatment % | Population # | In Treatment to Population |
|---|---|---|---|---|
| 20 - 29 | 478 | 32% | 503 | 1.0 |
| 30 - 39 | 669 | 45% | 448 | 1.5 |
| 40 - 49 | 268 | 18% | 213 | 1.3 |
| 50 - 59 | 58 | 4% | 83 | 0.7 |
| 60+ | 7 | 0% | 23 | 0.3 |
| Total | 1480 | 100% | 1270 | 1.2 |




| Ethnicity | In Treatment # | In Treatment % | Population # | In Treatment to Population |
|---|---|---|---|---|
| Asian | 28 | 2% | 126 | 0.2 |
| Black | 23 | 2% | 142 | 0.2 |
| Mixed | 115 | 8% | 52 | 2.2 |
| White | 1291 | 88% | 880 | 1.5 |
| Other | 16 | 1% | 11 | 1.5 |
| Total | 1473 | 100% | 1211 | 1.2 |

## MAIN DRUG

Figure 3.4.16 shows the main drug recorded for the in treatment population. Heroin is the most frequent main drug recorded.




*Above: Figure 3.4.16 - In treatment population by main drug.*

*Source: NDTMS.*

## COURSES

All courses are available for all prisoners to access, regardless of drug used. Those receiving substance misuse treatment can access SMART Recovery. Only those prisoners with medium to high levels of dependency can access the Inside Recovery programme. Currently a new Recovery Champion is being recruited.

Before a prisoner is trained to become a Recovery Champion, the following checks are made:

- The prisoner has to be engaging in groups.
- The prisoner has to be seen in the prison as a positive influence.
- The prisoner has to be checked by the prison security department.
- In addition, wing staff are asked about their opinions on potential Recovery Champions.

"Because HMP Bristol is a remand prison with a high turnover, it is difficult to retain the Recovery Champions once they are trained. They could be transferred to another prison, or they could be released into the community."

"At the moment there isn't an awful lot of training available to be a Recovery Champion. A prisoner just has to prove himself as a valued prisoner, and be in recovery themselves."

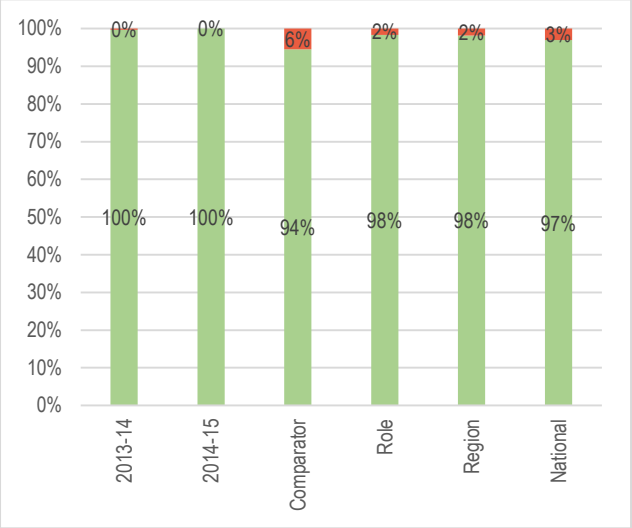
"We are aiming to run more SMART groups, so prisoners can access them."

## COMMUNITY DRUG TEAMS

South Gloucestershire CJIT and Bristol CJIT are delivered by AWP. There were not thought to be any shared targets between the community teams and the prison teams around continuity of care.

Bristol CJIT have employed 2 x resettlement workers to provide housing support for Bristol clients. The workers' time is split between the prison and the community.

There are no shared IT systems between the community teams and the prison teams. There is a plan to introduce a shared IT system between the areas covered by AWP and HMP Bristol. Additional hardware is needed for this to happen.




*Above: Figure 3.4.17 - Treatment exits.*

*Source: NDTMS.*

There has been a reduction in the proportions of prisoners that have completed treatment in 2014-15, compared to 2013-14.

*Below: Figure 3.4.18 - Planned and unplanned exits.*
*Source - NDTMS*

**TOTAL INDIVIDUALS DISCHARGED : 511**

| PLANNED : 511 (100%) | UNPLANNED : 0 (0%) |
|---|---|
| Treatment Completed - Drug Free<br>49 (10%) (17%) | Incomplete - Dropped Out<br>(0%) 0 (0%) |
| Treatment Completed - Alcohol Free<br>56 (11%) (15%) | Incomplete - Treatment Withdrawn by Provider<br>(0%) 0 (0%) |
| Treatment Completed - Occasional User (Not Heroin or Crack)<br>1 (0%) (3%) | Incomplete - Treatment Commencement Declined by Client<br>(0%) 0 (0%) |
| Transferred - Not in Custody<br>183 (36%) (25%) | Client Died<br>(0%) 0 (0%) |
| Transferred - In Custody<br>222 (43%) (40%) | |

90 (40%) (40% - Second bracket indicates 2013-14 performance)

## PEER MENTOR PICK UP SERVICE

A new initiative between AWP and the voluntary group, Bristol Roads, will start working with those that have been Peer Mentors in the prison, and are now in recovery in the community. It aims to use these Peer Mentors to pick up prisoners at the gate on release, and spend the first 48 hours of their release with them.

Initially there will be one prisoner per week that will be met at the gate. This initiative will only be for prisoners being released into Bristol.

"The Peer Mentors will stay with the prisoners when they are most vulnerable."

## DISCHARGES

The Clinical and Psychosocial teams jointly arrange the prisoner's substance misuse appointments in the community on their release.

55% of exits from HMP Bristol are for releases, with the remaining 45% classified as transfers to another prison.

Of those released, 33% did not have an onward referral.

## RELEASE PLANNING

Release planning begins as soon as the Psychosocial Team begin engaging with the prisoner. There is an aim for community drug teams to enter the prison every couple of months to see prisoners from their area. Staff said that this is important because: "we don't know how long a prisoner is going to be with us...we aim to build up strong links with the area teams."

There are difficulties in getting community providers to visit the prisoner before their release. One reason for this was given as the time involved. "The aim is to invite those community areas into the prison, so they can meet the prisoner before release."

When a prisoner is going to be released they are given a release plan, and the work they have completed in custody is reviewed. This includes what they have learnt, what their priorities are on release, where they can get support, and what appointments have been arranged for them.

Harm reduction and overdose information is also covered. The prisoners are given tailored release packs for the area that they are being released to.

| PRISON EXIT REASON | 2013-14 | | 2014-15 | |
|---|---|---|---|---|
| | # | % | # | % |
| Transferred to another prison | 654 | 59% | 229 | 45% |
| Released | 458 | 41% | 280 | 55% |
| Died | 0 | 0% | 0 | 0% |
| Absconded | 0 | 0 | 0 | 0% |
| Total | 1112 | - | 509 | - |

| RELEASED CLIENTS - REFERRALS | 2014-15 | |
|---|---|---|
| | # | % |
| Referred to Community Treat- | 37 | 13% |
| Referred to CJIT | 23 | 8% |
| Referred to CJIT and Community Treatment | 128 | 46% |
| No Onward Referral | 92 | 33% |
| Not Recorded | 0 | 0% |

*Above/right: Figure 3.4.19 - Treatment exit reasons.*

*Source - NDTMS*

PRE-RELEASE REVIEW

278/280 = 99%

(2013-14: 458/458 = 100%)

Figures 3.4.20 and 3.4.21 show the destinations of the transfers and releases to community.

39% of those transferred to another prison were picked up. This rate is higher than other local prisons, and the regional and national rates.

Transfers to HMP Portland that were picked up is low, at only 24%. This indicates that there needs to be some work done in HMP Portland around communication.

HMP Bristol had a rate of 29% for prison to community transfers that were picked up, which is in line with other local prisons, and the rates reported for the region and nationally.

53% of releases were referred to Bristol Community Team.

## PRISON TO PRISON TRANSFER

| Prison Transferred To | Referred | Picked Up | % Picked Up |
|---|---|---|---|
| HMP Bullingdon | 12 | 6 | 50% |
| HMP Channings Wood | 22 | 14 | 64% |
| HMP Dartmoor | 19 | 8 | 42% |
| HMP Erlestoke | 14 | 6 | 43% |
| HMP Exeter | 13 | 8 | 62% |
| HMP Guys Marsh | 43 | 24 | 56% |
| HMP Portland | 51 | 12 | 24% |
| Other | 44 | 8 | 18% |
| HMP Bristol | 218 | 86 | 39% |
| Comparator | 264 | 121 | 46% |
| Role | 6292 | 2261 | 36% |
| Region | 2147 | 691 | 32% |
| National | 9691 | 3146 | 32% |

*Above: Figure 3.4.20 - Prison transferred to and pick up rate.*

*Source: NDTMS.*

## PRISON TO COMMUNITY TRANSFERS

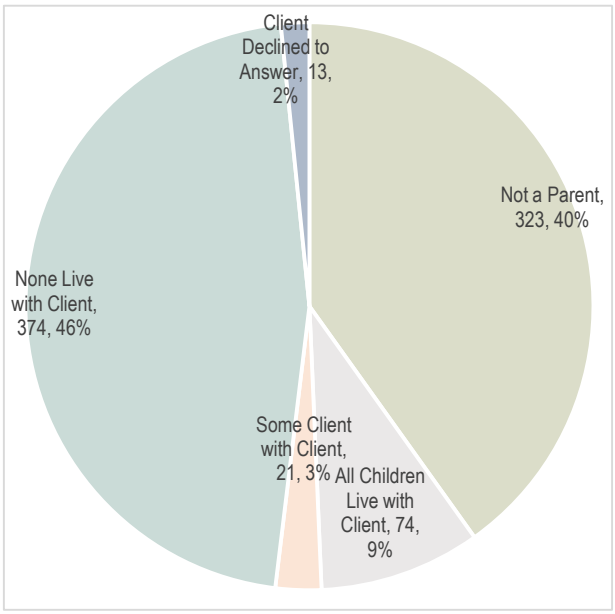
| Partnership Referred To | Referred | Picked Up | % Picked Up |
|---|---|---|---|
| Bath and NE Somerset | 13 | 4 | 31% |
| Bristol | 97 | 28 | 29% |
| Gloucestershire | 10 | 3 | 30% |
| North Somerset | 15 | 4 | 27% |
| South Gloucestershire | 10 | 3 | 30% |
| Other | 38 | 11 | 29% |
| HMP Bristol | 183 | 53 | 29% |
| Comparator | 339 | 53 | 29% |
| Role | 11737 | 2859 | 24% |
| Region | 2496 | 609 | 24% |
| National | 14971 | 3605 | 24% |

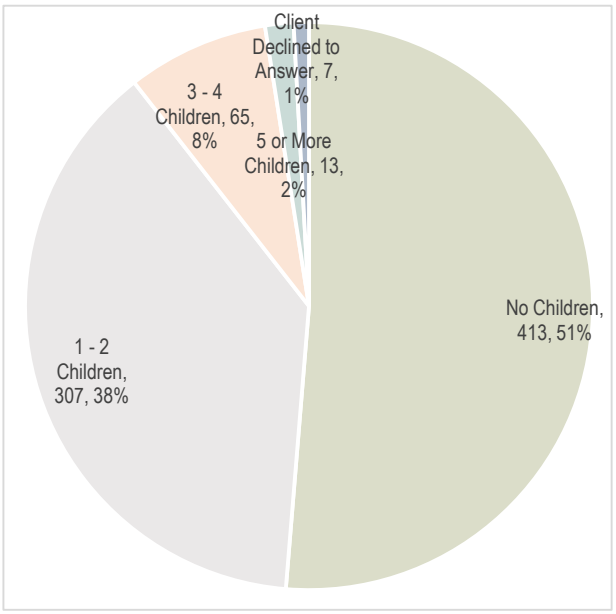
*Above: Figure 3.4.21 - Prison to community transfers.*

*Source: NDTMS.*

## PARENTAL STATUS

12% of prisoners known to Substance Misuse Services lived with some or all of their children.




*Above: Figure 3.4.22 - Parental status of those in treatment.*

*Source - NDTMS*

## SUBSTANCE MISUSE CHECKPOINT AND RECOMMENDATIONS

| ID / Pg | Consideration / Key Finding | Relevance to HMP Bristol | Recommendation |
|---|---|---|---|
| SM1 55 | Staff said that C wing should hold substance misuse patients only, however due to lack of space in the prison, non-substance misusing prisoners get housed there. | This can mean that prisoners that are in the recovery phase of their treatment are not in the ideal environment to recover. | There are occasions when it may be beneficial for a prisoner to remain on C wing if they have detoxed from opiate substitute medication. However, if a prisoner wants to move off C wing following detoxification this should be accommodated. |
| SM2 55 | The top landing of C wing is for prisoners that are being stabilised on opiate substitute medications. In addition to substance misusers, there are also prisoners in the unit that do not have substance misuse problems, but are kept on the unit due to lack of space in the rest of the prison. | The substance misuse clinical staff have to ensure there is enough space in the stabilisation unit for patients that are detoxing from opiates and alcohol. This can be a time consuming task, and divert nurses away from their primary role. | Where possible the stabilisation unit should only be used for prisoners requiring stabilisation. |
| SM3 55 | There are NA and AA services that come into the prison on a weekly basis. | Prisoners have access to 12 step groups. | No recommendations. |
| SM4 55 | Previously, B wing was the drug free wing in the prison, and prisoners were transferred there when they became stable, and ceased being prescribed opiate based medication. | There is no specific drug free wing available for prisoners that are stable following opiate detoxification. This can have an impact on substance misuse rehabilitation. | The re-instating of B wing as a drug free wing should be explored. |
| SM5 55 | Staff were worried that changing HMP Bristol into a resettlement prison would mean that prisoners would have a shorter stay. | The less time that staff have with prisoners means less time to stabilise a prisoner and make arrangements for continuity of care. | Information should be offered to staff on how the upcoming changes to the HMP Bristol population will affect the prison role. |
| SM6 56 | NPS are becoming an issue in HMP Bristol. | This is a need. | Prison staff should be offered training around identifying the signs of NPS use.<br>The viability of setting up a group for NPS should be explored. |
| SM7 56 | There are no specific courses covering NPS in HMP Bristol. | This means that prisoners using NPS are not being given information and advice on their substance misuse issues. | |
| SM8 56 | There is a Relapse Intervention Service in HMP Bristol. The service are planning to run some group work sessions, providing information and support for prisoners around relapse. | This service will provide a service to prisoners who wish to remain drug free in the prison. | It is important that prisoners that would benefit from the Relapse Intervention Service are identified at the earliest possible stage.<br>The group work sessions should begin |

| ID / Pg | Consideration / Key Finding | Relevance to HMP Bristol | Recommendation |
|---|---|---|---|
| SM9<br>56 | There is no specific relapse officer. | Substance Misuse staff found this role useful in dealing with issues of security surrounding illicit substances. | An alternative provision should be made to try and replicate the role of the relapse officer. |
| SM10<br>57 | The Psychosocial Service are exploring starting a one day alcohol course. | This will help meet the needs of those alcohol-only clients that do not want to engage with the general substance misuse courses.<br>29% of referrals to the IDTS were for alcohol-only problems. | The implementation of the alcohol course should be given a clear timeframe.<br>The introduction of a dedicated alcohol worker should be explored. |
| SM11<br>57 | Staff said that there was a need for a dedicated alcohol worker. | | |
| SM12<br>57 | There have been occasions where prisoners have not been identified as being alcohol dependent at the reception screen. | This has led to some prisoners stabilising without any clinical support. | Nurses on reception should be offered refresher training on identifying dependent drinkers. |
| SM13<br>61 | Relatively high numbers of non-opiate using prisoners are picked up after three weeks in prison. | With the high turnover of prisoners, this may leave less time for interventions. | This should be addressed, prisoners should be encouraged to engage in treatment as soon as possible. |

# SOCIAL CARE

SOCIAL CARE PG 73

# SOCIAL CARE

## INTRODUCTION

The Care Act sets out new responsibilities for local authorities for arranging and funding services to meet the care and support needs of adults who are detained in prison, or who are resident in approved premises.

The Act addresses the existing social care provision in prisons, which has been described as "variable, sparse, and non-existent."[1]

The Department of Health describe the importance of social care services for people in the criminal justice system:

"Social care services are important for people in the criminal justice system who have care and support needs. It supports their rehabilitation and may positively impact on the likelihood of reoffending, and the person's ability to rebuild their lives on release."[2]

### CARE ACT

The Act[3] states that it will be the local authority where the prison or approved premises is located, that is responsible for assessing the care and support needs of prisoners. The local authority will be responsible for providing care and support where those needs meet eligibility criteria.

### ELIGIBILITY CRITERIA

Prisoners will be assessed using the same eligibility framework used for people living in the community. As in the community, prisoners and people in approved premises will have to pay part of, or the full cost of their care, if they can afford to do so.

### CONTINUITY OF CARE

The local authority will also have responsibilities around the continuity of care for prisoners that are receiving care and support. The Care Act ensures that there should be continuity of care for prisoners that are receiving care and that are being transferred or released.

The local authority where the prisoner is located may carry out an assessment of the care and support they will need to support their release into the community. The Care Act will ensure that there will be continuity of care on release.

### DIFFERENCES FOR PRISONERS

There are a number of aspects of the Care Act that do not apply to prisoners:

- Prisoners will not be entitled to direct payments for their care and support.
- Prisoners will not be able to express a preference for particular accommodation, except when this is being arranged for after their release from prison.
- The Care Act clarifies that people will not be regarded as carers if they provide care as part of voluntary or paid work, and almost all care provided by prisoners is expected to fall within these exclusions.
- Prisons and approved premises will still be responsible for the safety of their detainees. This means that Safeguarding Adults Boards do not have a duty to carry out enquiries or reviews where a prisoner with care and support needs may be, or have been, at risk of abuse and neglect. However, the Boards can provide advice to prison governors and staff.

## BRISTOL CITY COUNCIL

HMP Bristol is located within the boundaries of Bristol City Council.

At the time of this H&SCNA, representatives from Bristol City Council and HMP Bristol were working together to prepare for the new arrangements for meeting the social care needs of prisoners in England from April 2015, as a result of the Care Act.

Partners shared a common view of the key characteristics of social care delivery within the prison:

- Integrated health and social care delivery.
- Equivalence with the community.
- Facilitating independent living, by seeking to create an enabling culture and physical environment.
- A prison regime which is informed by an understanding of prisoners' social care needs.
- Aids and equipment available to meet "prescribed" social care needs.

Partners agreed to bring together the various tasks identified into a joint action plan to formalise preparation for the Care Act from April 2015. The document reflects the involvement of the National Probation Service and bail accommodation in Bristol.

## HMP BRISTOL

There are two beds that are used for prisoners with social care needs in the Brunel Unit (a prison unit with enhanced MH support), but there is no commissioned social care service at HMP Bristol. There is one other cell in the prison that has been adapted for use by disabled prisoners.

Care for the prisoners with care needs that are held in the Brunel Unit falls to the mental health nurses.

As of November 2014, there were two prisoners with social care needs being kept in the Brunel Unit. Staff assisted the prisoners with moving from the cell to the shower, and with drying feet and some dressing tasks.

In the past, there had been a need for a full time healthcare assistant to be based at the Brunel Unit to support prisoners with care needs.

Staff at the Brunel Unit make referrals for occupational therapist (OT) assessments. It was highlighted that prisoners are generally in the prison for such a short period of time that the OT rarely assesses them.

When a prisoner with care needs first comes into the prison, a meeting is held where it is decided who is responsible for different aspects of the prisoner's care. It was highlighted that prison officers regularly refuse to carry out care tasks that have been allocated to them.

The use of prisoner carers to provide some care needs to prisoners is being looked into as part of the wider planning with the LA, for the implementation of the Care Act from April 2015.

## ACTION PLAN AND PROGRESS

An action plan for developing a social care pathway for South Gloucestershire prisons was drafted and implemented by representatives from:

- HMP Bristol
- Bristol City Council
- NOMS
- NHS England
- Public Health England
- Bail Accommodation Support Services

The table overleaf shows the status of progress against the action plan as at December 2014.

| Workstream | Planned outcome | Actions | Progress |
|---|---|---|---|
| Understanding Need. | Needs assessment is available to inform commissioning. | Share most up to date HNA (Health Needs Assessment) with LA and consider key social care questions within current HNA. | Most recent HNA shared with Bristol City Council. |
| | | Pilot reception screening via SystmOne health screen and share data. | Bristol City Council to view SystmOne and discuss. |
| | | Healthcare to identify with prison "test" cases that can be jointly worked prior to April 2015 with the LA. | This will occur when Bristol City Council visit the prison. |
| Developing Pathways and Service Provision. | Seamless social care pathway from reception to discharge/transfer, integrated with health & regime. | Work with BCH to develop screening checklist for nursing staff to indicate when to complete a referral form to the LA *(over 50s and older prisoners' assessments already undertaken by healthcare).* | A draft checklist has been developed by the LA. Health and custody screening templates have been shared. A basic custody screening tool is to be introduced in January 2015. |
| | | Document proposed referral and care pathway, including response times. | LA/prison/healthcare attended reception/ discharge process mapping meeting in August. so work now underway. |
| | | Develop a referral form and information sharing protocol. | Referrals: aim to avoid duplication of info and build upon screening undertaken in custody. |
| | | Pilot screening, referral, and financial assessment arrangements, and monitor arrangements via heads of department (HoD). | LA to consider financial assessment, liaising with Jo Hadden re: prisoners access to funds. |
| | | Hold multi-agency case conferences to establish integrated care & through the gate care planning: establish a dialogue with other establishments, DDC office and health/social care providers in respect of prisoners appropriate for transfer. | Bristol City Council (BCC) attending Head of Department meetings; social care is standing agenda item. Number of positive transfers made. Proposed that HoD consider allocations to Brunel. |
| | | Commissioning arrangements are confirmed for April 2015 delivery, informed by Care Act/national guidance. | Assessments are expected to be delivered in-house by BCC; care & support delivery arrangements are tbc. |
| Access to Equipment. | Timely access to appropriate equipment. | BCC to develop equipment access pathway/flowchart and to agree payment/charging arrangements with NRS and NHS England. | BCC confirms that the prison is included in the service specification for its equipment contract (with Medequip for Bristol and S Glos from April 15). Equipment can currently be accessed via BCH. |
| | | Respective responsibilities of HMPS, LA, and NHSE are clarified. | Joint presentation to SMT proposed. |
| Workforce development. | Appropriate training/induction informs delivery. | LA to make further visits to prison to understand reception and subsequent processes; consider arrangements for social workers to shadow prison staff. | Further visits made in July and August by social workers; the need to avoid duplication of resettlement team work noted. |
| | | Training/briefing of HMPS/healthcare/ Approved Premises (APs) and BCC/ social care provider staff are identified and addressed. | Training on thresholds, maximising independence, managing expectations, and social care pathway to be provided by LA to prison/ healthcare/APs. Prison to provide training on how prisons work (security & healthcare currently working on); BCH provides custodial awareness training & break away training for its staff). Opportunity to use whole establishment staff briefing noted. NPS to arrange training regarding AP environment/public protection. |
| | | Review options for the development of peer support/mentoring for low to moderate social care needs, informed by LA advice. | Prison supervisor of health champions may offer management capacity for peer carers. Prison has confirmed support in principle. |
| Physical Environment. | Independence is maximised. | Review environmental issues with partners and explore potential to address priority areas. | Earlier visit made by LA identified issues (e.g. taps); further visit to be arranged by LA. |

| Workstream | Planned outcome | Actions | Progress |
|---|---|---|---|
| Prison Regime. | Social care perspective informs delivery of the regime. | Review of key elements of prison regime in conjunction with LA. | No progress. |
| Service User Voice. | Ensure service users inform provision. | Provide LA with access to prisoners/ AP residents in order to inform understanding of need, current provision, and to facilitate on-going consultation. | Some opportunities to speak to prisoners during LA visits. |
| | | Establish arrangements for prisoners and AP residents to access independent advocacy services. | |
| Other in scope premises. | Incorporate Approved Premises and bail accommodation into LA planning. | Share information on provision within BCC. | Currently 6 BASS properties (2 female); approx. 21 beds; 3 x APs (Bridge House – 14 beds; Brigstocke Rd – 28 beds; Ashley House - 22 beds). |
| | | Arrange orientation visits to APs and clear pathways for APs and BASS residents into services. | Ongoing. |
| | | Invite AP representative(s) to attend social care meeting. | NPS attending meetings from August. |
| | | Arrange physical environment visit to APs. | |
| | | Inform regime at APs. | |
| Safeguarding. | Review arrangements in light of Care Act. | Continue prison engagement with Safeguarding Adults Board. | Safeguarding Policy for Bristol is due for review and needs updating in light of the Care Act. A PSI is being developed re: Safeguarding in light of the Care Act. Liaison work is going on with HMP Winchester. |
| | | Review policy in place | |

## INTRODUCTION

The data in this chapter was taken from SystmOne as at the end of October 2014. The information relates mainly to physical conditions that may require social care interventions. Other areas that may require social care interventions are covered in specific chapters.

Data from SystmOne uses the information gathered at the reception screen and the older person screen. A search of READ codes was also undertaken for the current prison population.

The accompanying data pack gives a comparison across the five prisons.

## RECEPTION SCREEN

Table 4.1.1 shows the information and rates at the reception screen and transfer screen. Table 4.1.2 shows the information recorded at the older persons screen.

The information relevant to social care is limited at the reception screen. There is a question that addresses disabilities. There are also questions relating to mental health and learning disabilities, which can be found in the relevant chapters.

The older persons screen provides a more detailed assessment relating to the needs of the older population, including reduced mobility and the ability to perform bathing activity.

| RECEPTION AND TRANSFER SCREEN | Oct-11 to Sep-12 | Oct-12 to Sep-13 | Oct-13 to Sep-14 | Oct-11 to Sep-12 | Oct-12 to Sep-13 | Oct-13 to Sep-14 |
|---|---|---|---|---|---|---|
| Number of Screens | 3444 | 3500 | 3640 | 3444 | 3500 | 3640 |
| Disabled | 142 | 185 | 174 | 4.1% | 5.3% | 4.8% |

*Above: Figure 4.1.1 - Disabled prisoners identified in the reception and transfer screen.*

*Source - SystmOne*

| OLDER PERSONS SCREEN | Oct-11 to Sep-12 | Oct-12 to Sep-13 | Oct-13 to Sep-14 | Oct-11 to Sep-12 | Oct-12 to Sep-13 | Oct-13 to Sep-14 |
|---|---|---|---|---|---|---|
| Number of Screens | 102 | 205 | 294 | 102 | 205 | 294 |
| (Ua1nH) Reduced mobility | 17 | 57 | 80 | 16.7% | 27.8% | 27.2% |
| (1C12.) Hearing difficulty | 14 | 30 | 50 | 13.7% | 14.6% | 17.0% |
| (Y2774) Impaired eyesight | 31 | 89 | 157 | 30.4% | 43.4% | 53.4% |
| (Xa0tn) Communication disorder | 0 | 5 | 3 | 0.0% | 2.4% | 1.0% |
| (Xa2uT) Ability to perform bathing activity | 4 | 9 | 7 | 3.9% | 4.4% | 2.4% |
| (Xa2n5) Dietary requirement observations | 8 | 12 | 16 | 7.8% | 5.9% | 5.4% |
| (14...) Past medical history | 15 | 52 | 42 | 14.7% | 25.4% | 14.3% |
| (YA741) H/O: mental health problem | 12 | 44 | 41 | 11.8% | 21.5% | 13.9% |
| (13Z81) Poor social circumstances | 3 | 25 | 15 | 2.9% | 12.2% | 5.1% |
| (Ua1QW) Care provision regimes | 1 | 1 | 2 | 1.0% | 0.5% | 0.7% |

*Above: Figure 4.1.2 - READ codes from the older persons screen.*

*Source - SystmOne*

## CURRENT PRISONERS - READ CODES

Figure 4.1.3 shows the result of a search of READ codes which may be related to or be an indicator of social care needs.

The range of READ codes used and the number of prisoners with the codes are limited.

| READ CODE - CURRENT POPULATION | # | % |
|---|---|---|
| Prison Population | 589 | |
| | | |
| (Y3415) Disabled | 37 | 6.3% |
| | | |
| (Y2776) Limited walking ability outdoors with or without aid | 1 | 0.2% |
| (N097.) Difficulty in walking | 1 | 0.2% |
| (Ua1nH) Reduced mobility | 25 | 4.2% |
| (YA420) Wheelchair ancillary equipment | 1 | 0.2% |

*Above: Figure 4.1.3 - READ codes identified in the current population.*

*Source - SystmOne*

## SURVEYS

For this H&SCNA, surveys were distributed to both the prison population and the staff population. The surveys includes a section on social care, and can be found on page 18.

## CURRENT PRISONERS - REDUCED MOBILITY

A search of current prisoners with reduced mobility returned a total of 25 prisoners. Looked at by age group, 14 are over the age of 60. The table shows that the rate of reduced mobility increases with age group.

67% of prisoners with reduced mobility were identified at the reception screen.

The information relating to the LA of the prisoner is limited, with over 50% not recorded. Where the LA is recorded, the twelve prisoners cover seven areas.

As part of the analysis, the researchers explored the overlap of those with reduced mobility and health needs. For the purpose of health needs, the QOF register is used. Figure 4.1.4 shows that a high percentage of those with reduced mobility appear on the QOF register. For example, 48% also appear on the hypertension register. This is expected due to the age profile of the prisoners, however, there are conditions such as asthma which show a higher than expected rate for the age group.

| QOF Register | Reduced Mobility | No Reduced Mobility |
|---|---|---|
| Atrial | 8% | 0% |
| Asthma | 16% | 7% |
| Cancer | 8% | 0% |
| CHD | 8% | 2% |
| Kidney | 8% | 0% |
| COPD | 16% | 0% |
| CVD | 16% | 4% |
| Dementia | 0% | 0% |
| Depression | 16% | 10% |
| Diabetes | 16% | 1% |
| Epilepsy | 4% | 4% |
| Heart Failure | 8% | 0% |
| Hypertension | 48% | 7% |
| LD | 4% | 7% |
| MH | 8% | 10% |
| Obesity | 32% | 10% |
| Arterial | 4% | 0% |
| Palliative | 0% | 0% |
| Arthritis | 0% | 0% |
| Stroke | 4% | 0% |

*Left: Figure 4.1.4 - Prisoners with reduced mobility on the various QOF registers.*
*Source - SystmOne*

| Age Group | Count | Population | % |
|---|---|---|---|
| Under 21 | 0 | 42 | 0.0% |
| 21 - 29 | 0 | 208 | 0.0% |
| 30 - 39 | 0 | 193 | 0.0% |
| 40 - 49 | 0 | 84 | 0.0% |
| 50 - 59 | 11 | 43 | 25.6% |
| 60+ | 14 | 19 | 73.7% |
| Total | 25 | 589 | 4.2% |

All those with reduced mobility are over the age over 50. Are those under the age of 50 not being identified as this need is only picked up through the older persons screen?

*Above: Figure 4.1.5 - Prisoners with reduced mobility by age.*

*Source - SystmOne*

| Local Authority | Count |
|---|---|
| Bristol, City of | 4 |
| Cheltenham | 1 |
| East Devon | 1 |
| North Somerset | 1 |
| South Gloucestershire | 3 |
| Stroud | 1 |
| Welwyn Hatfield | 1 |
| Not Stated | 13 |

*Above: Figure 4.1.6 - 'Home' local authority of prisoners with reduced mobility.*

*Source: SystmOne.*

## SOCIAL CARE CHECKPOINT AND RECOMMENDATIONS

| ID / Pg | Consideration / Key Finding | Relevance to HMP Bristol | Recommendation |
|---|---|---|---|
| SC1<br>76 | There is ongoing work between the local authority, healthcare service, and the prison around the implantation of a social care service. | HMP Bristol will have a social care pathway in place for appropriate prisoners. | Any new service should comply with the forthcoming PSI around social care. |
| SC2<br>74 | Care for the prisoners with care needs that are held in the Brunel Unit falls to the mental health nurses. | This is not within the remit of the mental health nurses. | Mental health staff should be aware of the social care pathways. |
| SC3<br>74 | When a prisoner with care needs first comes into the prison, a meeting is held where it is decided who is responsible for different aspects of the prisoner's care. It was highlighted that prison officers regularly refuse to carry out care tasks that have been | This affects the well-being of some prisoners. | The roles and responsibilities around social care provision should be clarified. |

# PRIMARY CARE AND LONG-TERM CONDITIONS


PRIMARY CARE PG 83

ASTHMA PG 89

CANCER PG 93

COPD PG 95

DIABETES PG 99

EPILEPSY PG 104

OBESITY PG 108

# PRIMARY CARE OVERVIEW

## CURRENT SERVICE

### STAFF RATIOS

Figure 5.1.1 shows the staffing to prisoner ratios of Band 5 Registered General Nurses (RGNs). HMP Ashfield and HMP Bristol have similar staffing levels at around one nurse for every 50 prisoners. HMP Eastwood Park has a slightly higher rate at one nurse for every 80 prisoners. HMP Erlestoke has one nurse for every 125 prisoners. HMP Leyhill has one nurse for every 167 prisoners.

Figure 5.1.2 shows the number of weekly GP sessions per prisoner. HMP Eastwood Park has the lowest number of prisoners per GP session at one session a week per 23 prisoners. HMP Bristol has one session for every 51 prisoners. HMP Ashfield, HMP Erlestoke and HMP Leyhill have similar ratios, at one GP session per 80-105 prisoners.

Figure 5.1.4 (overleaf) shows the staffing to prisoner ratios.

### STAFFING

Figure 5.1.3 shows the staffing make-up of the Healthcare Team. The Healthcare Team have access to a sexual health consultant. A hepatitis C nurse also visits the prison.

| Number of staff | Role |
|---|---|
| 1 | Prison Healthcare Manager |
| 1.4 | Band 6 RGNs |
| 4.2 | Band 5 RGNs |
| 0.8 | HCA |

*Above: Figure 5.1.3 - PC Team staffing make-up.*

*Source: Interviews.*


*Right/above: Figures 5.1.1 & 5.1.2 - Staffing ratios of Band 5 RGNs to prisoners, and no. of weekly GP sessions per prisoner.*

*Source: Local interviews.*

| | Ashfield | Bristol | Eastwood Park | Erlestoke | Leyhill |
|---|---|---|---|---|---|
| Population Size | 400 | 610 | 318 | 524 | 502 |
| No of HCAs (Ratio to Prisoner) | 3 (1:133) | 8 (1:76) | 1.3 (1:245) | 0.8 (1:655) | 2 (1:251) |
| No. of RGNs (RtP) | 8 (1:50) | 11 (1:55) | 4 (1:80) | 4.2 (1:125) | 3 (1:167) |
| No. of GP sessions per week (RtP) | 5 (1:80) | 12 (1:51) | 14 (1:23) | 5 (1:105) | 6 (1:84) |

*Above: Figure 5.1.4 - Staff to prisoner ratios.*

*Source: Interviews.*

## SPECIFIC CLINICS FOR LONG-TERM CONDITIONS

There is a plan to introduce individual specialist nurse led clinics. The introduction of these clinics is dependent on nursing staff accessing the necessary training and educational support that would allow them to expand their role.

This includes expanding the role of nurses to include dealing with COPD.

## CHRONIC DISEASE MANAGEMENT

At the time of this H&SCNA, there were two nurse led sessions per week and one GP led session per week.

## EXERCISE

All prisoners are able to attend the gym. Getting prisoners to the gym was described as difficult. Prisoners can access a remedial gym if required.

## RECEPTION

Reception staff do not routinely see the Prison Escort Record (PER). Prison officers on reception identify risk from the PER and other sources, this information should be passed to the nurse prior to them completing their screening.

## EXTERNAL HOSPITAL APPOINTMENTS

There is provision for nine external hospital appointments per week.

Prisoners that refuse to attend their hospital appointment see a nurse and the health implications of missing the appointment are explained. Prisoners sometimes have to refuse appointments due to court appearances or planned visits.

There are processes in place for appointments that are booked after a prisoner's release. On release, prisoners are told of any upcoming appointments that have been booked for them. HMP Bristol sometimes get notified of appointments after a prisoner's release. When this occurs, the prison try to notify the prisoner and their GP by letter.

## HEALTH PROMOTION

There is no identified health promotion clinic or session.

## SYSTMONE

Healthcare staff informed the researchers that the reception screens are used to monitor the numbers of prisoners with chronic conditions.

## IN-PATIENTS

There is no in-patients unit in the prison. There are occasions where prisoners require in-patient unit care. An example was given of a prisoner who needed constant social care. There are only two areas where the prisoner can be held: a cell that has been adapted for disabled access on D wing, or the mental health interventions unit.

## PHYSICAL ENVIRONMENT

The outpatient department is based in three rooms, and all services are delivered in these rooms. The outpatient unit is located at the top of a flight of stairs. This means that disabled prisoners cannot access these rooms.

The lack of space in the outpatient unit means a lot of the work needs to be done on the wings.

## PRIMARY CARE CHECKPOINT AND RECOMMENDATIONS

| ID / Pg. | Consideration / Key Finding | Relevance to HMP Bristol | Recommendation |
|---|---|---|---|
| PC1<br>84 | There is a plan to introduce individual specialist nurse led clinics. The introduction of these clinics is dependent on nursing staff accessing the necessary training and educational support that would allow them to expand their role.<br>The system for managing chronic diseases is a new one, and the nurses are in consultation with the GPs around the correct management of prisoners. with chronic diseases. | Currently only new receptions are being seen for review. | Once staff are trained in the management of long-term conditions, all prisoners should be reviewed for them. |
| PC2<br>84 | Reception staff do not routinely see the Prison Escort Record (PER). | Extra information given to nurses on reception can help them to risk assess prisoners and make judgements on their healthcare. | Processes in reception regarding the sharing of information should be formalised. |
| PC3<br>85 | The lack of space in the outpatient unit means a lot of the work needs to be done on the wings. | This can be positive, as carrying out work on the wings can make healthcare services more visible to prisoners that may not normally contact them. | The provision of healthcare on the wings could be extended to include drop-in clinics. |
| PC4<br>89 | Those identified at the reception screen and those on the asthma register is lower than is expected. | This may mean that the reception screen is not picking up asthma patients. | Staff are given advice or training to ensure they are capturing the health needs of all prisoners that are seen at reception. |
| PC5<br>91 | It is expected that younger age groups have higher rates of asthma, however this is not reflected in the data. | A high percentage of younger prisoners that have asthma are not being identified and treated. | There should be specific health promotion work aimed at capturing younger prisoners with health issues, including asthma. |
| PC6<br>91 | The rate of those identified with asthma is higher for the BME group. | This suggests that there is no inequality in identification when analysed by ethnicity group. | No recommendation required. |

| ID / Pg. | Consideration / Key Finding | Relevance to HMP Bristol | Recommendation |
|---|---|---|---|
| PC7<br>92 | Only 33% of the prisoners on the asthma register have an NHS number. | This will impact on the continuity of care for the prisoner. | Ensure that all prisoners have an NHS number. |
| PC8<br>94 | Staff said that there was no provision for bowel cancer screening in HMP Bristol. | There may be prisoners that are eligible for a screen in the prison. | Bowel cancer screening should be made available for those prisoners over 60. |
| PC9<br>97 | COPD usually affects people over the age of 35, although most are not diagnosed until they are over the age of 50. Considering the prison population is expected to have a higher rate than the community, there may be prisoners in the 45-64 age group with COPD that have not been diagnosed. | Prisoners with COPD are not being identified. | There should be the facility for spirometry to be carried out in HMP Bristol. This includes training for staff in the use and interpretation of spirometry tests. |
| PC10<br>95 | It was not possible for a nurse led clinic for COPD to be run at the time of this H&SCNA. There was no nursing resource with the training or experience to carry out spirometry tests. | There are plans for healthcare to purchase a new spirometer. | |
| PC11<br>95 | An award winning programme tackling COPD was launched in HMP Maidstone in 2013. The programme aims to identify more prisoners with the condition, and increase exercise and education. Early indications are that the implementation of the programme has resulted in a number of benefits. | HMP Bristol could benefit from following good practice examples such as the one in HMP Maidstone. | HMP Bristol should explore the implementation of a COPD programme similar to that in HMP Maidstone. |
| PC12<br>97 | No prisoners on the COPD register are from a BME background. | There could be unmet need amongst BME groups. | Identification procedures should be reviewed. |

| ID/ Pg. | Consideration / Key Finding | Relevance to HMP Bristol | Recommendation |
|---|---|---|---|
| PC13<br>106 | Epileptic prisoners aged 25-34 express a higher rate on the QOF register than at the reception screen. | This may indicate that certain age cohorts are not being identified for epilepsy at reception. | No recommendation. |
| PC14<br>105 | A high number of epileptic prisoners are on the QOF register in comparison to the other four prisons in this study. The rate is also higher than the expected rate. | Prisoners with epilepsy are being identified or there is a higher rate of epilepsy amongst the prisoner cohort in HMP Bristol. | No recommendation. |
| PC15<br>107 | Epileptic prisoners are located on the bottom bunk in cells. Healthcare staff inform prison staff if any of the prisoners that they come into contact with have epilepsy. Prison staff had not had any training around dealing with prisoners with epilepsy. | This reduces risk of injury for prisoners with epilepsy. | Patients' consent must be sought before informing prison staff about any of their health conditions.<br>Any prison staff first aid training should cover epilepsy, and how to deal with a fitting prisoner. |

# ASTHMA

## INTRODUCTION

Asthma is one of the most common long-term conditions in Britain, with 5.1 million people thought to suffer from the condition.

Asthma can affect almost anyone, although it tends to be worse in children and young adults.[1] Research has also shown that South Asian and Afro-Caribbean people in the UK are significantly more likely to be admitted to hospital for asthma related problems than those of White ethnicity.[2]

The study by Marshall et al[3] estimated that 13% of the prison population has asthma.

This is higher than the general population due to a number of reasons:

- a higher rate of heavy smokers;
- a younger population;
- lack of exercise;
- stress;
- prolonged periods indoors;
- and socio-economic status.

## PROVISION

Prisoners with asthma are identified at the reception screen. Patients are placed on the chronic disease management waiting list. The admin team will take prisoners off the waiting list and place them in a slot in the chronic disease management clinic the day before.

The system for managing chronic diseases is new, and the nurses are in consultation with the GPs around the correct management of prisoners with chronic diseases. Anyone that has an ongoing problem with asthma is seen by the wing nurse and then given a GP appointment.

Currently only new receptions are being seen for review. There is a plan to carry out training to create more specialist nurses with the skills to lead clinics. Once staff are trained, there is a plan for all prisoners with chronic diseases to be reviewed, not just the new receptions.

Prisoners with existing conditions are seen as and when required by the wing nurse or the chronic disease management nurse.

Prisoners with asthma are allowed to be in possession of inhalers.

A Smoke Stop service has just started in HMP Bristol. Smoking is covered as part of the chronic disease management clinic, and prisoners can be referred to smoking cessation from there.

If a prisoner is suffering with stress or anxiety, they will be referred to the mental health team.

## RECEPTION SCREEN

| SCREEN (12 MONTHS TO SEPTEMBER 2014) | EXPECTED | ACTUAL |
|---|---|---|
| HMP ASHFIELD | 10.4% (20) | 11.7% (23) |
| HMP BRISTOL | 12.6% (460) | 13.7% (499) |
| HMP EASTWOOD PARK | 13.7% (222) | 31.1% (506) |
| HMP ERLESTOKE | 11.4% (60) | 10.2% (54) |
| HMP LEYHILL | 10.3% (95) | 14.8% (95) |

*Above: Figure 5.2.1 - Expected and actual asthma rates at reception screen.*

*Source: SystmOne.*

## DISEASE REGISTER

*Below: Figure 5.2.2 - Expected and actual rates of current population.*

*Source: SystmOne.*

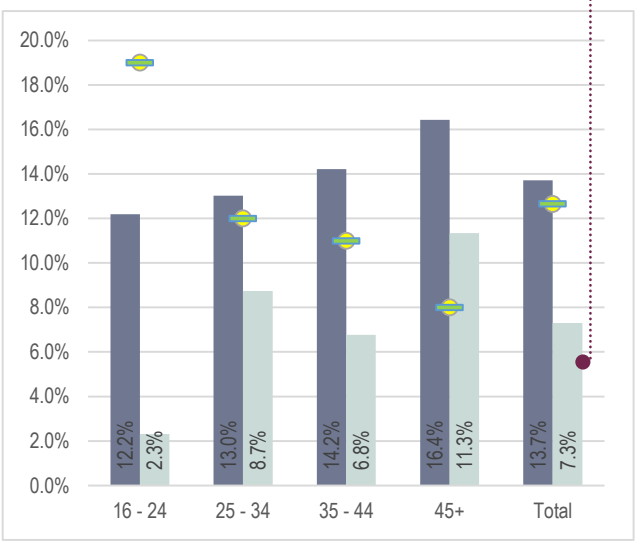
| REGISTER AS AT SEPTEMBER 2014 | EXPECTED | ACTUAL |
|---|---|---|
| HMP ASHFIELD | 10.1% (39) | 13.0% (50) |
| HMP BRISTOL | 12.7% (75) | 7.3% (43) |
| HMP EASTWOOD PARK | 13.8% (46) | 19.0% (63) |
| HMP ERLESTOKE | 10.8% (57) | 15.4% (81) |
| HMP LEYHILL | 9.9% (45) | 12.2% (56) |
| COMMUNITY | | 5.9% |

= 2%

As at the end of September 2014, there were 43 patients on the QOF register, equating to 7.3% of the prison population. This is lower than the expected prevalence of 12.7%.

The HNA toolkit reports a higher prevalence of asthma for the younger age groups, however this is not reflected in those on the asthma register.

Apart from the older age groups, the number of prisoners on the QOF register is lower than expected. Could the older prisoners with asthma have undiagnosed COPD?




| Age Group | 16 - 24 | 25 - 34 | 35 - 44 | 45+ | Total |
|---|---|---|---|---|---|
| 1st & Transfer Screens | 820 | 1374 | 795 | 651 | 3640 |
| Screen Expected # | 156 | 165 | 87 | 52 | 460 |
| Screen Actual # | 100 | 179 | 113 | 107 | 499 |
| Screen Expected % | 19.0% | 12.0% | 11.0% | 8.0% | 12.7% |
| Screen Actual % | 12.2% | 13.0% | 14.2% | 16.4% | 13.7% |
| Prison Population | 130 | 229 | 133 | 97 | 589 |
| QOF Expected # | 25 | 27 | 15 | 8 | 75 |
| QOF Actual # | 3 | 20 | 9 | 11 | 43 |
| QOF Expected % | 19.0% | 12.0% | 11.0% | 8.0% | 12.7% |
| QOF Actual % | 2.3% | 8.7% | 6.8% | 11.3% | 7.3% |

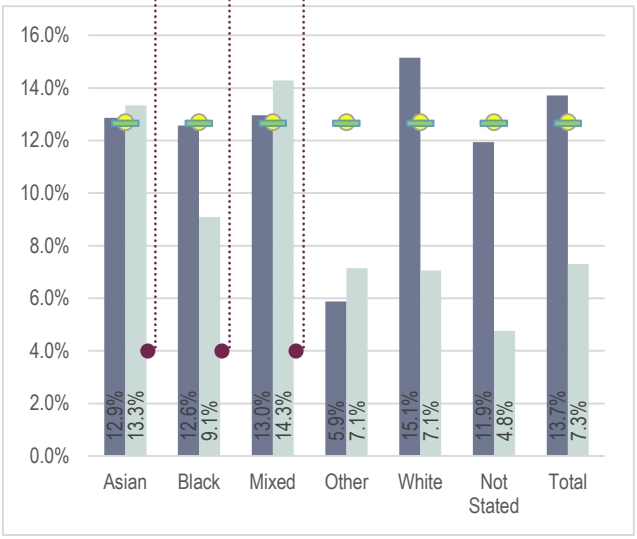
*Above: Figure 5.2.3 - Expected and actual asthma rates by age.*

*Source: SystmOne.*

A breakdown by ethnicity shows that the rates are higher for BME groups.

The number of prisoners identified at the reception screen is higher than the QOF register. The screen asks for a history of asthma, which could be a reason for the higher rates.

The prevalence rate for BME groups are higher than those of White ethnicity. There is research suggesting that BME groups have a higher rate.




| Ethnic Group | Asian | Black | Mixed | Other | White | Not Stated | Total |
|---|---|---|---|---|---|---|---|
| 1st & Transfer Screens | 70 | 191 | 108 | 68 | 2047 | 1156 | 3640 |
| Screen Expected # | 9 | 24 | 14 | 9 | 260 | 147 | 462 |
| Screen Actual # | 9 | 24 | 14 | 4 | 310 | 138 | 499 |
| Screen Expected % | 12.7% | 12.7% | 12.7% | 12.7% | 12.7% | 12.7% | 12.7% |
| Screen Actual % | 12.9% | 12.6% | 13.0% | 5.9% | 15.1% | 11.9% | 13.7% |
| Prison Population | 15 | 44 | 21 | 14 | 411 | 84 | 589 |
| QOF Expected # | 2 | 6 | 3 | 2 | 52 | 11 | 75 |
| QOF Actual # | 2 | 4 | 3 | 1 | 29 | 4 | 43 |
| QOF Expected % | 12.7% | 12.7% | 12.7% | 12.7% | 12.7% | 12.7% | 12.7% |
| QOF Actual % | 13.3% | 9.1% | 14.3% | 7.1% | 7.1% | 4.8% | 7.3% |

*Above: Figure 5.2.4 - Expected and actual asthma rates by ethnicity.*

*Source: SystmOne.*

## QOF PERFORMANCE

QOF performance in HMP Bristol was good.

*Below: Figure 5.2.5 - Asthma QOF scores.*

*Source: SystmOne.*

| Measure | Count | Min % | Target % | Actual % | Points |
|---|---|---|---|---|---|
| AST001 - Register | 56 | - | - | 9.1% | 4 / 4 |
| AST002 - With measures of variability or reversibility | 14 / 47 | 45% | 80% | 77.7% | 0 / 15 |
| AST003 - Review in previous 12 months | 8 / 56 | 45% | 70% | 14.2% | 0 / 20 |
| AST004 - Asthma (14 - 19 yrs) & Smoking status | 1 / 1 | 45% | 80% | 0.0% | 6 / 6 |
| **Asthma Total** | **-** | **-** | - | - | **10 / 45** |

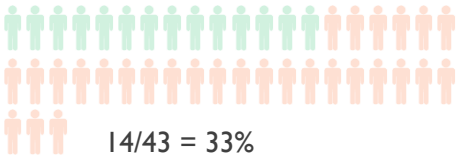
## READ CODES

| Read code | Patient Count | % |
|---|---|---|
| (14B4.) H/O: asthma | 121 | 21% |
| (H33..) Asthma | 60 | 10% |
| (XaINb) Asthma causes daytime symptoms 1 to 2 times per month | 6 | 1% |
| (XaINd) Asthma causes daytime symptoms most days | 5 | 1% |
| (XaIIZ) Asthma daytime symptoms | 4 | 1% |
| (663N.) Asthma disturbing sleep | 3 | 1% |
| (XaXZs) Asthma limits activities 1 to 2 times per month | 2 | 0% |
| (XaXZu) Asthma limits activities 1 to 2 times per week | 2 | 0% |
| (663e.) Asthma restricts exercise | 2 | 0% |
| (XaINc) Asthma causes daytime symptoms 1 to 2 times per week | 2 | 0% |
| (663N0) Asthma causing night waking | 1 | 0% |
| (XaXZx) Asthma limits activities most days | 1 | 0% |

Figure 5.2.6 shows the most common asthma related READ codes for the current prison population. The data would suggest that asthma is having an impact on the prisoner population.

*Left: Figure 5.2.6 - Asthma related READ codes.*
*Source - SystmOne*

## NHS NUMBER



14/43 = 33%

| Asthma | Ashfield | Bristol | Eastwood Park | Erlestoke | Leyhill |
|---|---|---|---|---|---|
| Register | 50 | 43 | 63 | 81 | 56 |
| NHS Number | 42 | 14 | 62 | - | 39 |
| % NHS Number | 84% | 33% | 98% | -% | 70% |

*Above: Figure 5.2.7 - Those with asthma and with an NHS Number.*

*Source—SystmOne*

# CANCER

## INTRODUCTION

In the UK, the most common natural causes of death in prison are heart attack and cancer. The demographics of the prison population make them a high risk group due to a number of factors:

- Tobacco use. It is estimated that 80 to 85% of the prison population smoke. 90% of lung cancer cases in the UK are caused by tobacco smoking.
- Excessive consumption of alcohol. It is estimated that 58% of remand and 63% of sentenced prisoners are drinking at hazardous levels.[4]
- Research shows that the two risk factors of smoking and excess alcohol combined increases the chance of developing mouth cancer by up to 30 times.
- Poor diet and lack of physical activity. Research has shown that poor diet and not being active are two key factors that can increase a person's cancer risk.[5]
- Lack of awareness. Research show that difference in socioeconomic status has a significant impact on the awareness and knowledge of cancer.

## HNA TOOLKIT

As outlined in the PHE toolkit[6], all eligible people in prison should have access to all cancer screening programmes. Male prisoners aged 60 to 69 should have a bowel cancer screening every two years; the programme is being expanded to include people up to the age of 75 years.

## PREVALENCE

The HNA toolkit does not include prevalence statistics for the prison population. In the community, the QOF cancer prevalence rate stood at 2.1%.

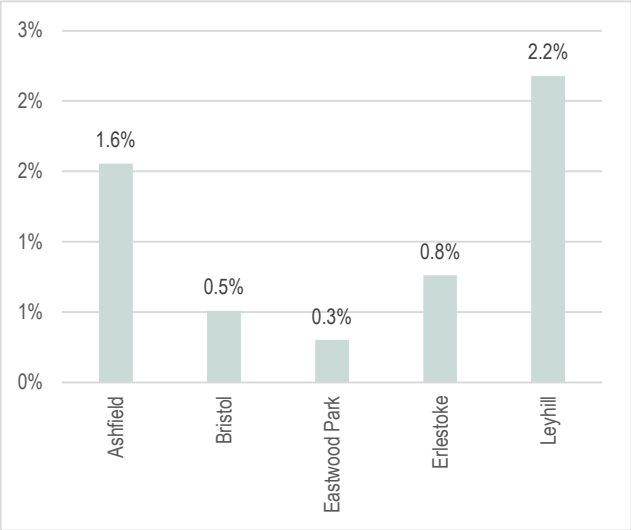
As outlined in the introduction, the prevalence of cancer is expected to be higher in the prison population. However, due to the lower age profile of HMP Bristol, the rates may be lower.

The QOF cancer register shows two prisoners in HMP Bristol, giving a prevalence of 0.5%. In terms of the other prisons in this study, HMP Ashfield and HMP Leyhill express the highest rates of cancer, which is expected given the age demographics of those establishments.

Both prisoners on the register for HMP Bristol are of White ethnicity; they are also all above the age of 40.

## BOWEL CANCER SCREEN

Staff said that there was no provision for bowel cancer screening in HMP Bristol.




*Left: Figure 5.3.1 - Cancer prevalence across the five prisons.*

*Source - SystmOne*

# COPD

## INTRODUCTION

There is currently no research into the prevalence of COPD in secure establishments.

In the UK, COPD is the one of the most common respiratory diseases. COPD usually affects people over the age of 35, although most are not diagnosed until they are in their fifties.

The main cause of COPD is smoking.[7] The rate in prison is expected to be higher due to the high rate of smokers.

It is estimated that 80% of prisoners smoke, with COPD present in 18% of male smokers in the UK. In addition, a survey of the physical health of prisoners in 1994 found that major illnesses in many organ systems such as COPD were much more common in prisoners compared with the general population.

## PREVALENCE

Modelled estimates from the community of the prevalence of COPD is 1.8-1.9% when applied to the age profile of HMP Bristol; however, the prison prevalence is expected to be higher.

## PROVISION

COPD and asthma are covered in the first and second reception screen. Any prisoners that have a history of COPD or asthma are referred to the GP.

It was not possible to run a nurse led clinic for COPD at the time of this H&SCNA. There is no nurse with the training or experience to carry out spirometry tests. There are plans for the Healthcare Team to purchase a new spirometer. It must be ensured that suitable training takes place for staff in the use and interpretation of the spirometer.

## GUIDANCE

The management of COPD is covered by NICE guidelines [CG101]. Clinical best practice for COPD is covered by NICE quality standards [QS10].

There is a quality standard for an annual comprehensive assessment. It states that people with COPD should have a comprehensive clinical and psychological assessment at least once a year, or more frequently if indicated.

## COMPARATIVE

HMP Maidstone introduced an initiative helping prisoners with long-term lung conditions breathe better and feel better.

The initiative involved nursing staff, a physiotherapist, and prison fitness instructors. A group of 40 prisoners with lung conditions were given a two hour session of education and exercise to help manage their conditions while in prison.

## RECEPTION SCREEN

| SCREEN (12 MONTHS TO SEPTEMBER 2014) | EXPECTED | ACTUAL |
|---|---|---|
| HMP ASHFIELD | 3.1% (6) | 3.6% (7) |
| HMP BRISTOL | 1.8% (51) | 0.5% (14) |
| HMP EASTWOOD PARK | 1.7% (27) | NOT ASKED |
| HMP ERLESTOKE | 1.9% (10) | 0.6% (3) |
| HMP LEYHILL | 2.4% (15) | 2.2% (14) |

*Above: Figure 5.4.1 - Expected and actual COPD rates at reception screen.*

*Source: SystmOne.*

## DISEASE REGISTER

*Below: Figure 5.4.2 - Expected and actual rates of COPD of current population.*

*Source: SystmOne.*

| REGISTER AS AT SEPTEMBER 2014 | EXPECTED | ACTUAL |
|---|---|---|
| HMP ASHFIELD | 3.3% (13) | 5.2% (20) |
| HMP BRISTOL | 1.9% (10) | 1.1% (6) |
| HMP EASTWOOD PARK | 1.5% (5) | 1.5% (5) |
| HMP ERLESTOKE | 2.1% (11) | 2.1% (11) |
| HMP LEYHILL | 3.0% (14) | 7.0% (32) |
| COMMUNITY | | 1.8% |

= 0.5%

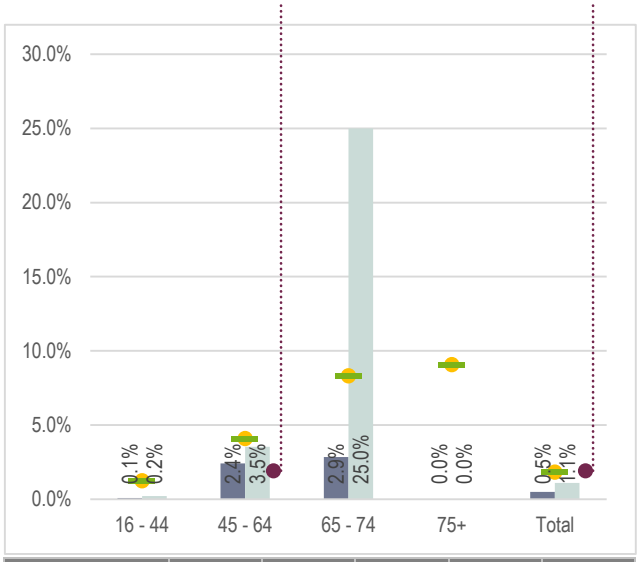
As at the end of September 2014, there were six patients on the QOF register for COPD, equating to 1.1% of the prison population. This rate is slightly lower than the expected rate of 1.9%.

A breakdown by ethnicity shows that the rates are higher for BME groups.

The number of prisoners identified at the reception screen is higher than the QOF register.

COPD usually affects people over the age of 35, although most are not diagnosed until they are over the age of 50. Considering the prison population is expected to have a higher rate than the community, there may be prisoners in this group with COPD that have not been diagnosed.

The prevalence of the QOF register is similar to the expected rate. The rate picked up at screen, however, is lower. COPD is often undiagnosed, which may explain the lower rates at screen.

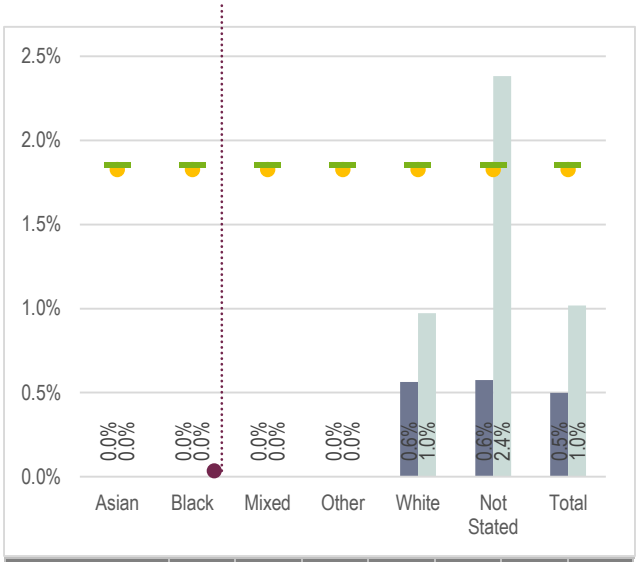



| Age Group | 16 - 44 | 45 - 64 | 65 - 74 | 75+ | Total |
|---|---|---|---|---|---|
| Reception Screens | 2310 | 455 | 35 | 9 | 2809 |
| Screen Expected # | 29 | 19 | 3 | 1 | 51 |
| Screen Actual # | 2 | 11 | 1 | 0 | 14 |
| Screen Expected % | 1.3% | 4.1% | 8.3% | 9.1% | 1.8% |
| Screen Actual % | 0.1% | 2.4% | 2.9% | 0.0% | 0.5% |
| Prison Population | 450 | 85 | 8 | 4 | 547 |
| QOF Expected # | 6 | 3 | 1 | 0 | 10 |
| QOF Actual # | 1 | 3 | 2 | 0 | 6 |
| QOF Expected % | 1.3% | 4.1% | 8.3% | 9.1% | 1.9% |
| QOF Actual % | 0.2% | 3.5% | 25.0% | 0.0% | 1.1% |

*Above: Figure 5.4.3 - Expected and actual COPD rates by age.*

*Source: SystmOne.*

No prisoners from a BME background were identified at screen.




| Ethnic Group | Asian | Black | Mixed | Other | White | Not Stated | Total |
|---|---|---|---|---|---|---|---|
| Reception Screens | 58 | 140 | 85 | 58 | 1772 | 696 | 2809 |
| Screen Expected # | 1 | 3 | 2 | 1 | 32 | 13 | 51 |
| Screen Actual # | 0 | 0 | 0 | 0 | 10 | 4 | 14 |
| Screen Expected % | 1.8% | 1.8% | 1.8% | 1.8% | 1.8% | 1.8% | 1.8% |
| Screen Actual % | 0.0% | 0.0% | 0.0% | 0.0% | 0.6% | 0.6% | 0.5% |
| Prison Population | 15 | 44 | 21 | 14 | 411 | 84 | 589 |
| QOF Expected # | 0 | 1 | 0 | 0 | 8 | 2 | 11 |
| QOF Actual # | 0 | 0 | 0 | 0 | 4 | 2 | 6 |
| QOF Expected % | 1.9% | 1.9% | 1.9% | 1.9% | 1.9% | 1.9% | 1.9% |
| QOF Actual % | 0.0% | 0.0% | 0.0% | 0.0% | 1.0% | 2.4% | 1.0% |

*Above: Figure 5.4.4 - Expected and actual COPD rates by ethnicity.*

*Source: SystmOne.*

## QOF PERFORMANCE

HMP Bristol shows poor performance across the QOF indicators.

*Below: Figure 5.4.5 - COPD QOF register.*
*Source - SystmOne*

| Measure | Count | Min % | Target % | Actual % | Points |
|---|---|---|---|---|---|
| COPD001 - Register | 6 | - | - | 1.1% | 3 / 3 |
| COPD002 - COPD confirmed by spirometry | 1 / 6 | 45 % | 80 % | 16.6% | 0 / 5 |
| COPD003 - Review + MRC | 0 / 6 | 50 % | 90 % | 0.0 % | 0 / 9 |
| COPD004 - FeV1 in the previous 12 months | 0 / 6 | 40 % | 75 % | 14.2 % | 0 / 7 |
| COPD005 - Oxygen saturation in last 12 months | 0 / 0 | 40 % | 90 % | 0.0 % | 0 / 5 |
| COPD007 - Influenza immunisation | 0 / 6 | 57 % | 97 % | 66.6 % | 1.5 / 6 |
| **COPD Total** | **-** | **-** | - | - | **3 / 35** |

## NHS NUMBER



2/6 = 33%

| COPD | Ashfield | Bristol | Eastwood Park | Erlestoke | Leyhill |
|---|---|---|---|---|---|
| Register | 20 | 6 | 5 | 11 | 32 |
| NHS Number | 17 | 2 | 5 | 0 | 23 |
| % NHS Number | 85% | 33% | 100% | 0% | 72% |

*Above: Figure 5.4.6 - Prisoners with COPD and an NHS Number.*

*Source - SystmOne*

# DIABETES

## INTRODUCTION

It is estimated that in the UK, there are 2.9 million people affected by diabetes, with a further 850,000 undiagnosed. Type 2 diabetes accounts for around 90% of all adults with diabetes, with the remaining 10% affected by type 1 diabetes.[8]

Although diabetes cannot be cured, the condition can be successfully managed, and the risk of developing further complications such as stroke, blindness, nerve damage, and kidney failure can be reduced.

Despite diabetes being recognised as one of the main challenges to the healthcare system, it is often overlooked within the prison environment, with limited research and literature available. The journal of diabetes states that "There is very little available literature about providing health care in prisons to inform the setting up of new diabetes services and providing good models."

It is argued that the prison environment can provide the opportunity to address the health needs of a "hard to reach" sector of society with diabetes.

## PROVISION

Prisoners with diabetes would be identified at the reception screen. Prisoners are identified as having either type 1 or type 2 diabetes. They are then placed on the chronic disease management waiting list. Nurses ensure that prisoners have their medication, as they often arrive without it.

The admin team will take prisoners off the waiting list and place them in a slot in the chronic disease management clinic.

Currently only new receptions are being seen for review. There is a plan to carry out training to create more specialist nurses with the skills to lead clinics. Once staff are trained, there is a plan for all prisoners with chronic diseases to be reviewed, not just the new receptions.

There is no targeting of certain groups that would be expected to have a higher prevalence of diabetes. Staff said that they are reliant on their patients telling them that they are sufferers of diabetes.

A retinopathy screening team come into the prison twice a year. Anyone that is diagnosed as being diabetic is seen when the screening team visit the prison.

## GUIDELINES

The management of type 1 diabetes is covered by NICE clinical guideline 15. Type 2 diabetes is covered by NICE clinical guideline 87. Clinical best practice is covered by NICE quality standard [QS6].

Quality standards include:

- People with diabetes and/or their carers receive a structured educational programme that fulfils the nationally agreed criteria from the time of diagnosis, with annual review and access to ongoing education.
- People with diabetes receive personalised advice on nutrition and physical activity from an appropriately trained healthcare professional or as part of a structured educational programme.
- People with diabetes are assessed for psychological problems, which are then managed appropriately.

Healthcare staff follow the NICE guidelines for the provision of diabetes care.

## PREVALENCE

Applying the prevalence rates from the PHE template gives a 1.0% rate for HMP Bristol for both those going through the reception screen, and as a snapshot as at the end of September 2014. This rate is split evenly between type 1 and type 2 diabetes, at around 0.5% each. This estimate is understood to be too low as it was based on community data for 1996, with the UK experiencing an increase since then.

More recently, the paper "Health Care in Prisons" states that "there are few direct estimates of the prevalence of diabetes in prison. In one male prison, 35% of an eligible population of inmates attended a Wellman Clinic. Attendees ranged in age from 21 to 62 (mean 32 years). 8% were found to be diabetic, well above the expected prevalence in this age group. Even if it is assumed that all diabetic inmates in the eligible population selectively attended this clinic, this implies a prevalence of 2.7%. If this figure is representative of the whole prison population, it implies that diagnosed diabetes is two to eight times as common in prison inmates as in the community."

An alternative estimate is provided by the APHO (now part of PHE) Diabetes Prevalence Model Estimates. Using this model gives an estimated prevalence of 5.5% for HMP Bristol.

## RECEPTION SCREEN

| SCREEN (12 MONTHS TO SEPTEMBER 2014) | EXPECTED | ACTUAL |
|---|---|---|
| HMP ASHFIELD | 12.2% (24) | 5.1% (10) |
| HMP BRISTOL | 5.5% (181) | 2.3% (74) |
| HMP EASTWOOD PARK | 3.0% (49) | 3.0% (48) |
| HMP ERLESTOKE | 7.3% (38) | 1.3% (7) |
| HMP LEYHILL | 10.3% (66) | 5.1% (33) |

*Above: Figure - 5.5.1 - Expected and actual diabetes rates at reception screen.*

*Source: SystmOne.*

## DISEASE REGISTER

*Below: Figure 5.5.2 - Expected and actual diabetes rates from the disease register.*

*Source: SystmOne.*

| REGISTER AS AT SEPTEMBER 2014 | EXPECTED | ACTUAL |
|---|---|---|
| HMP ASHFIELD | 12.2% (47) | 7.5% (29) |
| HMP BRISTOL | 5.5% (32) | 2.4% (13) |
| HMP EASTWOOD PARK | 3.0% (10) | 2.7% (9) |
| HMP ERLESTOKE | 7.3% (39) | 3.8% (20) |
| HMP LEYHILL | 10.3% (47) | 7.8% (36) |
| COMMUNITY | | 6.2% |

= 1%

Looking specifically at the screen data, the rate for type 2 diabetes is higher than the rate for type 1 diabetes. This does not follow the PHE toolkit where the rate is expected to be the same.

| HMP BRISTOL | Type 1 | Type 2 | Total |
|---|---|---|---|
| RECEPTION SCREEN # | 19 | 55 | 74 |
| RECEPTION SCREEN % | 0.6% | 1.7% | 2.3% |

*Above: Figure 5.5.3 - Type 1 and Type 2 diabetes identified at the reception screen.*

*Source - SystmOne*

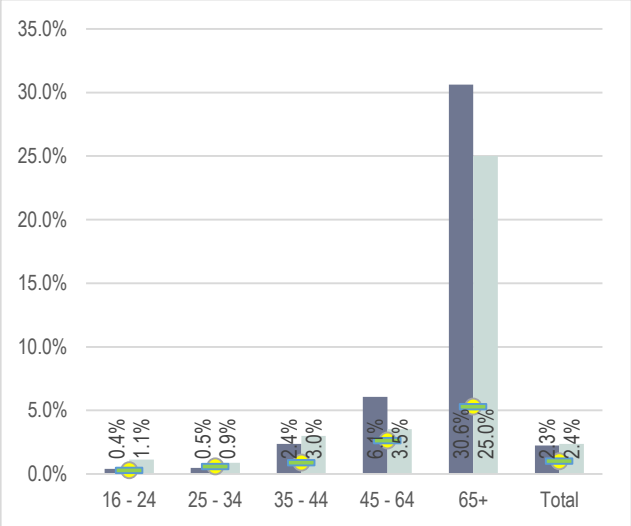
## DEMOGRAPHIC BREAKDOWN

The expected prevalence of diabetes used for this exercise is taken from the PHE toolkit, as it is broken down by age. As highlighted previously, this rate is expected to be too low.

The expected prevalence of diabetes increases with age, with the data in figure 5.5.4 reflecting this trend.

*Below/left: Figures 5.5.4 & 5.5.5 - Expected and actual diabetes rates by age and ethnicity.*

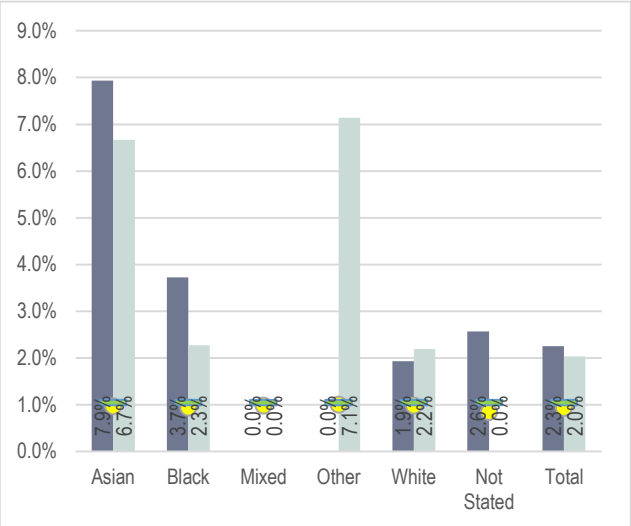
*Source: SystmOne*




| Age Group | 16 - 24 | 25 - 34 | 35 - 44 | 45 - 64 | 65+ | Total |
|---|---|---|---|---|---|---|
| 2nd Screens | 721 | 1250 | 721 | 544 | 49 | 3285 |
| Screen Expected # | 2 | 8 | 6 | 14 | 3 | 33 |
| Screen Actual # | 3 | 6 | 17 | 33 | 15 | 74 |
| Screen Expected % | 0.3% | 0.6% | 0.9% | 2.7% | 5.3% | 1.0% |
| Screen Actual % | 0.4% | 0.5% | 2.4% | 6.1% | 30.6% | 2.3% |
| Prison Population | 88 | 229 | 133 | 85 | 12 | 547 |
| QOF Expected # | 0 | 1 | 1 | 2 | 1 | 6 |
| QOF Actual # | 1 | 2 | 4 | 3 | 3 | 13 |
| QOF Expected % | 0.3% | 0.6% | 0.9% | 2.7% | 5.3% | 1.0% |
| QOF Actual % | 1.1% | 0.9% | 3.0% | 3.5% | 25.0% | 2.4% |

The prevalence of diabetes varies across ethnicity groups. For example, type 2 diabetes is up to six times more common in people of South Asian descent. It is also up to three times more common among people of African and African-Caribbean origin.

Figure 5.5.5 shows that the prevalence is higher in the Asian, Black, and Mixed ethnic groups, which reflects current available research. This indicates that the ethnic groups at higher risk of diabetes are being identified.




| Ethnic Group | Asian | Black | Mixed | Other | White | Not Stated | Total |
|---|---|---|---|---|---|---|---|
| Number of 2nd Screens | 63 | 161 | 89 | 58 | 1864 | 1050 | 3285 |
| Screen Expected # | 1 | 2 | 1 | 1 | 18 | 9 | 31 |
| Screen Actual # | 5 | 6 | 0 | 0 | 36 | 27 | 74 |
| Screen Expected % | 1.0% | 0.9% | 1.0% | 1.0% | 1.0% | 0.8% | 0.9% |
| Screen Actual % | 7.9% | 3.7% | 0.0% | 0.0% | 1.9% | 2.6% | 2.3% |
| Prison Population | 15 | 44 | 21 | 14 | 411 | 84 | 589 |
| QOF Expected # | 0 | 0 | 0 | 0 | 4 | 1 | 6 |
| QOF Actual # | 1 | 1 | 0 | 1 | 9 | 0 | 12 |
| QOF Expected % | 1.0% | 1.0% | 1.0% | 1.0% | 1.0% | 1.0% | 1.0% |
| QOF Actual % | 6.7% | 2.3% | 0.0% | 7.1% | 2.2% | 0.0% | 2.0% |

## NHS NUMBER



2/13 = 15%

| Diabetes | Ashfield | Bristol | Eastwood Park | Erlestoke | Leyhill |
|---|---|---|---|---|---|
| Register | 29 | 13 | 9 | 20 | 36 |
| NHS Number | 26 | 2 | 9 | - | 24 |
| % NHS Number | 90% | 15% | 100% | - | 67% |

*Above: Figure 5.5.6 - Patients with diabetes and an NHS Number.*

*Source - SystmOne*

# EPILEPSY

## INTRODUCTION

Epilepsy is the most common, serious neurological disorder in the world. In the general population, the prevalence of epilepsy is around 0.8% (QOF).

A paper by the Mersey Region Epilepsy Association[9] suggests that epilepsy in the prison population tends to have a higher rate of prevalence. The paper also shows that the factors that could trigger a seizure tend to increase in prison, for a number of reasons:

- Emotional stress: being in prison is stressful in itself, especially for those entering the system for the first time. In addition, breakdown of relationships with those in and out of the prison could add further stress.
- Alcohol: excessive drinking leads to an increase in seizure pattern because the effectiveness of antiepileptic drugs can be impaired.
- Boredom: research suggests that the regularity of seizures increases when the mind is unoccupied.

An audit of healthcare provision for UK prisoners[10] with suspected epilepsy in 2008 found that fewer prisoners than expected achieve seizure control as collaboration with specialist epilepsy services is poor, and significant discrepancies exist between the healthcare provision in prison and the NICE epilepsy guidelines.

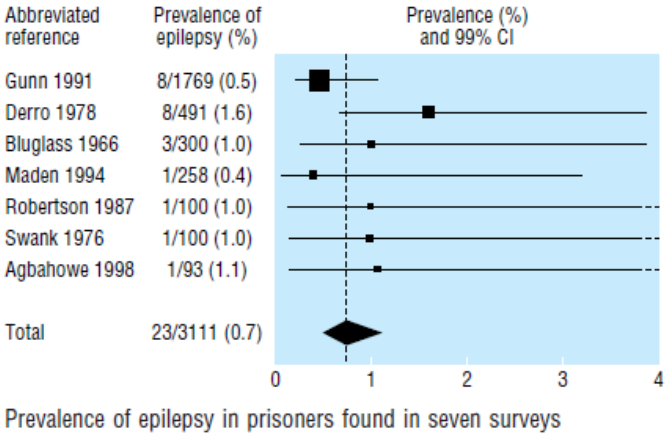
Prison staff are likely to encounter someone having a seizure at some point during the course of their work. It is therefore essential that all prison staff have the right training and knowledge to act appropriately in the given situation.

## PREVALENCE

Research into the prevalence of epilepsy in the prison population is limited.

Appendix A1 of the HNA toolkit does not provide an estimated prevalence of epilepsy for male prisoners. The HNA Toolkit provides an estimate from Stewart (2010), stating that "…of all those who were newly sentenced… he found that between 1-2% had diabetes and 2% of men had epilepsy and 5% of women."

Figure 5.6.1 shows a study by Seena Fazel, Evangelos Vassos and John Danesh in the British Medical Journal (2007). The study comments that "...this synthesis of seven surveys involving more than 3000 participants in general prison populations indicates that only about 1% reported a history of chronic epilepsy."




*Above: Figure 5.6.1 - Epilepsy prevalence.*

*Source - Seena Fazel, Evangelos Vassos, and John Danesh, BMJ*

Figure 5.6.1 has used the higher estimate of 2% as stated in the HNA toolkit. The 2% rate is for those newly sentenced; however, due to the nature of the condition, it was considered valid for this data exercise.

## RECEPTION SCREEN

| SCREEN (12 MONTHS TO SEPTEMBER 2014) | EXPECTED | ACTUAL |
|---|---|---|
| HMP ASHFIELD | 2.0% (4) | 1.5% (3) |
| HMP BRISTOL | 2.0% (73) | 4.0% (144) |
| HMP EASTWOOD PARK | 5.0% (81) | 6.0% (98) |
| HMP ERLESTOKE | 2.0% (11) | 1.9% (10) |
| HMP LEYHILL | 2.0% (13) | 1.7% (11) |

*Above: Figure 5.6.2 - Expected and actual epilepsy rates at reception screen.*

*Source: SystmOne.*

## DISEASE REGISTER

*Below: Figure 5.6.3 - Expected and actual epilepsy rates of current population.*

*Source: SystmOne.*

| REGISTER AS AT SEPTEMBER 2014 | EXPECTED | ACTUAL |
|---|---|---|
| HMP ASHFIELD | 2.0% (8) | 1.3% (5) |
| HMP BRISTOL | 2.0% (11) | 3.6% (22) |
| HMP EASTWOOD PARK | 5.0% (17) | 3.0% (10) |
| HMP ERLESTOKE | 2.0% (11) | 2.9% (15) |
| HMP LEYHILL | 2.0% (9) | 1.3% (6) |
| COMMUNITY | | 0.8% |

= 0.5%

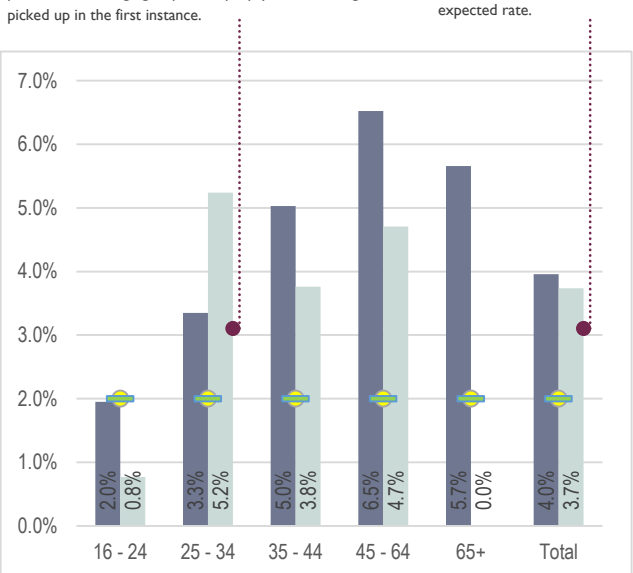
Figure 5.6.2 (on page 105) shows the percentage of HMP Bristol's population identified at the reception screen with epilepsy. Figure 5.6.3 shows the percentage of HMP Bristol's population on the QOF register.

There are no studies that show the expected prevalence of epilepsy on the prison population by age. The chart uses the expected 2% rate across the different age groups. A paper by the Joint Epilepsy Council shows the prevalence in the community increases from the age of 40 to the age of 70.

The rate of prisoners identified with a history of epilepsy at the reception screen increases with age. This pattern is not reflected on the QOF register.

Only this age group express a higher rate on the QOF register than at reception screen. This may indicate that prisoners in this age group with epilepsy are not being picked up in the first instance.

The rate of prisoners with epilepsy is higher than the expected rate.

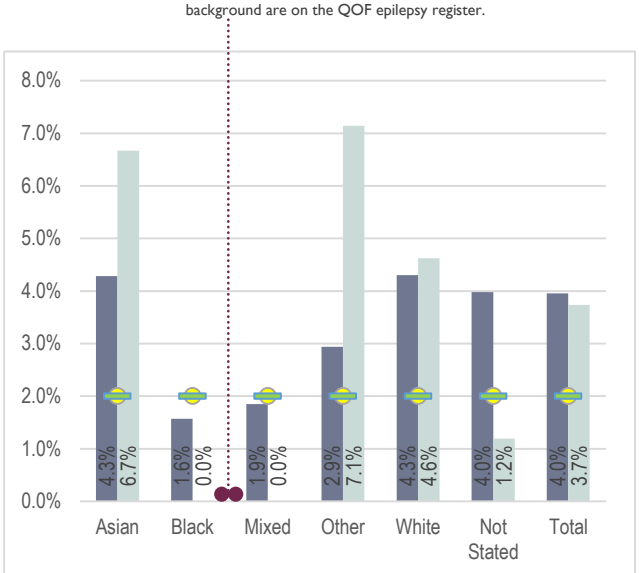



| Age Group | 16 - 24 | 25 - 34 | 35 - 44 | 45 - 64 | 65+ | Total |
|---|---|---|---|---|---|---|
| 1st & Transfer Screens | 820 | 1374 | 795 | 598 | 53 | 3640 |
| Screen Expected # | 16 | 27 | 16 | 12 | 1 | 73 |
| Screen Actual # | 16 | 46 | 40 | 39 | 3 | 144 |
| Screen Expected % | 2.0% | 2.0% | 2.0% | 2.0% | 2.0% | 2.0% |
| Screen Actual % | 2.0% | 3.3% | 5.0% | 6.5% | 5.7% | 4.0% |
| Prison Population | 130 | 229 | 133 | 85 | 12 | 589 |
| QOF Expected # | 3 | 5 | 3 | 2 | 0 | 12 |
| QOF Actual # | 1 | 12 | 5 | 4 | 0 | 22 |
| QOF Expected % | 2.0% | 2.0% | 2.0% | 2.0% | 2.0% | 2.0% |
| QOF Actual % | 0.8% | 5.2% | 3.8% | 4.7% | 0.0% | 3.7% |

*Above: Figure 5.6.4 - Expected and actual epilepsy rates by age.*

*Source: PHE toolkit; SystmOne.*

No prisoners from a Black or Mixed ethnic background are on the QOF epilepsy register.




| Ethnic Group | Asian | Black | Mixed | Other | White | Not Stated | Total |
|---|---|---|---|---|---|---|---|
| 1st & Transfer Screens | 70 | 191 | 108 | 68 | 2047 | 1156 | 3640 |
| Screen Expected # | 1 | 4 | 2 | 1 | 41 | 23 | 73 |
| Screen Actual # | 3 | 3 | 2 | 2 | 88 | 46 | 144 |
| Screen Expected % | 2.0% | 2.0% | 2.0% | 2.0% | 2.0% | 2.0% | 2.0% |
| Screen Actual % | 4.3% | 1.6% | 1.9% | 2.9% | 4.3% | 4.0% | 4.0% |
| Prison Population | 15 | 44 | 21 | 14 | 411 | 84 | 589 |
| QOF Expected # | 0 | 1 | 0 | 0 | 8 | 2 | 12 |
| QOF Actual # | 1 | 0 | 0 | 1 | 19 | 0 | 21 |
| QOF Expected % | 2.0% | 2.0% | 2.0% | 2.0% | 2.0% | 2.0% | 2.0% |
| QOF Actual % | 6.7% | 0.0% | 0.0% | 7.1% | 4.6% | 0.0% | 3.6% |

*Above: Figure 5.6.5 - Expected and actual epilepsy rates by ethnicity.*

*Source: PHE toolkit; SystmOne.*

## PROVISION

Prisoners with epilepsy are identified at the reception screen. The admin team will take prisoners off the waiting list and place them in a slot in the chronic disease management clinic.

Currently, only new receptions are being seen for review. There is a plan to carry out training to create more specialist nurses with the skills to lead clinics. Once staff are trained, there is a plan for all prisoners with chronic diseases to be reviewed, not just the new receptions.

Prisoners with epilepsy are located on the bottom bunk in cells. Healthcare staff inform prison staff if any of the prisoners that they come into contact with have epilepsy. Prison staff had not had any training around dealing with prisoners with epilepsy.

Healthcare staff do not inform prisoners sharing a cell with an epileptic prisoner of his condition. It is down to the prisoner with epilepsy to inform their cell mate of their condition.

Prisoners with epilepsy tend to be medicated as they enter the prison, regardless of whether there has been confirmation of their condition or not.

## COMPARATIVE

In the Prison Needs Assessment for Glasgow and Clyde, a system of "health care medical markers" are used. This is a process where healthcare staff can inform other staff of health conditions, such as epilepsy and provide clear written instructions of actions to be taken in certain circumstances without breaching confidentiality (for example if the prisoner has seizures). Medical markers are logged on the prisoner's record, and officers are informed in writing to ensure that this is communicated well.

## GUIDELINES

The management of epilepsy is covered by NICE clinical guideline 137. Clinical best practice is covered by NICE quality standard [QS26].

Quality standards include:

- Adults with epilepsy are seen by an epilepsy specialist nurse who they can contact between scheduled reviews.

## NHS NUMBER



3/22 = 14%

| Epilepsy | Ashfield | Bristol | Eastwood Park | Erlestoke | Leyhill |
|---|---|---|---|---|---|
| Register | 5 | 22 | 10 | 15 | 6 |
| NHS Number | 4 | 3 | 10 | 0 | 5 |
| % NHS Number | 80% | 14% | 100% | 0% | 83% |

*Above: Figure 5.6.6 - Prisoners with epilepsy and an NHS Number.*

*Source - SystmOne*

# OBESITY

## INTRODUCTION

NHS UK lists people eating more calories than they can burn off as the main cause of obesity. Other causes include the modern lifestyle which involves poor diets, stress, and lack of exercise.

Studies into the prevalence of obesity in the prison population is limited, however, in 2012, a review by the University of Oxford[11] showed that "male prisoners are slimmer than men in the general population."

The study went on to explain that whilst the amount of time spent on physical exercise is lower in the prison setting than in the general population, the diet provided by prisons gives the appropriate amount of calories.

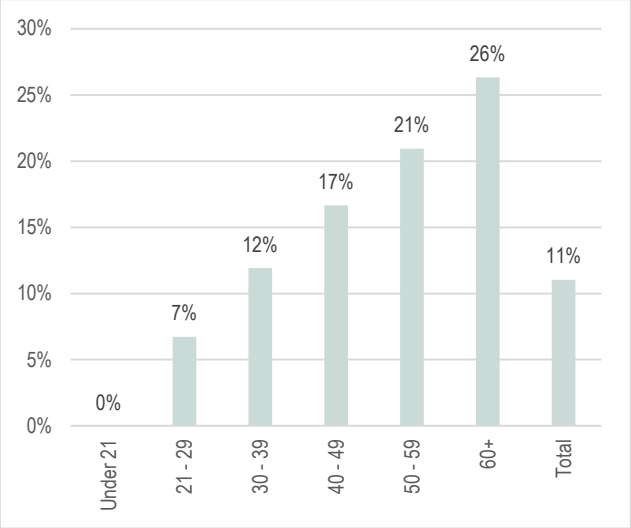
Key points taken from the PHE Toolkit are:

- Around 30% of men and 33% of women with no qualifications are obese compared to 21% of men and 17% of women with a degree or equivalent.
- Obesity is also linked to ethnicity: it is most prevalent among black African women (38%) and least prevalent among Chinese and Bangladeshi men (6%).
- Men who are obese are estimated to be around 5 times more likely to develop type 2 diabetes and 2.5 times more likely to develop hypertension than men who are not obese.

65 (11%) of the prison population are on the QOF obesity register.

Figure 5.7.1 gives the prevalence by age group. It can be observed that the rates increase with age, increasing from 7% for the 21-29 age group, to 26% for the 60+ age group.

Figure 5.7.2 shows the prevalence rates by age across the five prisons.




| Age Group | Under 21 | 21 - 29 | 30 - 39 | 40 - 49 | 50 - 59 | 60+ | Total |
|---|---|---|---|---|---|---|---|
| Prison Population | 42 | 208 | 193 | 84 | 43 | 19 | 589 |
| QOF Actual # | 0 | 14 | 23 | 14 | 9 | 5 | 65 |

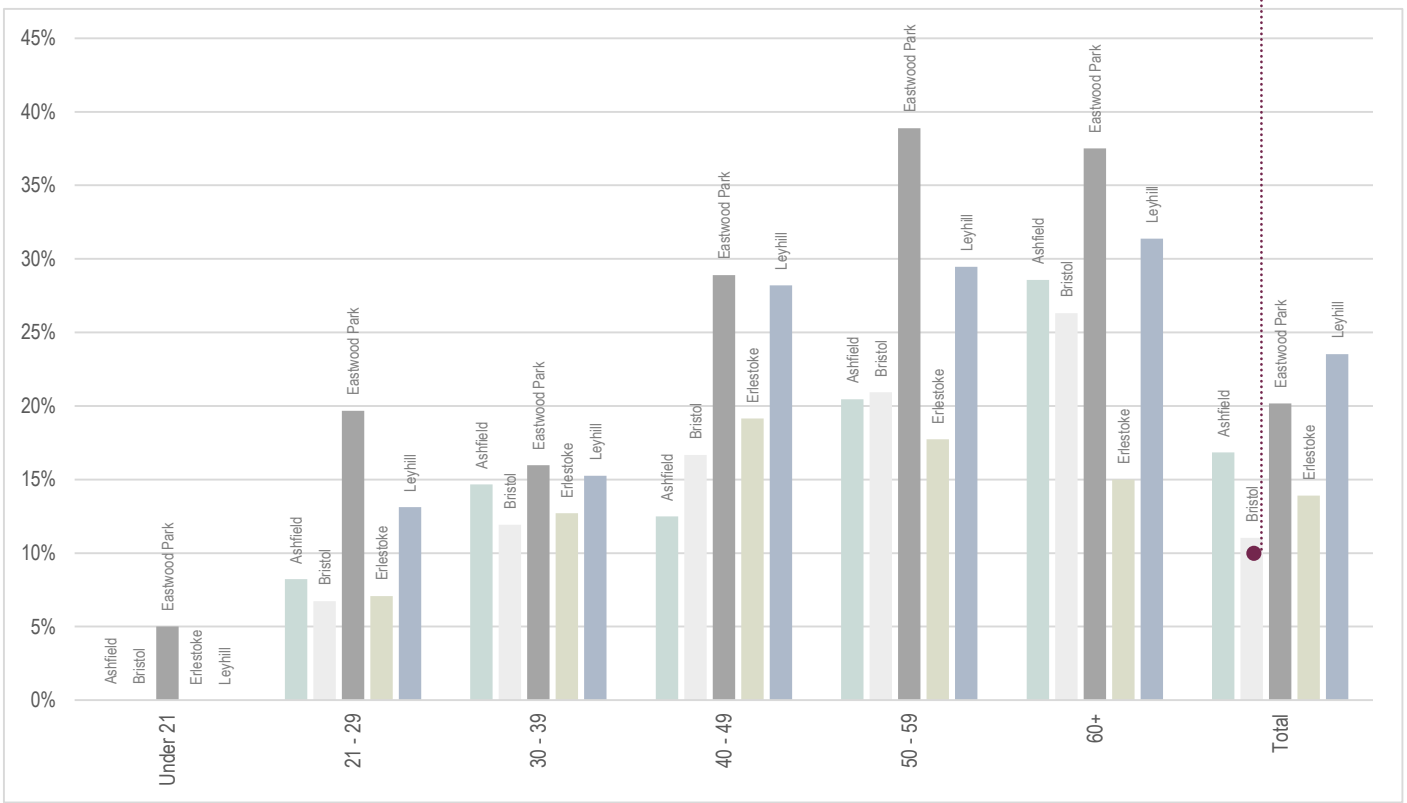
*Above: Figure 5.7.1 - Actual obesity rates by age.*

*Source: SystmOne.*

HMP Bristol has the lowest rates when compared against the four other prisons.

*Below: Figure 5.7.2 - Obesity prevalence rates by age, across the prisons in the cluster.*

*Source - SystmOne*



# COMMUNICABLE DISEASES

HEPATITIS PG 111

SEXUAL HEALTH PG 117

TUBERCULOSIS PG 121

# HEPATITIS

## INTRODUCTION

The prevalence of sexually transmitted diseases and blood borne viruses (BBVs) is higher in the prison population than in the general population, due to high risk behaviour such as unprotected sex, multiple partners, and injecting drugs.[1]

Although BBVs can cause serious illness and death, they are preventable and the prison setting provides an excellent opportunity to screen for and treat them.

A report released by the Health Protection Agency in 2011[2] shows that the increase in prison hepatitis B virus (HBV) vaccinations has significantly reduced the HBV rates for injecting drug users (IDU).

## COMPARATIVE

There are examples in other prisons of all prisoners being offered a hepatitis B vaccination programme.

There was an example of prisons in Scotland funding voluntary sector agencies to deliver hepatitis C prevention initiatives, including group work with prisoners at induction and pre-release groups.

Some prisons offer Dried Blood Spot testing, removing the need for venepuncture in people who may have poor venous access due to previous injecting drug use.

## CLINICAL GUIDELINES

In February 2014, The Hepatitis C Trust[3] convened an expert group of doctors, nurses, consultants, commissioners, and public health specialists to develop recommendations for how hepatitis C healthcare in prisons could be improved through the new commissioning arrangements. One of the recommendations was:

Advise NHSE on providing a nationally commissioned, locally implemented, clinically effective, and high quality hepatitis C healthcare service appropriate for, and adapted to the specific needs of prisons and other places of detention in England.[4]

## IDENTIFICATION

Every prisoner that comes through reception is placed on the hepatitis B waiting list. The prisoners' hepatitis treatment history is checked. Prisoners are seen by the identified hepatitis B nurse, usually the following day.

## TREATMENT

Prisoners are offered a treatment course; if they refuse this treatment they are offered a second course. Prisoners are offered the accelerated vaccination programme, and the yearly and five yearly vaccination as appropriate.

## OPT OUT TREATMENT

The prison are going to implement an opt out hepatitis treatment regime. The Healthcare Team have not been given a start date, but they are prepared for implementation.

## OUTSTANDING TESTS (KPIs)

There is an issue with data recording, particularly when the hepatitis status "unknown" is selected. These prisoners are still placed on the waiting list, but SystmOne does not record this.

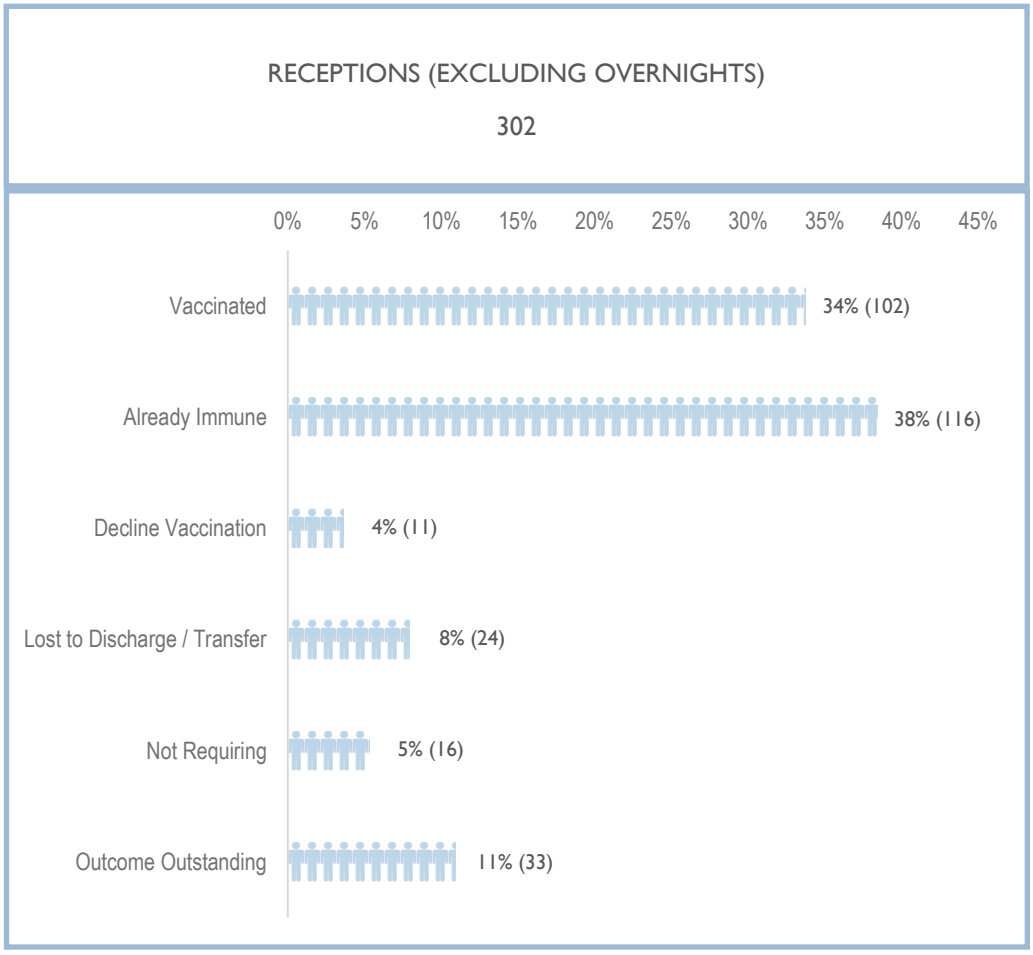



Figure 6.1.1 shows the performance in a typical month for the hepatitis B KPI. The data is based on April to June 2014, due to data gaps in previous months.

**KPI**

THE PRISON ACHIEVES HEPATITIS B VACCINE OF 80% OR MORE FOR ALL NEW RECEPTIONS RECEIVED INTO THE ESTABLISHMENT

TARGET : 80%

2014-15 PERFORMANCE : 72%

*Left/above: Figure 6.1.1 - Hepatitis treatment for new receptions.*
*Source - Local data*

## INTRODUCTION

Currently, hepatitis C treatment services are awaiting NICE guidance on the diagnosis and management of hepatitis C. The announcement on the approval for the NICE guidance has been deferred numerous times; one had been expected in January/ February 2015.

There are a range of new drugs for hepatitis C treatment, and some if approved in the NICE guidance, could reduce treatment time to 12 weeks. This is a reduction on the current treatment lengths of 24-48 weeks of treatment, depending on the strain of hepatitis C, how the patient responds to the drugs, and whether the patient was treatment naïve or a relapsed patient.

The new drug treatment is expected to cost around £36,000, while the current treatment can cost £20-26,000, depending on the treatment length and type of hepatitis C.

The viral hepatitis clinical nurse specialist said that patients who undertake hepatitis C treatment in prison have a lower dropout rate than those in the community.

The specialist also said that he will not start treatment with prisoners unless they will be in prison for the full length of their treatment. Following initial hepatitis C diagnostic work, prisoners would still have to have a minimum of four months left on their sentence before they are accepted for treatment.

Indicative timeline of current hepatitis C treatment (genotype 2 and 3):

| Task | Indicative length |
|---|---|
| Time from blood test to referral. | 1 – 1.5 months |
| Diagnostic stage: genotype identification, blood viral load check, FirbroScan examination, and psychiatric reports. | 1 – 3 months |
| Treatment | 4 months minimum |
| Total | 5 – 8.5 months |

*Above right: Figure 6.1.2 - Indicative time for hepatitis C treatment.*

*Source - Interviews.*

In situations where a prisoner has an active infection of hepatitis C diagnosis, the specialist nurse has asked healthcare staff in prisons not to make a referral to the hepatitis C service, if the prisoner is not going to be in the prison for long enough. In these cases, the liaison nurses will provide some education to prisoners around hepatitis C, including how to get treatment once they are released from prison.

If a prisoner undergoing hepatitis C treatment has depressive or psychiatric symptoms, the specialist nurse will refer them to Liaison Psychiatry in Bristol Royal Infirmary. Liaison Psychiatry will make contact with secondary services in the prison around any additional medication needed for patients undergoing hepatitis C treatment.

The specialist nurse noted that for a prisoner undergoing treatment, it is not always a straightforward process to change their medication following analysis of their blood samples. In prison it is necessary for a GP to rewrite a prescription, and the specialist nurse said that he also has to notify the nurses that may be administering the medication.

The specialist nurse has given training to prison officers around hepatitis C treatment in the past.

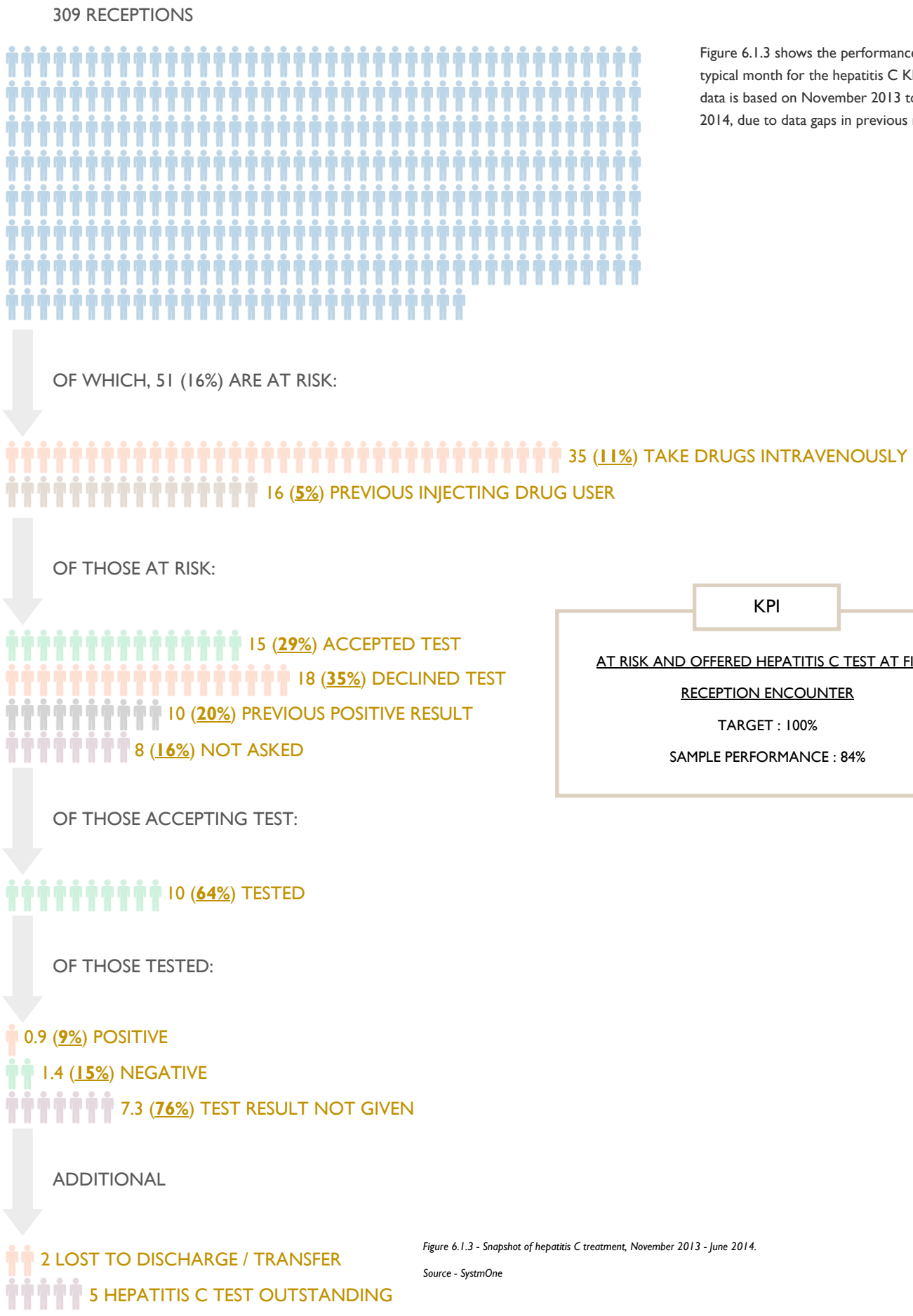



Figure 6.1.3 shows the performance in a typical month for the hepatitis C KPI. The data is based on November 2013 to June 2014, due to data gaps in previous months.

KPI

AT RISK AND OFFERED HEPATITIS C TEST AT FIRST RECEPTION ENCOUNTER

TARGET : 100%

SAMPLE PERFORMANCE : 84%

*Figure 6.1.3 - Snapshot of hepatitis C treatment, November 2013 - June 2014.*

*Source - SystmOne*

HMP BRISTOL

The hepatitis specialist nurse said that HMP Bristol has a slightly higher dropout rate than the other two prisons he provides services in.

He said he audited the referrals that he received and found that 80% of prisoners referred to him had a sentence length of six months or less, which meant they would only spend around three months in the prison.

The hepatitis C liaison nurse in HMP Bristol had spent time shadowing staff at the hepatitis C clinic in the Bristol Royal Infirmary.

There have been occasions when prisoners undergoing hepatitis C treatment in HMP Bristol have been transferred out of the prison. If the specialist nurse has sufficient warning, he is able to arrange for the transfer of the patient to the hepatitis C team local to the receiving prison. Sometimes the specialist nurse has not been notified of a transfer, but this was described as being infrequent.

The specialist nurse said that under the previous consultant, 15 prisoners from the local area had started hepatitis C treatment in HMP Bristol, and appointments were made for them at the Bristol Royal Infirmary on their release. None of the prisoners attended these appointments to complete the treatment.

The specialist nurse said that for prisoners with short-term sentences, it would be more effective for them to be treated when they were released from prison and more stable. In the community, if a patient declines treatment, they are offered a yearly follow up appointment.

## HEPATITIS CHECKPOINT AND RECOMMENDATIONS

| ID / Pg. | Consideration / Key Finding | Relevance to HMP Bristol | Recommendation |
|---|---|---|---|
| HP1<br>112 | The prison are going to implement an opt out hepatitis treatment regime. The Healthcare Team has not been given a start date, but they are prepared for implementation. | This should improve coverage of hepatitis B vaccinations. | No recommendation. |
| HP2<br>112 | There is an issue with data recording, particularly when the hepatitis status "unknown" is selected. These prisoners are still placed on the waiting list, but SystmOne does not record this. | This means that auditing is made more difficult. | Data recording should be clarified and corrected. |
| HP3<br>113 | Currently hepatitis C treatment services are awaiting NICE guidance on the diagnosis and management of hepatitis C. The announcement on the approval for the NICE guidance has been deferred numerous times; an announcement had been expected in January/February 2015. | Treatment times will change when the new hepatitis C treatments come in. | Staff should be made aware of the changes and new pathways when they occur. |

| ID / Pg. | Consideration / Key Finding | Relevance to HMP Bristol | Recommendation |
|---|---|---|---|
| HP4<br>113 | The hepatitis specialist nurse said that HMP Bristol has a slightly higher dropout rate for hepatitis C treatment than the other two prisons he provides services in. | This could mean there are some prisoners starting treatment in HMP Bristol before they are ready. | Prisoners should be given adequate support to minimise drop out rates. |
| HP5<br>113 | The specialist nurse said he audited the referrals that he received and found that 80% of prisoners referred to him had a sentence length of six months or less, which meant they would only spend around three months in the prison. | This means that there are large numbers of prisoners that would not meet the criteria for hepatitis C treatment if they are found to be positive. | Prisoners that do not start hepatitis C treatment in prison should be given information on how to start treatment on release. |
| HP6<br>113 | There have been occasions when prisoners undergoing hepatitis C treatment in HMP Bristol have been transferred out of the prison. | If the specialist nurse has sufficient warning, he is able to arrange for the transfer of the patient to the hepatitis C team local to the receiving prison. Sometimes the specialist nurse has not been notified of a transfer, but was described as being infrequent. | |
| HP7<br>113 | The specialist nurse said that under the previous consultant, 15 prisoners from the local area had started hepatitis C treatment in HMP Bristol and appointments were made for them at the Bristol Royal Infirmary on their release. None of the prisoners attended these appointments to complete the treatment. | On release, prisoners from HMP Bristol are unlikely to continue the hepatitis C treatment that they started in the prison. | |

# SEXUAL HEALTH

## INTRODUCTION

In England, the rate of total new STI diagnoses per 100,000 of the population has increased from 576 in 2002 to 817 in 2011. For chlamydia, the rate has increased from 160 to 357 during the same period, equating to an increase of 123%.[5]

Sexual relationships between prisoners and between staff and prisoners are prohibited, as prisons are classified as public places. However, prisoners should have free access to protection and condoms must be supplied if prisoners are thought to be at risk of contracting HIV or another STI.

Research carried out by the Prison Reform Trust reported that 55% of those under the age of 24 in prison are expected to have had unprotected sex in the past year with two or more partners.[6] In 2012 the Howard League for Penal Reform undertook the first ever review into sex in prisons.

Mr Hardwick, the Chief Inspector of Prisons, raised a number of concerns while giving evidence to the commission, including that inmates could be contracting sexually transmitted diseases because prisons are failing to support them. Mr Hardwick suggested that the Prison Service should implement a uniform approach to providing protection.

In an HM Inspectorate of Prisons survey, 1% of prisoners said that they were being sexually abused, rising to 2-3% among prisoners who considered themselves to be disabled.

In an academic study of 200 ex-prisoners, 91% said they had been coerced sexually. Yet only a small number of complaints about sexual issues are officially logged. The Probation and Prison Ombudsman (PPO) logged just 108 such complaints between 2007 and 2012.[7]

## CLINICAL GUIDELINES

In 2013, the Department of Health published a Framework for Sexual Health Improvement in England.[8]

It highlighted areas where improvements in services needs to made:

- More people in high risk groups being offered and accepting HIV tests.
- To ensure that people have access to free condoms and know how to prevent STIs.
- To continue to eradicate prejudice based on sexual orientation.
- To help people to have the confidence and ability to say "no" as well as "yes."

A 2011 article in the British Medical Journal[9] examined how to run a prison sexually transmitted infection service. It found that services should be commissioned with characteristics of the prison setting in mind, and link in with the local health strategy and action plan.

The quality of services must be assured by a monitoring and governance framework, grounded on national standards.

## ALTERNATIVE PROVISION

The sexual health consultant said that it was economical for him to go into the prison, due to the costs involved in getting a prisoner to an appointment in the community.

## SEXUAL HEALTH INFORMATION AND ADVICE

The sexual health consultant uses the standard sexual health leaflets from the Family Planning Association. These are available from the sexual health consultant. The consultant also provides counselling and advice on sexual health issues to all prisoners that he sees.

## RECEPTION SCREEN

All prisoners are vaccinated against hepatitis B, although prisoners are not checked to see if they have had hepatitis B in the past. This means that prisoners with active hepatitis B are not identified. This may not be a significant problem in the prison, as most are vaccinated.

## PHYSICAL ENVIRONMENT

The sexual health consultant sees prisoners in a private room with the equipment needed to carry out a consultation.

## HIV

In HMP Bristol the HIV care is provided by infectious disease specialists. The sexual health consultant may identify prisoners with HIV, but they would be immediately transferred to the infectious disease specialist nurse from Southmead Hospital.

## STAFF TRAINING

The sexual health consultant has given specific training to staff that have come to work with him. In the past there was a nurse who worked with the consultant for a year. The nurse sat in on clinics, took blood samples, and gave the results of the blood tests. This was a more efficient use of time, as the nurse could give the results of blood tests directly to prisoners.

"The system works a lot more efficiently if there is a nurse working alongside the sexual health consultant, as you don't have to take up appointment slots for just giving results."

There were some improvements that could be made to the current sexual health system. The Sexual Health Consultant suggested: "a sexual health consultant and a senior nurse to provide sexual health sessions on alternate weeks. The difficult cases could be brought back for the weeks the sexual health consultant is in the prison".

The sexual health consultant said that it would be possible for healthcare staff to sit in with his consultations if they required any training in sexual health issues. It would also be possible for staff members to visit the sexual health clinic in Bristol if necessary. There would be no cost to the Healthcare Team for this, apart from the cost of backfilling the staff member receiving the training.

As the consultant is only in the prison for one session per week, he has not been involved in any formal training sessions.

## TRANSFER/RELEASE

Prisoners that are transferred out of the prison, but are still awaiting results from sexual health related tests, are requested to contact HMP Bristol, who will then contact the sexual health specialist.

## PROVISION

Sexual health provision in HMP Bristol is provided by a sexual health consultant from University Hospital Bristol. The consultant provides one session per week. The same consultant provides sexual health services in the community.

## APPOINTMENTS

The sexual health consultant can see up to ten patients each week. The consultant has never seen less than two prisoners in a session. Normally there are one or two prisoners that refuse to turn up to their appointment.

Since the arrival of more substantial sexual health checks in reception, the sexual health consultant said that he is seeing fewer prisoners. However the sexual health test in reception does not test for all conditions, for example, syphilis. It also does not give any detailed sexual health advice.

## REFERRALS

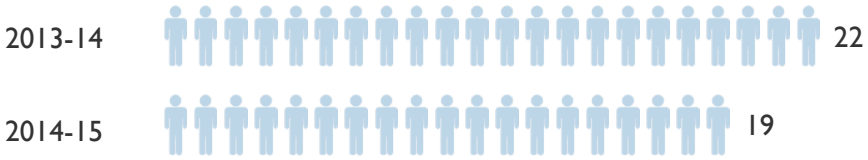
The vast majority of prisoners that see the sexual health consultant are self-referrals. There are occasionally patients that are referred to the consultant by the prison GPs.

## ELECTRONIC RECORDS

Electronic records are not available on SystmOne. The sexual health consultations are confidential, so are not shared on the patient's medical record.

If there is an extremely important health issue that the sexual health consultant feels prison doctors should know about, he will get prisoner consent before sharing information.

## AVERAGE NUMBER OF PATIENTS ADDED A MONTH



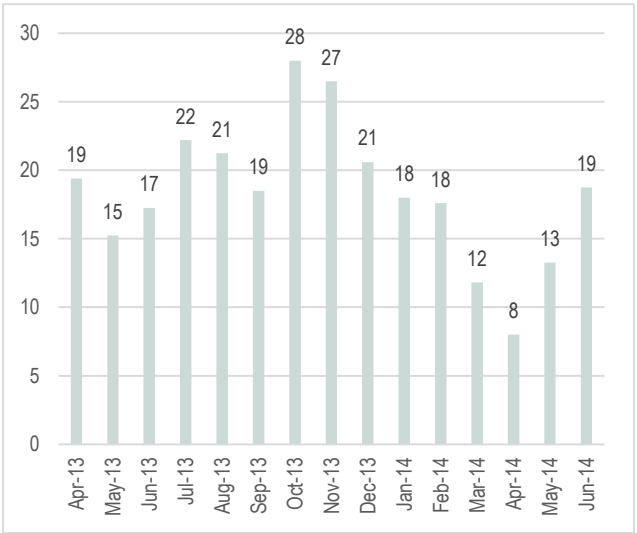

*Left: Figure 6.2.1 - Average number of prisoners added to sexual health clinic per month.*

*Source - Local data*

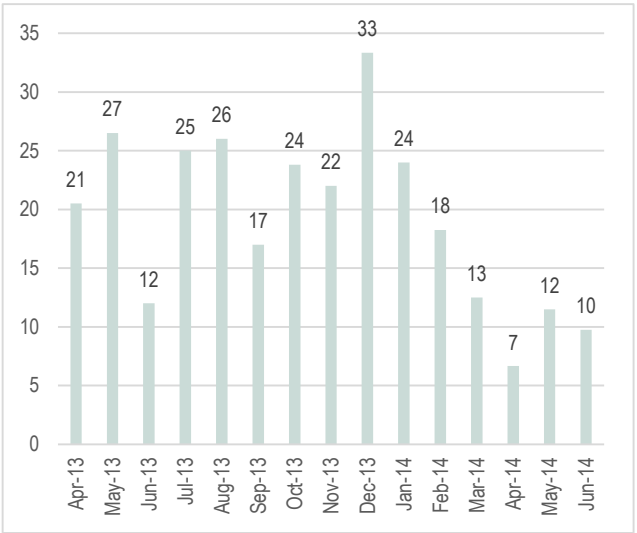
*Below/left: Figures 6.2.2 & 6.2.3 - Sexual health clinic waiting times.*

*Source - Local data*

## WAITING LIST




## WAITING TIME



## SEXUAL HEALTH CHECKPOINT AND RECOMMENDATIONS

| ID / Pg. | Consideration / Key Finding | Relevance to HMP Bristol | Recommendation |
|---|---|---|---|
| SX1<br>118 | The sexual health consultant can see up to ten patients a week. The consultant has never seen less than two prisoners in a session. Normally there are one or two prisoners that refuse to turn up to their appointment. | There are a number of prisoners that do not attend (DNA) their appointment with the sexual health consultant. | Prisoners that DNA should be invited back for another appointment with the consultant. |
| SX2<br>118 | Since the arrival of more substantial sexual health checks in reception, the sexual health consultant has said that he is seeing fewer prisoners. | The reception screen appears to be working in picking up sexual health issues. | No recommendation. |
| SX3<br>118 | A sexual health consultant and a senior nurse are to provide sexual health sessions on alternate weeks. | This would allow the difficult cases to be brought back for the weeks the consultant is in the prison. | No recommendation. |
| SX4<br>118 | Prisoners that are transferred out of the prison, but are still awaiting results from sexual health related tests, are requested to contact HMP Bristol, who will then contact the sexual health specialist. | Prisoners can find out results by contacting the prison. | No recommendation. |

# TUBERCULOSIS

## INTRODUCTION

There is a wealth of information and research, and many policies relating to TB in prisons, from organisations such as the World Health Organisation (WHO), the Health Protection Agency (HPA), and the National Institute for Health and Care Excellence (NICE).

Some of the key facts taken from the research include:

- Prison populations are at increased risk of TB due to the high prevalence of individuals with a history of drug and alcohol use, homelessness, a compromised immune system, and high incidence at the country of birth (HPA).[10]
- Prison conditions can spread diseases through overcrowding, poor ventilation, weak nutrition, and inadequate or inaccessible medical care (WHO).
- Late diagnosis, inadequate treatment, overcrowding, poor ventilation, and repeated prison transfers encourage the transmission
- Difficulties encountered in a prison setting include case detection, diagnosis, isolation facilities, movements within prison populations, limited awareness of TB in prisons, fear and stigma among prisoners and staff, and limited access to external resources in the community (HPA).
- Prisons act as a reservoir for TB, pumping the disease into the civilian community through staff, visitors, and inadequately treated former inmates (WHO).
- The rate of TB infection in the general UK population has been rising steadily. Prison populations are particularly vulnerable to TB infection, and both the National Institute of Health and Clinical Excellence (NICE) and the Chief Medical Officer (CMO) have highlighted the importance of prisons in TB control.

## PROVISION/LOCAL

Prisoners are only tested for TB if it is needed, that is if the prisoner has a history of TB, or if they are displaying symptoms.

If prisoners are identified as having a potential risk of TB they are isolated. Any cell mate would also be tested. Prison healthcare staff would be led by Public Health England in their response to a case of suspected TB.

New documentation has been sent to all staff as to how they can identify TB.

There is a risk around foreign nationals, who have not had any immunisations.

If a prisoner had active TB then they would not be transferred. A situation was described when a prisoner had to be transferred who no longer had active TB. The receiving establishment was contacted and the prisoner was transferred with medication.

If prisoners with TB are due for early release, the prison would inform the GP and Public Health.

# OTHER SERVICES

PHARMACY PG 123

CLINICS PG 126

# PHARMACY

## INTRODUCTION

There are various models that support pharmaceutical service delivery in prisons. The 2012 National Prescribing Centre report, "Safe Management and Use of Controlled Drugs in Prison Health in England," agreed on the requirements of a full pharmaceutical service to a prison, regardless of the service model. The requirements were:

- The supply of medicines (dispensing service).
- Medicines management advice from a pharmacist relating to the general use and management of medicines.
- Medicines management advice and recommendations from a pharmacist with specialist knowledge of the use of medicines within a prison healthcare environment. This last role may be supported by a registered pharmacy technician.

The Royal College of General Practitioners document, "Safer Prescribing in Prisons: Guidance for clinicians," highlighted that many prisoners, though not all, are accustomed to using illicit and prescribed drugs to ameliorate or treat symptoms and perceived wants and needs.

The RCGP guidance says that the involvement of a pharmacist in the determination of individual treatment to patients, can optimise risk mitigation and ensure cost-effective use of the most appropriate pharmaceutical form of medication.

## PROVISION

The pharmacy in HMP Bristol is open Monday to Friday, 8am - 4.30pm. There are out of hours medicine cabinets on several wings. If prescribed medications are not held in those cabinets, out of hours pharmacies can be used.

| Number of staff | Role |
|---|---|
| 0.5 | Head of Medicines Management |
| 1 | Band 7 Clinical Pharmacist |
| 1 | Band 6 Pharmacist |
| 1 | Band 6 Accuracy Checking Technician |
| 2 | Band 5 Accuracy Checking Technician |
| 1 | Band 3 Dispenser |
| Variable | Lead Pharmacist for Cluster (BCH) |

*Right: Figure 7.1.1 - Staffing make-up of the pharmacy service.*

*Source: SystmOne.*

## IN-POSSESSION MEDICATION

The in-possession policy has been reviewed and approved recently. Prisoners are assessed using an in-possession risk assessment. The pharmacy staff were described as very good at spotting out of date assessments.

## PRISONERS WITH MEMORY PROBLEMS

Pharmacy staff are able to administer medications via dosette boxes. Prisoners that are eligible for self-care but have memory problems would be eligible for a dosette box. Prisoners are screened for memory issues at the over 50's health check; this is logged on SystmOne and available to the pharmacy.

## TRANSFER/RELEASE

There are discharge pathways in place. If a prisoner is being released they can be given up to seven days' supply of medicines. If this cannot be arranged in time, then prisoners are given the necessary prescription to take with them.

## PAIN MANAGEMENT MEDICINES CLINIC

The pharmacist will start running a pain management clinic pilot in HMP Bristol. This will be a jointly led clinic between Bristol Community Health and Med Co. There may also be some involvement from AWP, the mental health service provider.

The results of this clinic will be compared against the pain management clinics that are being run in HMP Leyhill and HMP Ashfield. The lead pharmacist is in the process of collecting data around these pain clinics.

## PHARMACY LED USE AND REVIEW CLINICS

There are scheduled regular clinics that are run in HMP Bristol on various wings. It is anticipated that pharmacy technicians will become involved in delivering these clinics. Their role will be to try and improve patient adherence to medication, and to support nursing staff in dealing with any questions regarding medicines. These Medicines Use Review (MUR) clinics run twice a week.

## TRAINING

The pharmacy carry out induction days for new nurses.

## MINOR AILMENTS POLICY

There is a minor ailments policy in place. If a patient requires medication for minor ailments, then the nurse can provide some over-the-counter medication, providing the correct risk assessment procedure is followed. There is a training need in this area.

## INSPECTION REPORT

The HMIP Inspection Report from 2013 included findings related to the pharmacy. Below is a summary of the findings and an update of progress.

| Finding | Progress |
|---|---|
| General Pharmaceutical Council. | HMP Bristol pharmacy is registered with the GPC. |
| Pharmacy led, MUR clinics. | This are run on a regular basis. |
| Patient Group Directions. | The process to sign off PGDs changed in the 12 months prior to this H&SCNA. There are first night PGDs in place, so that if a patient enters HMP Bristol after the doctor has left, they can be stabilised. Additionally NHS England PGDs for medications and vaccinations are being used. |
| Controlled drugs. | Controlled drugs are stored and secured separately. |
| In-possession risk assessments. | These are paper documents, so are not fully available on SystmOne. The outcome of the in-possession risk assessment is listed on SystmOne. |
| Lockable cabinets. | Cells are not equipped with lockable cabinets. |
| Minor Ailments and Out of Hours Policy. | There are up to date Minor Ailments and Out of Hours policies that were signed off in September 2014. |
| Named medications. | Named medications are used for only those patients whose names are on the medication. |

## PHARMACY CHECKPOINT AND RECOMMENDATIONS

| ID / Pg | Consideration / Key Finding | Relevance to HMP Bristol | Recommendation |
|---|---|---|---|
| PH1<br>124 | The pharmacist will start running a pain management clinic pilot in HMP Bristol. This will be a jointly led clinic between Bristol Community Health and Med Co. There may also be some involvement from AWP, the mental health service provider. | It is hoped that these clinics will result in reductions in prescribed medications, and improved clinical outcomes. | Joint working roles and responsibilities around the pain clinic should be clarified. |
| PH2<br>124 | There are scheduled regular clinics run in HMP Bristol on various wings. It is anticipated that pharmacy technicians will become involved in delivering these clinics.<br>These MUR clinics run twice a week. | The pharmacy technician's role will be to try and improve patient adherence to medication, and to support nursing staff in dealing with any questions regarding medicines. | These clinics should be publicised across the prison. |

# CLINICS

## INTRODUCTION

NHS England's Specification Pack for Healthcare Services in the Prison Estate states that prison healthcare services must provide specialist healthcare advice and treatment for a range of specific health conditions.

Planned Care services including assessment and review must include:

- Long-term condition clinics
- Vaccination/BBV clinics
- Wellman/woman clinics
- Needs of the elderly population
- Health promotion

All clinics must be provided to the same standards as those delivered within the community, and in line with the requirements of the National Service Frameworks and published NICE guidelines. Nurses must operate regular review clinics and coordinate primary and secondary care referrals.

The timetable on page 127 shows the weekly clinics at HMP Bristol.

# CLINIC TIMETABLE

| Other Regular Services | |
|---|---|
| Diabetic Retinopathy held yearly within Healthcare | |
| General Health Assessments held daily on wings | |
| Hep B Clinics held daily on wings | |
| 5 day | Disability Clinic |
| 4 Week | Diabetes Clinic - Retinopathy |
| 12 Week | Hep B |

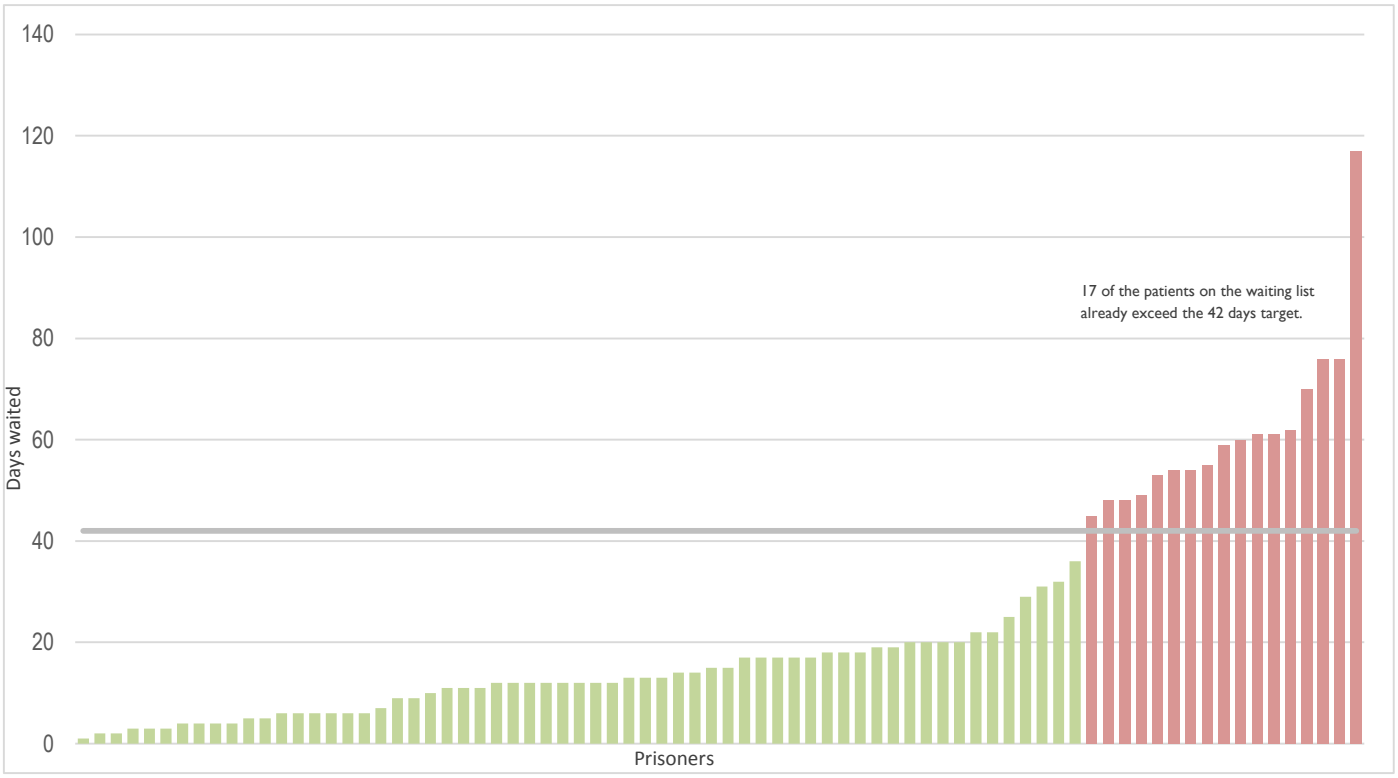
| | Monday | | Tuesday | | Wednesday | | Thursday | | Friday | |
|---|---|---|---|---|---|---|---|---|---|---|
| | AM | PM | AM | PM | AM | PM | AM | PM | AM | PM |
| PC1 | GP Clinic | GP Clinic | GP Clinic | GP Clinic | GP Clinic | GP Clinic | GP Clinic | GP Clinic | GP Clinic<br>Chronic Disease Clinic - GP Lead | Lock Down |
| PC2 | | Clinic 6<br>(Fortnightly) Optician | Clinic 7<br>Phlebotomy Clinic<br>HCAs | Clinic 5<br>(Fortnightly) Chiropody | | | | | Clinic 10h PCHMT<br>Visiting Professionals | Lock Down |
| PC3 | Clinic 4<br>Sexual Health | Chronic Disease Clinic<br>Nurse Led | Clinic 8<br>(Fortnightly Hep C) | Over 40s | ECG Clinic<br>HCAs | Chronic Disease Clinic - Nurse Led | Clinic 10a<br>PCHMT | Clinic 10a<br>PCHMT | | Lock Down |
| Dentist | Clinic 1<br>Dentist | Clinic 1<br>Dentist | | | Clinic 1<br>Dentist | Clinic 1<br>Dentist | Clinic 1<br>Dentist | Clinic 1<br>Dentist | | Lock Down |
| CR1 | Clinic 10<br>PCMHT Triage | Clinic 10<br>PCMHT | Clinic 10<br>PCMHT Triage | Clinic 10<br>PCMHT Service User Forum | Clinic 10<br>PCMHT Triage | Clinic 10h<br>PCMHT | Clinic 10<br>PCMHT Triage | Clinic 10h<br>PCMHT Visiting Professionals | Clinic 10<br>PCMHT | Lock Down |
| OT Suite | | Smoke Stop | | | | | | | | Lock Down |
| Group Room | | CMHT Team Meeting First Monday of Every Month | Clinic 10h<br>PCMHT Visiting Professionals | Clinic 10h<br>PCMHT Visiting Professionals | Clinic 10h<br>PCMHT Visiting Professionals | Clinic 10h<br>PCMHT Visiting Professionals | Clinic 10h<br>PCMHT Visiting Professionals | Clinic 10h<br>PCMHT Visiting Professionals | | SPEM Meeting PCMHT Weekly |

## CURRENT WAITING LIST

Figure 7.2.1 gives a snap shot of the waiting list as at the end of September 2014, with each bar representing a prisoner and the length of time (in days) that they have been waiting.

The aim is for dentists to see patients within 42 days of their application. There were 78 prisoners on the waiting list, of which 17 (22%) had waited over the 42 day target.

*Below: Figure 7.2.1 - Dental waiting list, and days waited.*
*Source - SystmOne*



The same dental provider provides services across four prisons in the cluster: HMP Ashfield, HMP Bristol, HMP Eastwood Park, and HMP Leyhill.

The provider completed a survey that used a selection of questions taken from Public Health England's "A survey of dental services in adult prisons in England and Wales".

The questions covered the surgery, the dentist, dental staff, equipment, cross-infection control, the technology, the diary, oral health promotion, training, communication, complaints, and the patient journey.

All responses are presented here for a comparison.

| | HMP Ashfield | HMP Bristol | HMP Eastwood Park | HMP Leyhill |
|---|---|---|---|---|
| **THE SURGERY** | | | | |
| Is the dental surgery wheelchair accessible? | Yes | | | |
| When was the surgery last refurbished? | <12 months | U - but probably 10 years | U - probably about 10 years ago | 1-5 years |
| When was the surgery last redecorated? | <12months | U - but partly just in past month | U - probably about 10 years ago | 1-5 years |
| Any additional comments on The Surgery: | Just refurbished to meet HTM0105 standards. Good surgery, although quite cramped. Needs PC ASAP | Good size. Needs redecoration. Likely full refurb within next 5 years. Needs vertical blinds for privacy in winter | Very cramped. Difficult working environment. Could do with a full refurb. The chair is starting to show it's age and will be difficult to repair if it breaks. Ideally should find larger rooms. Windows can't be closed and debris/insects etc always getting blown in. Heating and temperature control poor so can get very hot or cold. Ceiling track-suspended light is not ideal. Short of storage space within surgery. | Very nice surgery, but no separate room for decontamination, therefore does not meet HTM 0105 gold standard. Needs new filing cabinet - lock is broken/ temperamental and is kept in main corridor of H/C |
| **ABOUT THE DENTIST** | | | | |
| How long have you worked in this prison? | less than one year | | | |
| What is the total number of clinical sessions worked by all dentists at this prison per week? | including therapists = 4 sessions/ week average | including therapists = 4 sessions/ week | including therapists = 5 sessions/ week | including therapists = 4 sessions/ week |
| How long have you worked in prison dentistry? | 3-5 years | | | |
| Is there a signed Service Level Agreement (SLA) in place? | Yes | | | |
| To your knowledge, has an oral health needs assessment been carried out at this prison? | No | | | |
| **DENTAL STAFF** | | | | |
| How many dentists are employed in the prison? | variable - 6 dentists and 2 therapists shared between all cluster | | | |
| How many dental nurses are employed in the prison? | variable - 6 dental nurses shared between cluster | | | |
| Do any of the following work at the prison? | Dental Therapist. Oral Health Promoter going through clearance | | | |

| | HMP Ashfield | HMP Bristol | HMP Eastwood Park | HMP Leyhill |
|---|---|---|---|---|
| **EQUIPMENT** | | | | |
| Does any of the following equipment need to be updated or replaced? | No | Dental chair and delivery system will likely need replacement soon, some additional hand instruments still need to be brought in to the prison. Some forceps need replacing. Full surgical kits, flooring getting tired. IT cable trailing around water pipes - could be tidied up. Windows need replacing or renovated. None of them close properly at the moment. Vertical Blinds required for privacy in winter. Gets very hot in the summer | Dental chair, dental light and delivery system will definitely need replacement soon. some additional hand instruments still need to be brought in to the prison. Some forceps need replacing. Full surgical kits, flooring getting tired | No - suction occasionally a bit weak. |
| Who is responsible for organising the maintenance of equipment? | Contract holder | | | |
| Who is responsible for payment of the maintenance contracts? | Contract holder | | | |
| Are maintenance contracts in place for equipment that needs regular certification? | Yes | | | |
| What items are currently without a maintenance contract? | all areas covered | | | |
| Are there any items of equipment that urgently need replacing or updating? | No | N - Flooring, chair, delivery system soon | Chair, Flooring, worksurfaces and Delivery system very soon | No |
| What equipment urgently needs replacing or updating? | none | | | |
| Any additional comments on The Equipment: | Rotary endodontic system with apex locator required. Additional ultra sonic scaler handpieces required. Oral surgery motor and separate suction unit required and to be shared across the cluster | | | |
| **CROSS INFECTION CONTROL** | | | | |
| When was the most recent HTM 01-05 audit carried out? | Apr-14 | | | |
| What was the result of the HTM 01-05 audit? | non-compliant, but action plan completed to achieve compliance | | | |
| Has a full CQC inspection (England) or an equivalent inspection (Wales) been carried out? | No | Joint inspection with HMIP in August 2014 | No | No |
| When was the CQC inspection carried out? | n/a | <6 months ago - but NB not CQC full inspection | n/a | n/a |
| Any additional comments on Cross Infection Control: | decontamination room a little cramped and one unnecessary sink in place in design- but otherwise good set-up. | Adequate set-up | Very cramped space in decontamination room. Could be redesigned. Needs ventilation | No separate decontamination room present. Need to identify separate room for decontamination to be compliant with best practice HTM0105 |

| | HMP Ashfield | HMP Bristol | HMP Eastwood Park | HMP Leyhill |
|---|---|---|---|---|
| **THE TECHNOLOGY** | | | | |
| Is SystmOne used in the dental surgery? | Yes | | | |
| For which of the following do you use SystmOne? | Appointments/Waiting lists/Prescribing/Tasks/Dental Notes/Messaging/Other | | | |
| How many SystmOne training sessions did you attend? | 0 | | | |
| Is the dental surgery registered with the Information Commissioner's Office (ICO)? | Don't know | | | |
| Any additional comments on The Technology: | SystmOne is not fit for purpose for dental use. Requires development of elements for dental charting, dental record-keeping and submission of forms to NHS BSA | | | |
| **THE DIARY** | | | | |
| Who manages the dental appointment diary? | DCP - remotely at present, but changing to local dental nurse and dentist | Receptionist | DCP - remotely at present, but changing to local dental nurse and dentist. Receptionist staff can book urgent patients within 24 hours of clinic | DCP - remotely at present, but changing to local dental nurse and dentist. Receptionist staff can book urgent patients within 24 hours of clinic |
| Who manages the dental waiting list? | DCP | | | |
| How long is the waiting list for routine examinations? | 6-12 weeks | less than 6 weeks | 6-12 weeks | 6-12 weeks |
| After the initial examination, how soon is a follow-up appointment for treatment available? | 4-6 weeks | 3-4 weeks | 5-6 weeks | 5-6 weeks |
| How many patients, on average, are booked into a clinical session? | 9 patients | | | |
| 6.6 How long do you book for an average new patient exam? | 20 minutes -and deal with presenting problem and full assessment | | | |
| How quickly are patients requiring emergency dental treatment (trauma, haemorrhage, etc.) seen by the dentist or other appropriately trained staff? | These genuine emergency dental cases are rare. If dentist present will be seen within an hour. If dentist not present will be seen by GP for an assessment and can use triage algorithm to determine if need onward referral to A&E | | | |
| How quickly are patients with dental pain normally seen by the dentist or other appropriately trained staff? | Genuine urgent dental pain and care cases are seen within 24-48 hours | | | |
| On average, how many external dental referrals are arranged each month for specialist dental care outside the prison? | 1 | | | |
| For which of the following are referrals made? | Occasional oral surgery - most done in-house. Oral Medicine occasionally. | | | |
| Are there any problems with making referrals for specialist dental care in your area or for patients attending these appointments? | No | | | |
| What are the problems with making referrals for specialist care in your area or for patients attending these appointments? | n/a | n/a | Difficult to arrange referrals for specialist care within time-frame of stay of most patients if | n/a |

| | HMP Ashfield | HMP Bristol | HMP Eastwood Park | HMP Leyhill |
|---|---|---|---|---|
| **THE DIARY CTD.** | | | | |
| Are there administrative problems in providing escorts for external referrals? | not as far as I am aware. Very few referrals made though | | | |
| How frequently do the following cause DNAs? | | | | |
| Escort problems | very rarely/never/na | very frequently | very rarely | very rarely/never/na |
| Prison security (lock downs, counts, bad behaviour, etc.) | very rarely | very rarely | very rarely | very rarely |
| Patients being released or transferred without notice | rarely | rarely | rarely | rarely |
| Patients unavailable due to court appearances or video links, etc. | rarely | frequently | rarely | rarely |
| Patient out of prison due to medical appointments | very rarely | very rarely | rarely | rarely |
| Patient has visitors | very rarely | frequently | very rarely | very rarely |
| Patient refuses to attend | very rarely | frequently | rarely | very rarely |
| Unknown | very rarely | frequently - although we are not always sure of the reasons given. We are informed by escorts. | very rarely | very rarely |
| | | | | |
| Do you have an issue with patients being transferred or released before laboratory work is fitted? | Yes | | | |
| Any additional comments on The Diary: | | | | Only times we have had significant DNAs have been when we have booked clinics at short notice and patients have not been able to make appointments - out on work experience. |
| **TRAINING** | | | | |
| Which of the following prison training have you received? | Prison Induction and Key Training/ | Prison Induction and Key Training | Prison Induction and Key Training | |
| Do you receive regular updates for your prison training? | training programme offered - upcoming | not yet | not yet | Mental health awareness training offered, but not able to attend |
| Does your healthcare department provide any additional training (e.g. Risk Management, CPR, etc.)? | Don't know - all mandatory training done via contract holder's NHS Trust | | | |
| How do you ensure that your educational needs are met with respect to your role in prison dentis- | NAPDUK events - for specific prison dental CPD. Deanery events/ Other verifiable CPD courses - for generic dental CPD | | | |
| Do you feel that the prison, the provider, and your local deanery are supportive of your need to participate in prison dental education? | Don't know | | | |

| | HMP Ashfield | HMP Bristol | HMP Eastwood Park | HMP Leyhill |
|---|---|---|---|---|
| **ORAL HEALTH PROMOTION** | | | | |
| In what ways is OHP delivered? | One-to-one in the surgery/ Prison health fayres and other educational events/ Oral health educators providing group work - in development/ Posters and OHP information leaflets/ | | | |
| Is there a specialist smoking cessation team in the prison? | Yes | | | |
| Do you offer smoking cessation advice in the surgery? | Yes | | | |
| Any additional comments on Oral Health Promotion: | Getting security clearance for members of OHP team to permit their entry and participation in oral health promotion needs assessment | | | |
| **COMMUNICATION** | | | | |
| How would you rate cooperation and liaison between the dental staff and other healthcare staff? | Good | | | |
| Does the dental team meet regularly with doctors and nursing staff to discuss healthcare issues? | y - but not frequently | n - not yet | y - but not frequently | y - but not frequently |
| Are you invited to attend healthcare governance meetings that report to the Partnership Board? | Yes | | | |
| **If yes:** Have you ever attended any of these meetings? | Yes | No - not yet | Yes | Yes |
| Do you attend them regularly? | Yes | No - not yet | Yes | Yes |
| Do you find these meetings worthwhile? | Yes | Don't know | Yes | Yes |
| **COMPLAINTS** | | | | |
| How many patient complaints have been received in the last 12 months concerning the dental service? | 3-5. | 0 | 3-5. | 1-2. |
| Which of the following have been the subject of complaints? | Patient waiting too long due to length of waiting list | Patient waiting too long due to length of waiting list | Patient waiting too long due to length of waiting list | Patient waiting too long due to length of waiting list |
| **THE PATIENT JOURNEY** | | | | |
| Is there a patient care pathway in place? | Yes | | | |
| Is there an effective dental triage pathway in place? | No | | | |
| Is Language Line translation services or an equivalent service available for your use in the surgery? | Yes | Don't know | Yes | Yes |
| Any additional comments on Communication: | Good communication with other members of health team, through Clinical Lead and receptionists. Most of the "complaints" have been comments. New process should distinguish complaints from comments | Communication via healthcare manager generally good | Good communication through prison and service liaison officer. Most of the "complaints" have been comments. New process should distinguish complaints from comments | Good communication through Clinical Lead and reception/ admin staff |

## PODIATRY

The podiatry service are commissioned to deliver two sessions each month at HMP Bristol, as well as providing services to HMP Ashfield, HMP Eastwood Park, and HMP Leyhill.

The waiting list is managed by Bristol Community Health, but the podiatrists will prioritise cases that they deem as urgent or high risk.

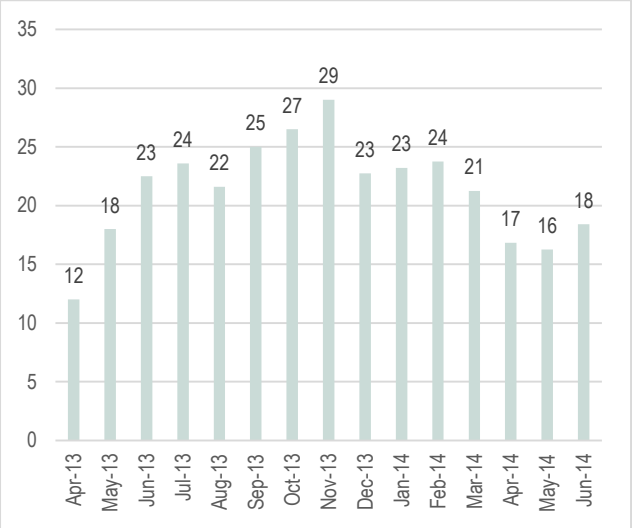
During 2013-14, a total of 180 patients were added, equating to an average of 15 per month. The number in 2014-15 to date is similar, at 16 per month.

Figure 7.2.3 shows that the number of prisoners on the waiting list ranges from around 12 to 29 at any point. Figure 7.2.4 shows the mean waiting time.

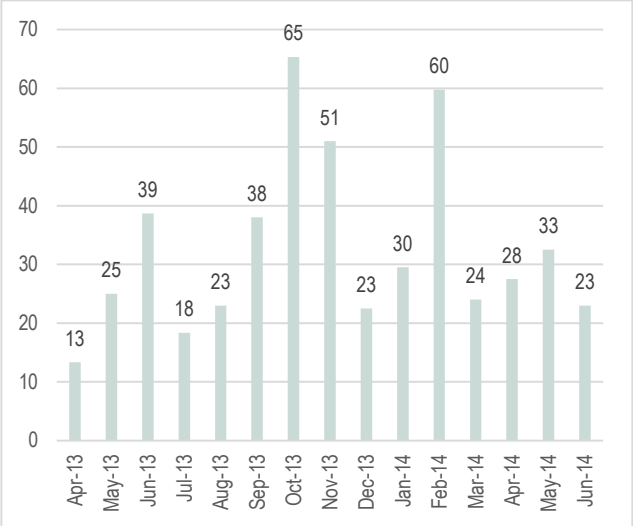
The facilities in HMP Bristol consists of a clinical room, which were described as not being ideal for podiatry. There were no direct access to IT systems in the room.

| | Patients Added Total | Patients Added Average |
|---|---|---|
| 2013-14 | 180 | 15 |
| 2014-15 | 47 | 16 |

*Above: Figure 7.2.2 - Podiatry clinic data*




*Above: Figure 7.2.3 - Podiatry clinic (average waiting times).*




*Above: Figure 7.2.4 - Podiatry clinic (Mean waiting time).*

## OPTICIAN

### CURRENT WAITING LIST

As at the end of September 2014, there were 44 prisoners on the waiting list.

## INTRODUCTION

GP Services in HMP Bristol are provided by Med-Co. Med-Co also provide an auxiliary nurse that provides the over 40's health checks and the smoking cessation clinic.

Figure 7.2.5 below shows the current GP clinic timetable. Monday to Friday GP clinics run for 2.5 hours in the morning and 2.5 hours in the afternoon, with a 2 hour clinic in the evening. In addition there is a 4 hour clinic on Saturday, and a 2 hour clinic on Sunday.

| | Morning (2.5 hours) | Afternoon (2.5 hours) | Evening (6pm - 8pm) |
|---|---|---|---|
| **Monday** | GP Clinic | GP Clinic | GP Clinic (new receptions with substance misuse problems) |
| | GP Clinic | | |
| **Tuesday** | GP Clinic | GP Clinic | GP Clinic (new receptions with substance misuse problems) |
| | GP Drug Misuse and Relapse Clinic | | |
| **Wednesday** | GP Clinic | GP Clinic | GP Clinic (new receptions with substance misuse problems) |
| **Thursday** | GP Clinic | GP Clinic | GP Clinic (new receptions with substance misuse problems) |
| | GP Clinic | | |
| **Friday** | GP Clinic | | GP Clinic (new receptions with substance misuse problems) |
| | GP Chronic Disease Management Clinic | | |
| **Saturday** | | GP Clinic (1-5pm) | |
| **Sunday** | GP Clinic for emergencies and any receptions that arrived after 5pm on Saturday (2 hours) | | |


1 GP works long days Mon, Tues, Wed and 0.5 day Thu


1 GP works long days Thu and Fri


1 GP works Mon and Tue mornings


1 GP works Fri mornings

These GPs rotate to cover Sat and Sun. GP cover is provided by a back up team of 4 different GPs.

*Above: Figure 7.2.5 - GP timetable.*

The GPs had worked there for a varying amount of time. One has worked in the prison for around ten years; two have worked in the prison for around four years; and one has worked in the prison for one and a half years.

GP clinics take place in the central healthcare unit. Until about one year ago, the GP clinics took place on the wings. It was found that moving the GP clinics to the central healthcare unit increased efficiency and allowed more prisoners to be seen. The GP clinic takes place in a dedicated room, set out with an appropriate couch, desk, and equipment.

The drug relapse clinic takes place on the IDTS wing.

## GP APPOINTMENTS

Nurses carry out a basic triage of GP appointments. The researchers were informed that most prisoners that apply to see the GP get put onto the GP list. Bristol Community Health (BCH) have been working on triage templates to make the triage system more robust. Staff said that there were far less inappropriate referrals to the GP than there used to be.

GP appointments last for ten minutes. The researchers were informed that this was around the same amount of time as someone would get in the community. If a patient has language issues they would be given a double appointment. Appointments in the drug misuse and relapse clinic last 30 minutes. Appointments in the chronic diseases clinic last for 20 minutes.

Prisoners can have same day GP access if their need is urgent. There are two or three GP slots each session that are reserved for emergencies. Much of the time, these get filled with substance misuse clients that were not seen the night before.

## GP TRAINING

All GPs working in the prison have completed substance misuse training. Med-Co have an online learning portal which has training modules, such as: safeguarding vulnerable adults, mental health awareness, and encouraging mental wellbeing.

## MEETINGS

Once a month there is a "mini" Partnership Board meeting, attended by representatives from all of the providers (Med-Co, BCH, AWP, and Somerset Partnership) and a representative from the prison. GPs also attend the Drugs and Therapeutic meetings and the Medicine Management meetings.

## MENTORING SERVICE

Med-Co are exploring setting up a mentoring service for prisoners when they leave the prison. This service would build on the existing healthcare champions that provide basic health advice in HMP Bristol. The aim of the service would be to offer Healthcare Champions paid employment when they leave the prison providing a similar mentoring service outside prison. The service is dependent on winning a research grant; this decision was pending at the time of writing.

## QUALITY OF INFORMATION

The GPs normally get good medical information if the prisoner has been transferred in from another prison. Where the prisoner has come into prison through the courts, information was described as patchy. The GPs have to rely on the patient remembering who and where their local GP is. If the prisoner has brought medication with them, the GP can normally track down the community pharmacy they have used, and then contact the prisoner's GP.

With all of the substance misusing prisoners, the prison GPs always contact the prisoner's community pharmacy to ensure that the prisoner has been picking up their medication regularly, and is able to be prescribed opioid substitutes.

The researchers were informed that a high proportion of prisoners had not seen a GP for a long time.

## SOCIAL CARE EQUIPMENT

The GPs can request the wing officers to provide equipment, such as high backed chairs and extra mattresses for those with bad backs. The GP can also request that a prisoner is located on the ground floor if they have mobility issues.

## CHRONIC DISEASE MANAGEMENT

The chronic disease clinic has been running for the past two months. The plan for the next two or three months is for the clinic to change from a GP led and GP delivered service, to a GP run and nurse delivered service. Prior to the chronic disease clinic, any prisoners with chronic diseases were seen as part of the normal GP clinic.

The GPs have recently been loaned a piece of telemedicine equipment. This will allow consultants or out of hours providers to see trends in blood pressure, and trends in blood sugar levels, via a remote link. This means that the consultant or out of hours provider does not have to rely on the prisoner remembering his previous blood sugar and blood pressure levels.

The telemedicine system also has the facility for video consultations, should that be required in the future. It is hoped that this would reduce the numbers of escorts needed.

## PLANNING FOR RE-DESIGNATION AS A RESETTLEMENT PRISON

It was felt that the re-designation of HMP Bristol as a resettlement prison should not mean there are major changes to the services already provided. The prisoners would still have the same problems around drug misuse and chronic diseases. From the point of view of the GPs, there are no major concerns with the transition.

The re-designation as a resettlement prison was expected to be beneficial in terms of care for chronic diseases. The researchers were told that at a point last year, the prison was nearly 70% remand, with an average stay of 21 days. This was not conducive to the treatment of chronic conditions, or to completing a smoking cessation course.

## PERFORMANCE

The GP highlighted an issue with the way their performance is monitored. Prisoners are being booked straight into a clinic, rather than being placed on the GP waiting list. This means that there is no way of easily telling whether the prisoner's appointment needs to be within 48 hours, or if it is a follow up appointment. Staff said that they would rather see the SystmOne waiting list used, as this would give a clearer picture of who was being seen within the target time and who was not.

# GP APPOINTMENTS LAST FOR 10 MINUTES

Community: Doctors spend an average of eight to ten minutes with each patient.

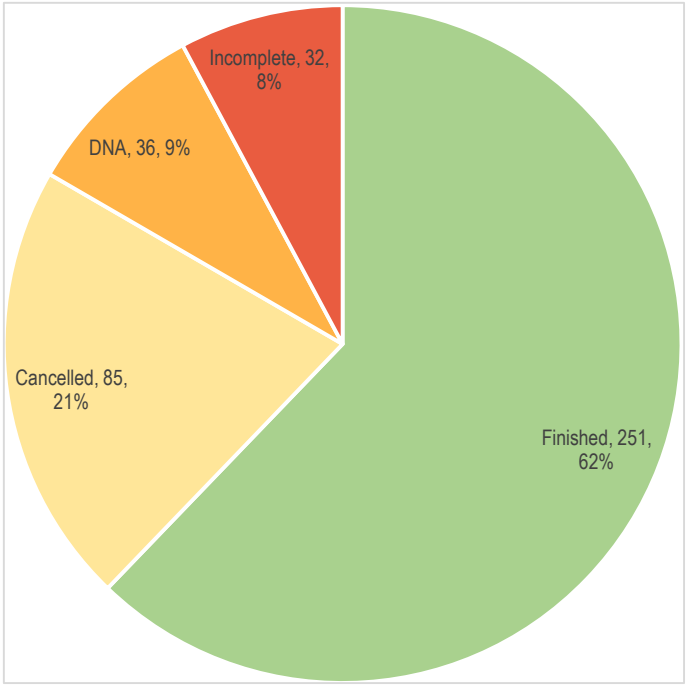
*Below: Figure 7.2.6 - GP average wait.*

*Source - Local data.*

## MONTHLY AVERAGE

### 2013-14

**Number of GP Appointments: 403**

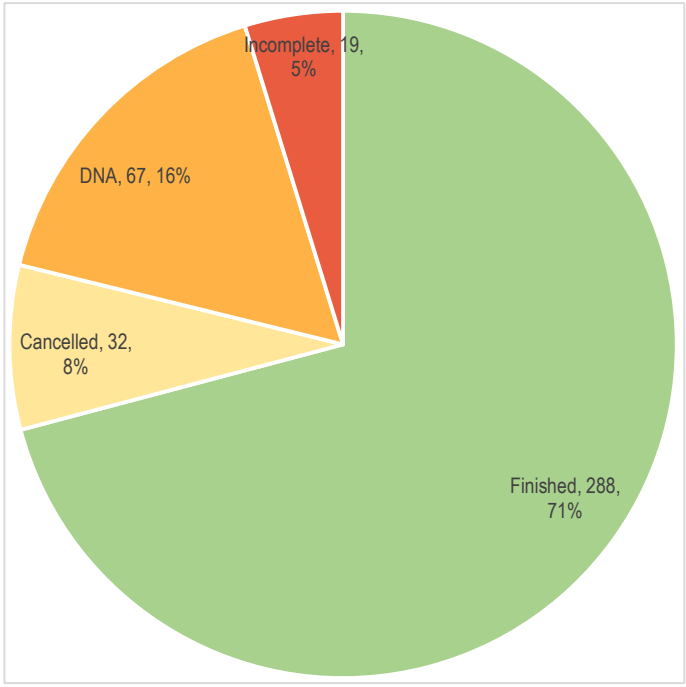



**Finished appointments within 48 hours**

**56%**

### 2014-15

**Number of GP Appointments: 406**




**Finished appointments within 48 hours**

**53%**

A concern raised during 2013-14 was the number of incomplete outcomes. Steps have been taken to ensure that no appointments are left outstanding, which has been reflected in the reduced percentage of incomplete outcomes in 2014-15.

The KPI target for finished appointments within 48 hours is 95%. Performance in 2013-14 and 2014-15 is similar at 56% and 53% respectively.

## SMOKING CESSATION

The current smoking cessation clinic started at the beginning of August 2014. There is currently no data available. The uptake rate for the smoking cessation course was described as "brilliant."

Prior to the current service there was an ad hoc smoking cessation service, which was fairly basic and did not include any counselling.

## NHS HEALTH CHECK

This service started at the beginning of August 2014. The service invites all prisoners between the ages of 40 and 74 to attend the Health Check by letter. If they do not get a response to the first invitation letter within two weeks, a second invitation letter is sent out.

The Health Check screens for hypertension, diabetes, cardiovascular disease, obesity, any other cardiovascular risk factors. It includes a cholesterol check and height, weight, and BMI checks. The nurse giving the Health Check has also been trained to give motivational health care advice, such as weight management counselling.

# WIDER DETERMINANTS OF HEALTH

SPECIFIC POPULATION GROUPS PG 141

HEALTHY LIFESTYLES PG 143

ENVIRONMENT PG 144

# SPECIFIC POPULATION GROUPS

## OLDER PRISONERS

### NATIONAL PICTURE

The recent report from the House of Commons Justice Committee into the needs of older prisoners found that older prisoners are the fastest growing group within the prison population; the number of those aged over 60 grew by 120% and those aged 50–59 by 100% between 2002 and 2013.

The reasons are partly due to prisoners serving longer sentences and more being convicted at an older age, including convictions for historic offences such as sexual offences (which themselves carry long sentences).

At the end of September 2014, around 3% of prisoners in HMP Bristol were over 60, and 7% were between 50 and 59.

The main problems identified by Justice Committee report are:

- Disability and mobility.
- A lack of communication between prison and healthcare staff, contributing to delays in older prisoners accessing healthcare, and a failure to connect IT systems between prisons themselves and the community.
- There was a lack of a basic social care model or what exists is ad hoc.
- The Committee reiterated the findings of Professor Jenny Shaw from the Offender Health Research Network. It was found that there were high rates of chronic illness: 80% of those aged 60–64 had at least one moderate or severe disorder; so did 91% of those aged 65–69, and 92% of those over the age of 70.
- The most common illnesses were cardiovascular (35-55%), musculoskeletal (24-66%), and respiratory (15-36%).
- 70% of older prisoners reported to HMIP that they were taking medication compared with 44% of the prison population as a whole
- Dementia is fairly rare, with a prevalence of 1 -5% in those over 50 years.

## MINORITY ETHNIC GROUPS

While it is not possible to tailor healthcare to every race, ethnicity, or nationality, an understanding of a prisoner's cultural norms is essential for a good diagnosis of a health problem, and for the patient to comply with any treatment.

This is especially true of mental health problems, which are not always recognised as such in some cultures. Links with third sector organisations and culturally specific literature can help with this.

Prisoners with chronic diseases that observe Ramadan will be given formal advice from healthcare staff.

A snapshot of prison data showed that 17% of prisoners were from BME groups at the time of this H&SCNA.

## FOREIGN NATIONALS

The HMP Inspectorate of Prisons "Thematic Report on Foreign Prisoners"[1] found that foreign prisoners were more likely than British prisoners to claim they had health problems. Foreign national prisoners complained of different health problems compared to British prisoners, this could possibly be linked to a less serious pattern of previous substance misuse.

The report also found that language problems made it more difficult to apply for healthcare services or to benefit from a medical consultation, and Language Line or interpreters were rarely used.

As at September 2014, 92 out of the 610 prisoners in HMP Bristol were foreign nationals, equivalent to 15% of the population.

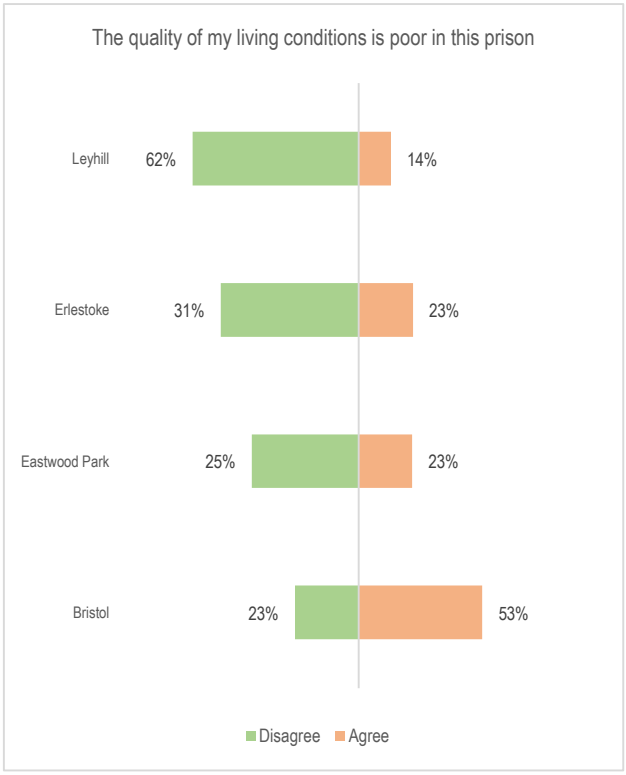
# HEALTHY LIFESTYLES

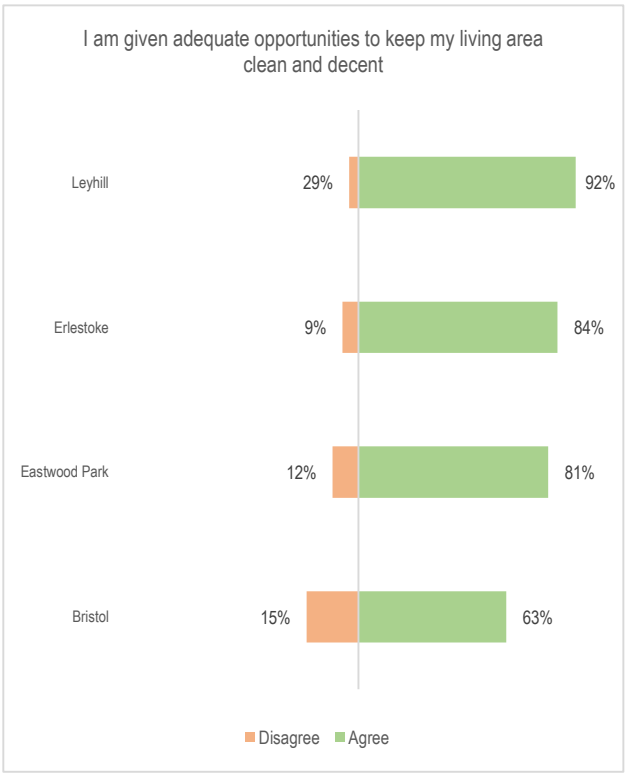
EXERCISE

There has been no systematic analysis to assess the prevalence of poor diet, inadequate physical activity, and obesity in prisoners. A report that reviewed existing international evidence[2] showed that male prisoners in the UK were less likely than the general male population to do adequate physical activity.

The 2006 Audit Office report "Serving Time"[3] found that while most prisoners have the opportunity to exercise regularly, participation in physical activities is low in some prisons. The report makes a number of recommendations for prisons around exercise:

- All prisons should provide exercise opportunities in the evenings and at weekends to increase participation of prisoners who work or attend educational classes full time during the week.
- All physical education departments should consult prisoners over which activities they would like to take part in and then offer them if suitable, and promote activities which involve greater participation.
- Specific groups who would otherwise be reluctant to participate, such as the over 50's and foreign nationals, should be targeted.
- Prisoners should have equality of opportunity to access physical education activities in each prison, including vulnerable prisoners, as far as is commensurate with maintaining good order and the privileges system in place in each prison.
- There is a duty among prisons to ensure that there are appropriate physical exercise facilities, and that prisoners are encouraged and enabled to take part in recreational physical exercise in safe and decent surroundings.




*Above: Figure 8.3.1 - Figures from the MQPL Survey.*

*Source - MQPL*

## MEASURING QUALITY OF PRISON LIFE SURVEY (MQPL)

The MQPL survey includes questions on living conditions in prison. The survey took place in HMP Bristol on 11th January 2011.

Prisoners were asked if they thought: "The quality of my living conditions is poor in this prison."

53% of respondents in HMP Bristol agreed with the statement.

Prisoners were also asked to comment on the statement: "I am given adequate opportunities to keep my living area clean and decent."

63% of respondents in HMP Bristol agreed with the statement.

# GLOSSARY & REFERENCES

GLOSSARY PG 146

REFERENCES PG 147

# GLOSSARY

ACCT - Assessment, Care in Custody and Teamwork

AWP - Avon and Wiltshire Mental Health Partnership

BBV - Blood Borne Virus

BCH - Bristol Community Health

BME - Black and minority ethnic

BNSSG - Bristol, North Somerset, South Gloucestershire

CESI - Client Evaluation of Self at Interview

CHD - Coronary heart disease

CNA - Certified Normal Accommodation

COPD - Chronic obstructive pulmonary disease

CPR - Cardiopulmonary resuscitation

CVD - Cardiovascular disease

CVD-PP - Cardiovascular disease primary prevention

DBS - Disclosure and Barring Service

DNA - Did not attend

GOOD - Good Order or Discipline

GP - General Practitioner

HCA - Healthcare Assistant

HF - Heart failure

HMIP - Her Majesty's Inspector of Prisons

HMP - Her Majesty's Prison

HNA - Health Needs Assessment

HPA - Health Protection Agency

MDT - Multidisciplinary Team

MH - Mental Health

MQPS - Measuring Quality of Prison Life Survey

NDTMS - National Drug Treatment Monitoring System

NICE - National Institute for Clinical Excellence

NOMS - National Offender Management Service

NPS - Novel Psychoactive Substances

OASys - Offender Assessment System

OHRN - Offender Health Research Network

PCT - Primary Care Trust

PEP - Post-exposure prophylaxis

PHPQI - Prison Health Performance and Quality Indicators

PHE - Public Health England

PPO - Prison and Probation Ombudsman

RGN - Registered General Nurse

RMN - Registered Mental Health Nurse

SOTP - Sex Offender Treatment Programme

STIA - Stroke and transient ischaemic attack

TB - Tuberculosis

TIA - Transient ischaemic attack

TSP - Thinking Skills Programme

WHO - World Health Organisation

# REFERENCES

## INTRODUCTION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