

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

HMP Birmingham

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Acknowledgements

Many individuals have been involved in this Health Needs Assessment and supported its undertaking.

Thanks are extended to Staffordshire & Shropshire Local Area Team, the HNA Steering group, to all staff at HMP Birmingham and to the men who participated in focus groups and completed questionnaires.

We would also like to thank staff at the visitors centre and the families and friends of men at HMP Birmingham who completed the visitors' questionnaire.

Thanks are extended to the members of the HNA team involved in conducting the site visits, collating the data required and contributing to the development of this report.

Maggie Wood M.A, R.N

OHNA Ltd

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

Foreword

This Health Needs Assessment has been commissioned by NHS England Health & Justice Staffordshire & Shropshire Local Area Team.

The following Health Needs Assessment report is compiled as one of a series of reports for each of the prisons in the West Midlands prison cluster. The series of reports are as below:-

Report Number 1	West Midlands Prisons Health Needs Assessment 2015 – Introduction & Context
Report Number 2	HMP Birmingham
Report Number 3	HMYOI Brinsford
Report Number 4	HMP Dovegate
Report Number 5	HMPYOI Drake Hall
Report Number 6	HMP Featherstone
Report Number 7	HMP Stafford
Report Number 8	HMPYOI Stoke Heath
Report Number 9	HMPYOI Swinfen Hall
Report Number 10	HMYOI Werrington
Report Number 11	West Midlands Prisons Health Needs Assessment 2015 – Regional Analysis

The Health Needs Assessments have been undertaken utilising the Public Health England Health and Justice Health Needs Assessment Template: Adult Prisons.¹

The initial report in the series provides an introduction and context to the HNAs, including a review of the burden of disease and the met and unmet needs of the prison population. It is therefore recommended that this local report is read in conjunction with Report Number 1 for a wider overview of the health needs of the prison population.

Each local prison report in the series then provides a description of the prison and its population, an account of healthcare services provided and an analysis of whether services provided meet the health needs of the local prison population. Local recommendations are made for each individual prison site, along with an indication of recommendations that may be carried forward to the regional analysis.

A final report (report number 11 of the series) provides a regional overview of all the Health Needs Assessments to collate themes into a number of regional recommendations.

1

www.gov.uk/government/uploads/system/uploads/attachment_data/file/331628/Health_Needs_Assessment_Toolkit_for_Prescribed_Places_of_Detention_Part_2.pdf - Accessed 07.02.15

Executive Summary

HMP Birmingham is a Victorian local prison which holds adult male convicted and un-convicted prisoners and has an operational capacity of 1450. The prison serves the Birmingham court circuit - the Crown and Magistrates' Courts of Birmingham, Shrewsbury and Telford, along with the Magistrates' Courts of Burton, Cannock, Lichfield, Rugeley, Sutton Coldfield and Tamworth. The primary role of HMP Birmingham is to hold remand and trial category B & C prisoners, as well as a small population of retained category D prisoners.

In 2004 the prison underwent a period of considerable change as a result of a multi-million pound investment program by the Prison Service. HMP Birmingham now comprises of 12 wings: a detoxification unit, first night centre, vulnerable prisoner unit, social care unit and 6 residential units (one unit housing vulnerable and at risk prisoners, one unit holding category C prisoners and enhanced regime category B prisoners and four residential units of mixed prisoners). There is a healthcare unit with inpatient wards for both physical and mental health.

HMP Birmingham was the first public sector prison to be transferred into the private sector estate and is currently contracted to G4S Care and Justice Services until 2026.

At the time of undertaking this Health Needs Assessment there were 1391 prisoners in the establishment.

This Health Needs Assessment has been commissioned by NHS England Health & Justice Staffordshire & Shropshire Local Area Team and was carried out between December 2014 and March 2015.

In providing an overview of the findings of the Health Needs Assessment for this executive summary, each section within the report is briefly revisited, areas of met need are succinctly outlined and any gaps identified are described.

Population & Demography

- HMP Birmingham has an operational capacity of 1450 and a high population turnover suggesting a population churn of 4.5 times per year.
- Approximately three quarters of the prison population are serving sentences of less than four years, with 23% serving less than 12 months, providing a short window of opportunity for healthcare engagement.
- Efficient reception screening and processes for rapid referral and meeting of immediate healthcare needs is therefore essential.
- At the time of undertaking the HNA, 38% (n=523) of the population were between 21-29 years old and 37% (n=520) were between 30-39 years old.
- A quarter of the prison population were over the age of 40 (and therefore of the age for which NHS CVD risk assessment screening is recommended).
- Less than 3% of men were 60 years or older.
- 88% of men at HMP Birmingham are UK nationals.
- On 31st December 2014, 61% of the prison population was of White ethnicity.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

- The percentage of Black/Black British men (13%) is higher than the national prison average of 11% and disproportionate to the 2.8% of Black Britons in the general population.
- The percentage of Asian/Asian British prisoners (16%) is much higher than the national prison average of 6%.
- The Health Survey for England 2004² indicates increased risk and prevalence of long term conditions in Black and Asian minorities, impacting on the health needs of the population at HMP Birmingham.

Facilities & Resources

- The healthcare centre is well equipped and resources are adequate. As a result of an energetic recruitment campaign, many vacancies from the first half of 2014 have been filled and staffing levels have stabilised, resulting in a lower reliance on agency and temporary staff.
- The pharmacy requires refitting to create space to accommodate the volume of medicines and the associated workload.
- The nurse consultation room in the reception area requires some refurbishment, but it is understood that plans are in place for this.
- A review of the two inpatient wards and capacity and demand analyses of these facilities has not been undertaken within this HNA as a regional **Inpatient Unit review** has been separately commissioned and recommendations are awaited.

Screening

- Ministry of Justice figures are incomplete for the months of April, May and June 2014, however, on average there were approximately 540 receptions per month, equating to approximately 6,480 receptions per year.
- There is a comprehensive first night reception screening process, ensuring health needs are appropriately identified and managed.
- PHE are currently supporting the team in the implementation of the national CVD risk screening programme.
- Many elements of CVD screening for over 40's are already incorporated into the screening template. A mapping exercise should be undertaken to identify any additional referral prompts required to ensure initial and CVD risk screening dovetail and are undertaken as efficiently as possible and without unnecessary duplication of effort. A rolling programme of screening should utilise healthcare assistants and health trainers to provide lifestyle advice and information.
- All men eligible for bowel cancer screening should be identified through SystemOne clinical reporting function and an awareness programme and screening 'catch up' programme launched to ensure all those eligible have been offered screening.
- Bowel cancer screening should then be offered as a rolling programme.
- SystemOne should be utilised to auto-generate flags when men reach the age of 65 and become eligible for AAA screening.

² Health Survey for England 2004: The Health of Minority Ethnic Groups– headline tables at www.hscic.gov.uk

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

- The generation of quarterly reports detailing the age and ethnicity of those accessing national screening programmes (utilising SystemOne clinical reporting functionality) would enable evaluation of equality of access.

Primary Care

- A range of primary health care services are delivered to meet the needs of the prison population.
- Waiting times for routine care between July and December 2014 were as follows :-
 - GP: 6 to 15 days
 - Dentist: 4 to 6 weeks
 - Physiotherapy: 10 days
 - Podiatry: 10 to 35 days
 - Optician: 9 to 49 days
 - Nurse triage: 1 to 2 days
 - Sexual Health: 7 days
- There is an experienced, directly-employed lead GP.
- There are two GP clinics each weekday morning (providing 36 appointments) and one GP clinic (providing 14 appointments) each weekday afternoon from Monday to Thursday.
- In addition, a GP is available to cover evening receptions from 18:00 to 21:00 from Monday to Friday and there is an IDTS clinic on Saturdays for receptions received from court.
- A range of nurse clinics are delivered from the health centre and from wing based treatment rooms.
- Nurse clinics include: well-man clinics, general clinics, INR clinic, vaccination clinic, older prisoners clinic, diabetes clinic, asthma clinic, COPD clinic, respiratory rehabilitation and wound clinics, as well as IDTS and mental health clinics.
- There is an overall DNA (did not attend) rate of 42% (calculated over 6 months for GP, Optician, Dentist, Physiotherapy and podiatry)
- The Healthcare Director has already implemented actions to reduce DNAs.
- A continued rigorous approach to DNA management is required and a number of additional recommendations have been made to support this.
- As access targets are currently met despite high DNA rates, a robust DNA management policy could further reduce waiting time, improve access and create financial efficiencies through a reduction in the number of commissioned sessions required for some services.

Management of Physical Disease and Long Term Conditions

- There is a designated nurse with responsibility for the management of Long Term conditions.
- Asthma, Diabetes, COPD and Respiratory Rehabilitation clinics are held regularly.
- The reported prevalence of asthma (12.6% from SystemOne data) is much higher than national prevalence of 5.9%³ and also higher than prevalence estimates in the Birmingham toolkit (7%).

³ Asthma prevalence by CCG area

<http://fingertips.phe.org.uk/search/ASTHMA#gid//pat/44/ati/19/page/0/par/E4000002/area>

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

- The prevalence of diabetes (4.6%) at HMP Birmingham is lower than national expected prevalence (6%)⁴, although higher than the estimated prevalence of 3.1% in the 2010 HNA.
- The prevalence of epilepsy (1.8%) is almost twice the national prevalence of 9.7 per 1,000 (0.97%)⁵.
- The prevalence of obesity (7.5 %) is significantly below national prevalence (23%)⁶.
- The QOF 'How Am I Driving?' report suggests that 21% of asthmatics have had an asthma review in the last 12 months. With the rapid churn of the prison it may be that a proportion of prisoners are released prior to reviews being undertaken, however it should be ensured that all activity is READ coded and captured accurately to reflect the work being undertaken.
- A local READ code formulary should be developed and READ codes assigned to screening templates, diabetes clinic templates and free text consultations that differentiate between type I and type II diabetes.
- It should be ensured that all activity associated with the review of Long Term Conditions Is READ coded appropriately to accurately reflect activity undertaken.
- Plans to conduct diabetic retinopathy screening on site should be pursued to ensure accessibility and uptake and also reduce unnecessary hospital escorts.

Communicable Disease

- There are weekly nurse led sexual health clinics.
- Most recent available data suggests Hepatitis B vaccination coverage of 30%, however, it is suggested that this does not accurately reflect actual activity and that true vaccination levels are higher than this.
- Recommendations have been made to support accurate data collection.
- The prison has an outbreak plan that has been shared with Public Health England.

Physical Disability

- Data capture regarding physical disability is poor and it is suspected that physical disability is under-reported.
- A local SystemOne READ code formulary should be developed and screening templates background coded to ensure all data regarding disability is accurately recorded.

Lifestyle, Health Promotion and Well-being

- The screening process and services delivered assist prisoners in identifying key lifestyle issues.
- There is a whole prisons health promotion action plan and regular health promotion events are held.
- There is an opportunity to increase service user and family and carer engagement in health promotion activity. It is recommended that a designated member of the primary care team is identified to link with the visitors centre to develop an innovative and inclusive health promotion programme that maximises service user and family/carers engagement.

⁴ APHO Diabetes Prevalence model England Male over 16 at www.yhpho.org.uk/default.aspx?RID=81090

⁵ Joint Epilepsy Council, 2005. Epilepsy prevalence, incidence and other statistics. <https://www.epilepsy.org.uk/> Accessed 23.01.15

⁶ www.yhpho.org.uk/

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

Mental Health

- Mental health services are provided by Birmingham and Solihull Mental Health Trust.
- The mental health services offered are comprehensive and well managed. The prison has the facilities and range of experienced staff required to appropriately manage some very challenging clients.
- The team provides primary mental health, secondary mental health, dual diagnosis and forensic mental health services and liaise extensively with other health and justice mental health and diversion services.
- During the 12 months from 1st July 2013 to 30th June 2014, 1,500 new mental health assessments were undertaken (an average of 125 assessments per month).
- During the same period, the secondary care caseload ranged from 77-124 patients per month, with an average monthly caseload of 112 clients.
- A total of 1505 patients were managed via CPA (Care Programme Approach) – including patients located on the inpatient ward.
- The Mental Health First Aid Training (MHFA) planned for officers and health champions should be progressed.
- The visitors centre at HMP Birmingham is very proactive and their expertise could be leveraged to widen the audience for key mental health awareness messages. Opportunities for additional funding to include families and carers in mental health first aid training should be explored.

Learning Disability & Autistic Spectrum Disorders

- There are significant gaps in the identification, referral, assessment and support of prisoners with learning disabilities and Autistic Spectrum Disorders.
- A number of recommendations have been made regarding this, some of which will be carried forward to regional recommendations.

Substance Misuse

- From April 2013 to April 2014, a total of 2,350 receptions commenced new drug treatment episodes.
- Of the total new treatment entrants, 58.26% (n=1326) were opiate users, 13.4% (n=306) were non-opiate new treatment entrants and 28.3% (n=644) were primary alcohol new treatment entrants.
- For all treatment groups the most common treatment combination was clinical and non-clinical structured intervention (70% opiate users, 46% non-opiate users and 49% primary alcohol users).
- Heroin was cited as the primary drug of use by 40.34% (n=809) of men, followed by alcohol (28.5% n=572).
- Clinical substance misuse services are delivered by the IDTS team and psychosocial services by DART (Drug and Alcohol Recovery Team).
- The teams work closely together but opportunities exist for further integration and joint working.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

- It is recommended that the implementation of electronic prescribing via SystmOne is considered and that all prescribers utilise this single electronic prescribing system as there is an inherent clinical risk when multiple prescribers (e.g. Primary care GPs, Substance Misuse, Psychiatry) separately prescribe. This has been evidenced in several Death In Custody reviews where poly-pharmacology is cited as a causative factor.
- A process mapping exercise should be undertaken to identify and remove duplication in IDTS and DART pathways.
- Advice should be sought from service providers Corporate Information Governance Teams regarding DART staff having access to SystmOne, enabling the use of one electronic patient record to facilitate patient centred joint care planning approaches.
- Development of a recovery wing to support men post detoxification should be explored by IDTS and DART services in liaison with Commissioners and the prison provider.
- The service should continue to liaise closely with prison colleagues regarding the use of New Psychoactive Substances (NPS) and the misuse of prescribed medications, ensuring that appropriate information sharing and intelligence sharing policies are in place to facilitate a cohesive approach to creating a safer substance environment.

Planned & Unplanned Secondary Care

- The healthcare department are currently allocated 5 appointment slots per week day for hospital escorts.
- There are three escort slots in the morning and two in the afternoon.
- It was reported that on occasions the team struggle to manage the number of patient appointments required within the number of escort slots available.
- The highest number of specifically identified escorts were for x-rays (n=46).
- Projected figures suggest approximately 184 appointments per year for x-rays.
- At the time of writing this report, HMP Birmingham had begun to utilise on site x-ray facilities supported by radiography staff from Birmingham City Hospital and have already seen a marked reduction in the number of hospital escorts.
- Dialysis, Accident & Emergency, Ultrasound and Fracture Clinic were also specialities accounting for higher numbers of escorts.
- Outpatient visits to the most frequently accessed specialities combine to account for approximately 49.48% of all appointments. Rigorous targeting of reduction of escorts in these areas could significantly reduce numbers and costs and improve patient experience.
- The healthcare department should liaise with Birmingham City Hospital to enable pre-operative assessments to be conducted by nursing staff at the prison.
- The potential for undertaking minor oral surgery procedures on site should be explored.
- An on-site x-ray facility has recently become operational. It is recommended that consideration is given to expanding this to incorporate ultrasound scans.
- Telemedicine has significantly reduced hospital escorts within the North East Cluster of prisons. It is recommended that Commissioners undertake a regional cost-benefit analysis for the introduction of telemedicine facilities. This is discussed further in the regional analysis.
- At HMP Birmingham, a combination of on-site x-ray and telemedicine consultations could be used to reduce fracture clinic and orthopaedic appointments.

- Unplanned visits to hospital (Accident & Emergency) should be analysed and a training needs analysis undertaken to identify training that would support on site management - for example minor illness / injuries training, suturing wound adhesions etc.

A full list of recommendations made can be found in section 22 of the HNA report.

Table of Contents

Acknowledgements.....	2
Foreword.....	3
Executive Summary.....	4
1. HMP Birmingham - Prison Population & Demographics	15
1.1 Age	15
1.2 Nationality.....	16
1.3 Ethnicity	16
1.4 Length & Type of Sentence	17
1.5 Movements In & Out of Prison	18
1.6 Key Findings – Population & Demographics	21
2. Overview of Health Services Provided.....	23
3. Facilities & Resources.....	24
3.1 Primary Care Nursing and Medical Resources.....	24
3.1 Outpatient Areas.....	25
3.2 Inpatients	26
3.3 Recommendations: Facilities	27
4. Screening.....	28
4.1 Reception Screening	28
4.2 National Screening Programmes	30
4.2.1 Abdominal Aortic Aneurysm (AAA) Screening	30
4.2.2. Bowel Cancer Screening	30
4.2.3 NHS CVD Risk Screening	30
4.3 Recommendations: Screening	31
5. Primary Care Clinics	32
5.1 GP Clinics.....	32
5.2 Nurse Clinics.....	32
5.3 Physiotherapy	33

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

5.4 Optician	33
5.5 Podiatry	34
5.6 Dentist	34
5.7 Appointments Lost to None-Attendance	35
5.8 Recommendations: Clinics	35
6. Prevalence of Physical Disease and Conditions	37
6.1 Asthma	37
6.2 Diabetes	38
6.3 Epilepsy	39
6.4 Obesity	40
6.5 Hypertension / CVD	42
6.6 Recommendations – Physical Health	42
7. Communicable Diseases	43
7.1 Tuberculosis	43
7.2 Hepatitis	43
7.3 Recommendations	44
8. Sexual Health	45
9. Physical Disability	46
10. Health Promotion and Well-being	46
10.1 Health Promotion	46
10.2 Smoking	46
10.3 Weight Management	47
10.4 Physical Exercise	47
10.5 Recommendations – Health Promotion and Well-being	47
11. Social Care Needs	47
11.1 Recommendation – Social care	48
12. Mental Health	49
12.1 Integrated Mental Health Services	49
12.2 Screening and Referral	50
12.3 Inpatient Care	51
12.4 Forensic Psychiatry	53
12.5 Transfers under Mental Health Act	53
12.6 Recommendations: Mental Health	55

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

13. Learning Disabilities & Autistic Spectrum Disorders.....	55
13.1 Recommendations: Learning Disabilities and Autistic Spectrum Disorder	56
14. Substance Misuse	58
14.1 Substance Misuse Services	58
14.2 Substance Misuse Need	59
14.3 Services Delivered to Meet Need	60
14.1 Stakeholder feedback	62
14.3 Recommendations Substance Misuse	67
15. Planned and Unplanned Secondary Care	68
15.1 Recommendations – Planned and Unplanned Secondary Care	70
16. Stakeholder Analysis	71
16.1 Methodology.....	71
16.2 Questionnaires.....	71
16.3 Qualitative feedback.....	73
16.4 Visitor Questionnaires	75
16.5 Recommendations: Stakeholder Feedback	78
17. Independent Scrutiny.....	79
18. Compliments and Complaints.....	80
19. Incidents & Serious Untoward Incidents	80
20. Deaths In Custody	81
21. Local Summary and Gap Analysis.....	82
22. Local recommendations.....	83
Appendix 1	92

Table of Figures

Figure 1 Age Distribution of Population 30 th June 2013-31 st December 2014	15
Figure 2 First Receptions 2013-September 2014.....	19
Figure 3 Sentenced Receptions September 2013 to September 2014.....	19
Figure 4 GP Clinics.....	32
Figure 5 Physiotherapy Clinics	33
Figure 6 Optician Clinics.....	33
Figure 7 Podiatry Clinics.....	34
Figure 8 Dental Clinics.....	34
Figure 9 Summary of Appointments Lost to Non-Attendance	35
Figure 10 Asthma: October 2013 to March 2014	37
Figure 11 Diabetes: October 2013 – March 2014.....	38
Figure 12 Epilepsy: October 2013 – March 2014.....	39
Figure 13 Obesity: October 2013 - September 2014	40
Figure 14 Hypertension/CVD October 2013 - March 2014.....	42
Figure 15 Hepatitis B & C Screening Uptake	43
Figure 16 HIV Testing (Source: HMP Birmingham HJIP spreadsheet).....	44
Figure 17 Sexual Health Clinics (Source: HMP Birmingham HJIP spreadsheet).....	45
Figure 18 National and Regional Prevalence of Sexually Transmitted Infections	45
Figure 19 Mental Health Services Staff Resources	50
Figure 20 Time from First Assessment to Transfer under MHA	54
Figure 21 IDTS & DART Staff Resources	58
Figure 22 Substance Use April 13-April 14 (Source: Adult Prisons Quarterly Treatment Report).....	59
Figure 23 Age of Respondents DART Questionnaires.....	62
Figure 24 Respondents Receiving Prescribed Medicines for Drug and Alcohol Problems	63
Figure 25 Respondents Reporting Problems with Access to Medication	63
Figure 26 Drug and Alcohol Services – Frequency of Access.....	64
Figure 27 Respondents Perception of Information Received about Substance Misuse Services.....	65
Figure 28 Service User Comments Drug and Alcohol Services	65
Figure 29 Appointments by Speciality 2014	69
Figure 30 HMP Birmingham General Questionnaires Age of Respondents	71
Figure 31 HMP Birmingham General Questionnaires Length of Sentence of Respondents	71
Figure 32 HMP Birmingham General Questionnaires Information about Healthcare Services	72
Figure 33 HMP Birmingham Service User Perception of Quality of Services	72
Figure 34 HMP Birmingham Comments from General Questionnaires	73
Figure 35 Visitors Questionnaire Frequency of Visits.....	75
Figure 36 Visitors Questionnaire Relationship to Service User	75
Figure 37 Visitor Questionnaires Perception of Healthcare Services	76
Figure 38 Visitor Questionnaires Perception of Information about Healthcare Services	76
Figure 39 Comments from Visitors	78
Figure 40 Incidents and Serious Untoward Incidences.....	80

Table of Abbreviations

AAA	Abdominal Aortic Aneurysm
ACCT	Assessment, Care, and Custody Teamwork
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autistic Spectrum Disorder
BME	Black Minority Ethnic
BMI	Body Mass Index
CBT	Cognitive Behavioural Therapy
CHD	Chronic Heart Disease
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care
CQC	Care Quality Commission
CQUIN	Care Quality
CVD	Cardio Vascular Disease
DART	Drug and Alcohol Recovery
DIP	Drug Interventions Project
DNA	Did Not Attend
DRSS	Diabetic Retinopathy Screening Service
EBW	Escorts and Bedwatches
EDR	Expected Date of Release
ENT	Ears Nose and Throat
GP	General Practitioner
HMIP	Her Majesty's Inspectorate of Prisons
HMPS	Her Majesty's Prison Service
HNA	Health Needs Assessment
INR	International Normalised Ratio
IPC	Infection Prevention and Control
LTC	Long Term Conditions
MASH	Multi Agency Safeguarding Hub
MHA	Mental Health Act
MHFA	Mental Health First Aid
MOJ	Ministry of Justice
MSK	Musculo-Skeletal
NHS	National Health Service
NICE	National Institute for Care and Health Excellence
NPS	New Psychoactive Substances
PALS	Patient Advice and Liaison Service
PHE	Public Health England
QOF	Quality Outcomes Framework
RGN	Registered General Nurse
RMN	Registered Mental Health Nurse
SCU	Separation and Care Unit
SSOPT	Staffordshire and Stoke-on-Trent Partnership NHS Trust
STI	Sexually Transmitted Infection
TAG	Threshold Assessment Grid
UDA	Units of Dental Activity

1. HMP Birmingham - Prison Population & Demographics

HMP Birmingham is a Victorian local prison which holds adult male convicted and un-convicted prisoners, with an operational capacity of 1450. The prison serves the Birmingham court circuit - the Crown and Magistrates’ Courts of Birmingham, Shrewsbury and Telford, along with the Magistrates’ Courts of Burton, Cannock, Lichfield, Rugeley, Sutton Coldfield and Tamworth. The primary role of HMP Birmingham is to hold remand and trial prisoners. These are category B and C prisoners as well as a small population of retained category D prisoners.

In 2004 the prison underwent a period of considerable change as a result of a multi-million pound investment program by the Prison Service. HMP Birmingham now comprises of 12 wings: a detoxification unit, first night centre, vulnerable prisoner unit, social care unit and 6 residential units (one unit housing vulnerable and at risk prisoners, one unit holding category C prisoners and enhanced regime category B prisoners and four residential units of mixed prisoners). There is a healthcare unit with inpatient wards for both physical and mental health.

HMP Birmingham was the first public sector prison to be transferred into the private sector estate and is currently contracted to G4S Care and Justice Services until 2026.

The narrative in the section below is based upon statistics provided by the Analytical Services Directorate, Ministry of Justice (MOJ).

Within the population data provided, asterisks denote where numbers fall below 5 and data has been suppressed for confidentiality reasons.

In providing this data, the Analytical Services Directorate state that figures have been drawn from administrative IT systems which, as with any large scale recording system, are subject to possible errors with data entry and processing.

At the time of undertaking this Health Needs Assessment there were 1391 prisoners in the establishment.

1.1 Age

Figure 1 Age Distribution of Population 30th June 2013-31st December 2014

Population by Age Group	30 Jun 2013	30 Jun 2014	31 Dec 2014
18-20	0	0	0
21-24	270	263	210
25-29	316	324	313
30-39	468	494	520
40-49	229	235	226
50-59	64	77	89
60 +	38	40	33
All	1,385	1,433	1,391

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
 HMP Birmingham : Final Version April 2015

In December 2014, there were 1,391 men serving at HMP Birmingham. Of these men, 38% (n=523) were between the age of 21-29 years old and 37% (n=520) were between the ages of 30-39 years old.

A quarter of the prison population were over the age of 40.

Less than 3% of men were 60 years or older.

This figures compare similarly to those provided in June 2013 when 42.3% (n=586) were between the age of 21-29 years old, 33.8% (n=468) were between the ages of 30-39 years old and less than 3% of men (n=38) were 60 years or older. The number of prisoners over the age of 40 has risen marginally by 1.2%.

1.2 Nationality

Figure 2 Population by Nationality 30th June 2013-31st December 2014

Population by Nationality	30 Jun 2013	30 Jun 2014	31 Dec 2014
Not Recorded	15	26	*
Foreign National	224	197	*
UK National	1,146	1,210	1,225
All	1,385	1,433	1,391

In December 2014, 88% (n=1,225) of the prison population were UK Nationals. Data for the number of foreign nationals serving at HMP Birmingham has been suppressed due to low numbers and therefore identifies the percentage of foreign nationals serving in the prison as significantly lower than the current national prison average (13%⁷).

1.3 Ethnicity

Figure 3 Population by Ethnicity

Population by Ethnicity	30 Jun 2013	30 Jun 2014	31 Dec 2014
Unrecorded	*	15	*
Asian or Asian British	236	220	226
Chinese or Other	30	20	*
Black or Black British	173	176	181
Mixed	81	74	88
Not Stated	*	51	30
White	860	877	851
All	1,385	1,433	1,391

⁷ Ministry of Justice Statistics at <https://www.gov.uk/government/publications/offender-management-statistics-quarterly>
 Accessed 03.01.15

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

On 31st December 2014, 61% (n=851) of the prison population at HMP Birmingham were White, 16% (n=226) Asian or Asian British and 13% (n=181) Black or Black British.

These figures compare very similarly to those recorded in June 2013, when 62.1% (n=860) of the prison population at HMP Birmingham were White, 17% (n=236) were Asian or Asian British and 12.5% were Black or Black British. There was an increase in the amount of prisoners whose ethnicity was ‘Not Stated’.

The percentage of Black / Black British men is above the national prison average of 11% and disproportionate to the 2.8% of Black Britons in the general population.

The percentage of Asian / Asian British prisoners (17%) is much higher than the national prison average of 6%.

Ethnicity and health is reviewed in Report 1 of this series, however key facts from the Health Survey for England 2004⁸ report that:-

- South Asian people living in the UK (people from India, Pakistan, Bangladesh and Sri Lanka) have a higher premature death rate from CHD (46% higher for men; 51% higher for women)
- Among minority ethnic groups, the prevalence of angina and heart attack was highest in Pakistani men and Indian men and women, and lowest in Black African and Chinese ethnicities.
- The prevalence of angina was highest in Pakistani men (30.9%)
- Black Caribbean men had the highest prevalence of stroke (11.5%)
- Black African, Black Caribbean, Indian, Pakistani and Bangladeshi men aged 35-54 had higher prevalence of type 2 diabetes than the general population.

1.4 Length & Type of Sentence

Figure 4 Population by Sentence Length 30th June 2013-31st December 2014

Population by Sentence Length	30 Jun 2013	30 Jun 2014	31 Dec 2014
Less than or equal to 6 months	176	169	148
More than 6 months to 12 Months	61	55	56
More than 12 months to 4 years	307	358	325
More than 4 years to less than life	195	196	210
Indeterminate	44	31	24
Recalls	117	95	112
All	900	904	875

In December 2014, 23% of prisoners at this establishment were serving 12months or less, 37% were serving sentences of more than 12 months to 4 years, 24% more than 4 years to less than life and 3% indeterminate sentences. 13% of prisoners were licence recalls.

⁸ Health Survey for England 2004: The Health of Minority Ethnic Groups– headline tables at www.hscic.gov.uk

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

This data compares similarly to that provided for June 2013, when 34.1% (n=307) of prisoners were serving sentences of more than 12 months to 4 years, 26.4% (n=176+61) were serving 12 months or less and 21.7% (n=195) more than 4 years to less than life.

Exactly the same percentage of prisoners (13%, n=117) were licence recalls, however, prisoners serving indeterminate sentences had risen by almost 2% (n=44, June 2013).

Figure 5 Population by Sentence Type 30th June 2013-31st December 2014

Population by Sentence Type	30 Jun 2013	30 Jun 2014	31 Dec 2014
Remand	445	512	500
Sentenced	907	910	883
Non-criminal	33	11	8
All	1,385	1,433	1,391

In both June 2013 (65.4%, n=907) and December 2014 (63.4%, n=883), the majority of the prison population at HMP Birmingham were sentenced male prisoners.

However, there has been an increase in the percentage of remand prisoners from 32.1% (n=445) in June 2013 to 36% (n=500) in December 2014.

There were significantly more prisoners serving non-criminal sentences in June 2013 (2.4%, n=33) than in December 2014 when this group accounted for less than 1% (n=8) of the prison population.

1.5 Movements In & Out of Prison

As a busy local remand jail, HMP Birmingham has a high throughput or ‘churn’ of prisoners coming in and out of the prison.

The figures below illustrate movements in and out of the establishment.

Ministry of Justice figures are incomplete for the months of April, May and June. However, on average there were approximately 540 receptions per month, equating to approximately 6,480 receptions per year.

The ‘churn’ of a prison is the phrase used to describe the population turnover, or the number of times each place within the prison is used in a year.

HMP Birmingham: Total number of receptions per year ÷ operational capacity = 6480 ÷ 1450 = **4.47**

This is useful when considering health needs. Activity required to meet the needs of the current population provides a snapshot of healthcare activity, however, it is essential to remember that in busy prisons with a high turnover, this is multiplied several times over due to the churn.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

Figure 2 First Receptions 2013-September 2014

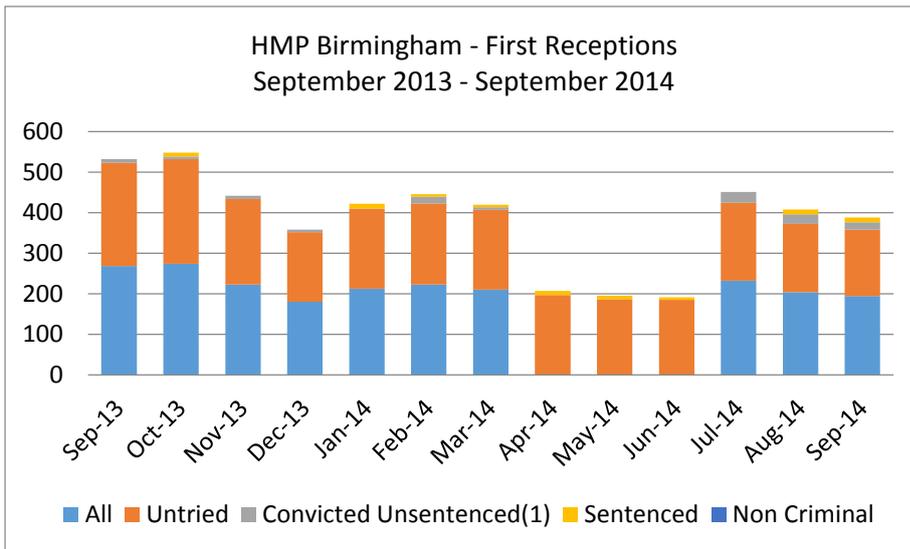


Figure 3 Sentenced Receptions September 2013 to September 2014

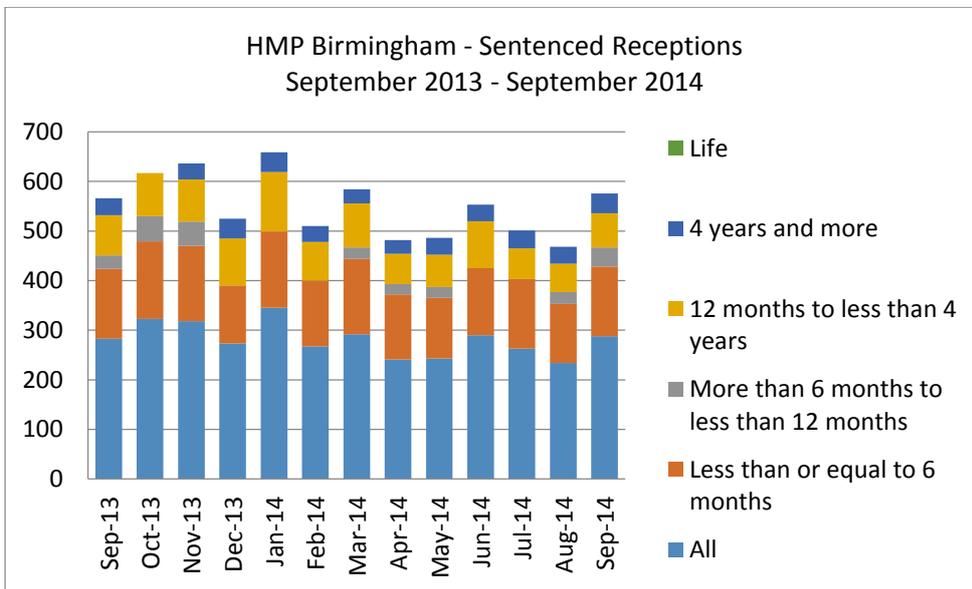
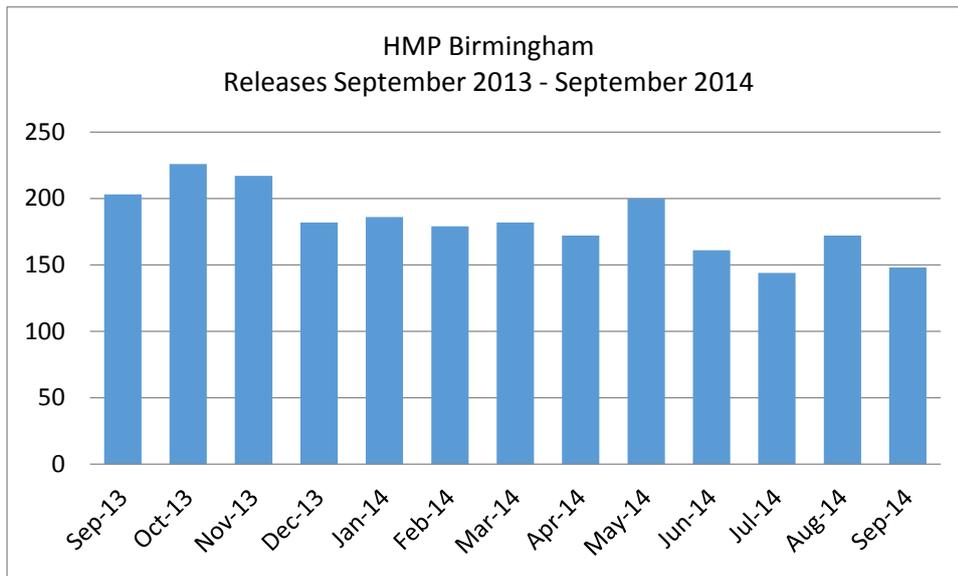


Figure 6 Releases September 2013-September 2014

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015



There were 2372 releases in the 13 month period reviewed, giving a mean average of 182 releases per month.

The number of releases per month ranged from 144 in July 2014 to 226 in October 2013.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

1.6 Key Findings – Population & Demographics

HMP Birmingham has an operational capacity of 1450, and a high population turnover suggesting a churn of 4.5 times per year.

Approximately three quarters of the population are serving sentences of less than 4 years, with 23% serving less than 12 months, providing a short window of opportunity for healthcare engagement.

Efficient reception screening and processes for rapid referral and meeting of immediate healthcare needs is therefore essential.

At the time of undertaking the HNA, 38% (n=523) of the population were between 21-29 years old and 37% (n=520) were between 30-39 years old.

A quarter of the prison population were over the age of 40 (and therefore of the age for which NHS CVD risk assessment screening is recommended).

Less than 3% of men were 60 years or older.

88 % of men at HMP Birmingham are UK nationals.

On 31st December 2014, 61% of the prison population was of White ethnicity.

The percentage of Black / Black British men (13%) is higher than the national prison average of 11% and disproportionate to the 2.8% of Black Britons in the general population.

The percentage of Asian / Asian British prisoners (16%) is much higher than the national prison average of 6%.

The Health Survey for England 2004⁹ indicates increased risk and prevalence of Long Term Conditions in Black and Asian minorities, impacting on the health needs of the population at HMP Birmingham.

In addition, the 2014 Public Health Profile for Birmingham¹⁰ suggests:-

- Birmingham is significantly worse than the England average for deprivation, statutory homelessness, violent crime and long term unemployment.
- The health of people in Birmingham is generally worse than the England average.
- Deprivation is higher than average and life expectancy for both men and women is lower than the England average (8.4 years lower for men in the most deprived areas of Birmingham than in the least deprived areas).
- The rate of alcohol related harm hospital stays is worse than the average for England (6,327 per year), as is the rate of self-harm hospital stays (2,295 per year).

⁹ Health Survey for England 2004: The Health of Minority Ethnic Groups– headline tables at www.hscic.gov.uk

¹⁰ Public health profiles at <http://www.apho.org.uk/resource> Accessed 14.01.15

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

- The rate of smoking related deaths, hip fractures, Sexually Transmitted Infections and TB are also worse than average.
- Estimated levels of adult physical activity are worse than the England average, with almost a quarter (23%) of the adult population classed as obese.
- Estimated levels of adult smoking are better than the England average¹¹.

Overall the population profile suggests that within this busy prison there will be a high volume of complex health needs requiring significant resource and activity to meet needs and reduce and redress health inequalities.

¹¹ <http://www.apho.org.uk/resource/item.aspx?RID=50321>

2. Overview of Health Services Provided

At HMP Birmingham a range of on-site healthcare services are provided, with clinics delivered on an 'outpatient' basis from the healthcare centre, reflecting a community delivery service model.

There is 24 hour nursing presence, including an emergency response for incidents occurring within the prison that require attendance from a healthcare professional.

There are also two inpatient wards. Ward 1 is for patients requiring physical health care and Ward 2 for patients with mental health needs.

Primary healthcare is provided through Birmingham and Solihull Mental Health Foundation NHS Trust and Birmingham Community NHS Trust.

Clinical Substance Misuse services (IDTS) are provided by Birmingham & Solihull Mental Health NHS Foundation Trust. Psychosocial Services are provided by the South Stafford and Shropshire NHS Foundation Trust Drug & Alcohol Recovery Team (DART).

Mental Health In-Reach services are delivered by Birmingham and Solihull Mental Health Foundation NHS Trust.

Clinic utilisation is managed, monitored and reviewed via the appointments reporting functionality on SystemOne and reported via monthly performance dashboards which are shared with Commissioners.

In order to provide evidence for Health & Justice Performance Indicators, the data currently collated on a monthly basis requires expansion and recommendations have been made regarding this at relevant points throughout the report.

3. Facilities & Resources

3.1 Primary Care Nursing and Medical Resources

Staff resources are outlined in the table below.

Figure 7 Primary Healthcare Staff Resources

HMP Birmingham Primary Healthcare Staff Resources	
Job Title	WTE currently in post
Acting head of primary care.	1
GP	2.5
Primary Care team leader	1
Ward manager	1
Senior staff nurse	6
Staff Nurse	19

There is 24 hour nursing presence at the prison.

Primary care nurses are based on B3 and this is a central location.

There is a designated emergency response nurse who carries a prison radio at all times.

There are two general nurses (RGNs) on duty on Ward 1 during the day and one nurse on a night.

Mental health nurses work from the healthcare centre and Ward 2. There are two mental health nurses (RMNs) on Ward 2 during the day and one on a night.

IDTS and DART work from the healthcare centre and B wing (see section 14 of report).

It was reported that there had been a number of vacancies at the beginning of the year, resulting in a high reliance on agency and temporary staff. However, a sustained recruitment campaign has resulted in all vacancies being filled and the staffing structure is now stable. Whilst acknowledging the challenges of working within secure environments, all staff met during the site visit were very positive and enthusiastic about the services that they deliver and about working within health and justice.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
 HMP Birmingham : Final Version April 2015

3.1 Outpatient Areas

Figure 8 Healthcare Facilities Outpatient areas: Healthcare centre - Ground Floor

Healthcare Facilities Outpatient Areas: Healthcare Centre - Ground floor		
Area	No. of rooms	Comments
Reception area/ reception office	1	Access to 3 x computers/printers
Staff offices / work areas	2	2 staff offices – 1 housing 5 staff members and 1 housing 2 staff members. All fully equipped with computers and printers.
Consulting rooms	6	Access to computers/printers in each room.
Patient waiting rooms	2	Toilets available within waiting area
Patient toilet facilities	2	See above
Dental Suite	2 + 1	X 2 dental rooms one being the contamination room. X 1 shared room with B3 nurses – all have access to computers and printers except for the contamination room.
Pharmacy		See Healthcare 2 nd floor
Medicines administration areas (Healthcare centre medicines hatches or treatment rooms)	6	These are also referred to as consulting rooms.
Others (please specify)	4	Server room Clinical waste store room Admin/Stationary store room Domestic store room.

There is only one nurse consulting room in the reception area. The room is carpeted but there are plans to replace flooring and refurbish the room to a clinical consulting room standard. In addition, IDTS nurses see men at tables / booths that are set up daily on the first night centre, lacking privacy and confidentiality.

Figure 10 Healthcare Facilities Outpatient Areas: Healthcare centre - First floor

Healthcare Facilities Outpatient Areas: Healthcare Centre - First floor		
	No. of rooms	Comments
Staff offices / work areas	2	2 staff offices – 1 housing Head of Healthcare, other houses PA to Head of Healthcare and G4S Healthcare Manager Computer and Printer access.
Staff rest room	1	With suitable facilities
Staff wash/ toilets	3	Male, female and disabled

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
 HMP Birmingham : Final Version April 2015

Healthcare Board room	1
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Figure 11 Healthcare Facilities Outpatient Areas: Healthcare Centre - Second Floor

Healthcare Facilities Outpatient Centre: Second floor		
Areas	No. of rooms	Comments (e.g. access to computer, equipment, space etc.)
Staff offices / work areas	3	1x Community Mental Health team office with PCs and printer 1x Medics office for 2x staff with PCs and printers 1x Mental Health Manager office for 2x staff with PCs and printers
Pharmacy department	3	Computer and printers

The pharmacy facilities lack work bench space and requires refitting to make optimum use of the space available. There is only one SystemOne computer in the pharmacy and no contingency should there be a systems or hardware problem.

Figure 12 Healthcare Facilities Outpatient Areas: Wing Based Rooms / Other Facilities

Wing Based Rooms / Other Facilities		
	No. of rooms	Comments
Wing based medicines administration areas / treatment rooms	11 areas (exc wards)	Most have access to computers and printers, except J wing/P wing treatment has no computer access.
Wing based consulting rooms	9	Some of these consulting rooms double up for administration of medications. On G, J & P there is no computer access
Wing based group rooms	9	Health staff can access prison group rooms on request
Wing based healthcare offices	2 (B3)	1 of these rooms is shared with the dental team

Prisoners have access to electronic 'kiosks' on the wings, through which they can request healthcare appointments. Healthcare administrators have access to the system (N-Force) and can access requests, allocate times and complete notification slips informing men of their appointments.

3.2 Inpatients

A separate review of the use of Inpatient Units across prisons in the West Midlands Cluster is being conducted in parallel to the Health Needs Assessments, and therefore specific detailed analysis of the use of the Inpatient Unit is not detailed within this report.

There are two inpatient wards at HMP Birmingham – one for physical health and the other for mental health patients. The mental health ward facilities are described separately in section 12. 3 of the HNA report.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
 HMP Birmingham : Final Version April 2015

Figure 12 Inpatient Unit: Ward 1 - First floor

<i>Inpatient Unit: Ward 1 - First floor</i>		
	No. of Rooms	Comments
Single cells	15	<i>3 cells have non-fixed bed (NHS style)</i>
Double cells	0	
Gated cells	2	<i>Utilised as Constant Watch cell when required</i>
CCTV cells	0	
Safer cells	0	
Association room, patient dayroom	1	<i>Association area/dining area and recess area with TV</i>
Patient bathrooms	1	<i>1 communal shower block and 1 bath</i>
Patient toilets	1	<i>1 communal toilet plus each cell has its own toilet</i>
Facilities for those with physical disabilities / special adaptations	All	<i>Individual assessment of prisoner needs</i>
Palliative care facilities	1	<i>1 fully equipped cell</i>
Offices	0	
Medicines administration room	1	<i>Computer/printer access</i>
Consulting rooms	1	<i>Consulting room/group room</i>
Group rooms	1	
Patient waiting rooms	0	
Other (please describe)	3	<i>Nursing Station (computer/printer access) Domestic store room/kit room</i>

The Inpatient Unit has a total patient capacity of 15. All cells are single cells. The unit is adequately equipped to look after patients with a range of physical health needs.

3.3 Recommendations: Facilities

- The pharmacy work space requires refitting to optimise working space to accommodate the volume of work required.
- The nurses consulting room in reception requires upgrading to meet clinical standards.
- It is recommended that a review is undertaken of space available for IDTS & DART screening consultations to enable all consultations to be undertaken confidentially.

4. Screening

4.1 Reception Screening

All new receptions received into HMP Birmingham have an initial reception screen followed by a secondary health screen on the day after their arrival. Transfers in from other establishments also have a transfer health screen.

A process is in place to identify men who are unable to have a secondary screening assessment on the following day due to court appearances and arrangements are made to conduct secondary screening at the earliest opportunity.

The first night reception screening comprises the following:

Prisoner status

- Medical/psychiatric report status
 - Health information status
 - Prison history
 - Homelessness/no fixed abode history
 - Religion
 - Significant relationships
 - GP registration
- Current medication status
 - Doctor contact
 - Appointment status
 - Medication status
 - Current medication
 - Sensitivities and allergies
 - Special diet
- Diagnosis & history
 - Asthma status
 - Diabetes status
 - Epilepsy status
 - Chest pain status
 - Tuberculosis status
 - Sickle cell status
 - Diagnosed disability
 - Self-reported disability
- General observations
 - Prisoners physical appearance – body front and back, head and neck, abdomen
 - Physical injuries status
 - Physical health concerns
 - Health information patient thinks is important
 - Reasons to see a doctor
- Substance misuse

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

- Average weekly alcohol intake
- Weekly intake prior to custody
- Drug use history
- Specific drug use history
- Misuse in 28 days prior to custody and if so how much
- Intravenous drug use history
- Urinalysis
- Mental health
 - Psychiatric treatment history
 - Psychiatric admissions history
 - Psychiatric nurse/care work status
 - Mental health medications history
 - Self-harm history
 - Self-harm status
 - Impressions of behaviour and mental status
- Outcome of screening
 - Referral to doctor
 - Referral to nurse clinic
 - Referral to drugs service
 - Referral to CARAT
 - Referral for mental health assessment
 - Open ACCT
 - Fit for work and cell occupancy

Second reception screening comprises:

- Baseline observations
 - Height
 - Weight
 - Temperature
 - Peak flow rate
 - Urinalysis
 - Blood pressure
 - Family history
 - Cholesterol
- Immunisation status
 - Hepatitis B
 - Hepatitis C
 - Influenza
 - Meningitis C
 - BCG
- BBV
- Smoking status

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

- Sexual health concerns
- Wounds/skin
 - Any wounds
 - Any skin infections
- Mental health conditions
 - Medication
 - Self-harm/suicide risk
- Disabilities
- TB Screening
- MRSA
- Clostridium difficile

Referrals for identified needs can be made to G.P, substance misuse team, mental health, dentist, sexual health nurse, smoking cessation, optician and podiatrist and also to nurse based well man clinics.

Although the screening templates contain questions on physical disability, learning disability and sickle cell anaemia, they do not appear to capture this data through SystemOne READ codes. A recommendation has been made regarding this.

4.2 National Screening Programmes

4.2.1 Abdominal Aortic Aneurysm (AAA) Screening

- The NHS AAA screening programme offers an ultrasound scan to screen for abdominal aortic aneurysm to all men in the year of their 65th birthday.
- Screening has not yet commenced and a recommendation has been made regarding this.

4.2.2. Bowel Cancer Screening

- The NHS Bowel Cancer Screening Programme (NHSBCP) offers screening every two years to all men and women aged 60 to 69 and to people over 70 years old on request.
- At the time of the HNA there were 33 men eligible for screening.
- Bowel cancer screening has not yet been started and a recommendation has been made regarding this.

4.2.3 NHS CVD Risk Screening

- The NHS Health Check Programme is offered to everyone between the ages of 40 and 74 who has not already been diagnosed with CVD, diabetes, or Chronic Kidney Disease.
- Every five years a health check is offered which includes a CVD risk assessment (plus screening for diabetes and chronic kidney disease in high risk groups); an assessment of physical activity and of alcohol consumption and an assessment for dementia in those aged 65-74.
- A person's 10 year CVD risk should be assessed using the QRISK[®]2 assessment tool and advice and support provided to reduce CVD risk (lifestyle measures such as weight loss, smoking cessation, healthy eating and physical activity).
- Statin treatment should be offered for the primary prevention of CVD to people with an estimated 10 year CVD risk of 10% or more if lifestyle interventions have not proved effective.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

- Screening has not yet commenced at HMP Birmingham. However, the healthcare team have been liaising with Public Health England and planning to introduce screening in the near future. On 21st April 2015, PHE are providing training for staff in the completion of the QRISK[®]2 assessment tool.
- Patients identified as moderate to high risk by the risk assessment tool will be referred to the GPs for consideration of prescribed statins and / or antihypertensive medication if indicated.
- The Long Term Conditions nurse is currently in the process of mapping the current reception screening process against CVD risk assessment questions to identify the most efficient way of introducing the screening programme.
- CVD risk screening will be offered to those under 40 identified as being of potentially higher risk.

4.3 Recommendations: Screening

- The current reception screening template should be reviewed and back ground READ codes assigned to ensure that all data is captured and able to be reported through the SystmOne reporting functionality.
- SystmOne and the reception screening template should be utilised to identify patients eligible for Abdominal Aortic Aneurysm screening, Bowel Cancer screening and NHS CVD Risk national screening programmes.
- Aligned with HJIP reporting requirements, SystmOne READ codes should be allocated within a local READ code formulary to assign when the above screening is offered, accepted or declined and negative or positive results recorded. This will provide local evidence of implementation of screening programmes and may also contribute to regional and national data sets.
- All men eligible for bowel cancer screening should be identified through SystmOne clinical reporting function and an awareness programme and screening `catch up` programme launched to ensure all those eligible have been offered screening.
- Bowel cancer screening should then be offered as a rolling programme.
- Many elements of CVD screening for over 40's are already incorporated into the screening template. A mapping exercise should be undertaken to identify any additional referral prompts required to ensure initial and CVD risk screening dovetail and are undertaken as efficiently as possible and without unnecessary duplication of effort. A rolling programme of screening should utilise healthcare assistants and health trainers to provide lifestyle advice and information.
- SystmOne should be utilised to auto-generate flags when men reach the age of 65 and become eligible for AAA screening.
- All patient records should detail NHS numbers to facilitate inclusion and continuation of national screening programmes.
- The generation of quarterly reports detailing the age and ethnicity of those accessing national screening programmes (utilising SystmOne clinical reporting functionality) would enable the evaluation of equality of access.

5. Primary Care Clinics

5.1 GP Clinics

Figure 4 GP Clinics

G.P clinics	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Number of patients expected to be seen	840	756	919	945	739	820
Number of patients actually seen in clinic	579	536	678	660	502	582
Clinic utilisation (%)	69	71	74	70	68	71
Waiting time for routine care (days)	No data	9	6	12	15	7
Contracted sessions	100	83	62	64	62	No data
Delivered sessions	100	83	62	64	62	No data
Cancelled sessions						

- There are two GP clinics each weekday morning (36 appointments available) and one GP clinic (14 appointments) each weekday afternoon from Monday to Thursday.
- In addition, a GP is available to cover evening receptions from 18:00 to 21:00 Monday to Friday and there is an IDTS clinic on Saturdays for receptions received from court.
- There is an experienced, directly-employed Lead GP.
- GPs visit the Care and Separation Unit each day and are available for medical emergencies occurring in the prison within working hours.
- Out of Hours services are provided by Badger, a local GP social enterprise.
- Between July and December 2014, a total of 3,537 GP appointments were delivered, giving a mean average of 590 appointments per month.
- Clinic utilisation ranged from 68% to 74%, with an average monthly utilisation of 70%.
- Waiting times for routine appointments ranged from 6 to 15 days.
- At the time of the HNA, the next available routine appointment was in 5 days.
- Patients requiring urgent appointments were seen on the same or next working day.
- Over the six months reviewed, a total of 1,482 appointments were lost to none attendance. This equates to a loss of 247 appointments/41 hours of appointment time per month.
- No contracted sessions were cancelled.

5.2 Nurse Clinics

There are 4 Long Term Conditions clinics per week including a diabetic clinic, cardiovascular clinic, Asthma/ COPD clinic and respiratory rehabilitation. The Long Term Conditions nurse also links with community services for support in other speciality areas such as tissue viability and learning disability.

Well-man and vaccination clinics are delivered from wing based treatment rooms.

5.3 Physiotherapy

Figure 5 Physiotherapy Clinics

Physiotherapy clinics	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Number of patients expected to be seen	87	82	94	56	76	60
Number of patients actually seen in clinic	76	63	58	36	41	51
Clinic utilisation (%)	87	77	62	64	54	85
Waiting time for routine care (days)	No data	No data	No data	No data	33	10
Contracted sessions	10	8	9	9	8	6
Delivered sessions	7	8	9	7	7	6
Cancelled sessions	3	0	0	2	1	0

- There are two physiotherapy sessions per week.
- Between July and December 2014, a total of 325 physiotherapy appointments were delivered, giving a mean average of 54 appointments per month.
- Clinic utilisation ranged from 54% to 87%.
- Some data for routine waiting times was unavailable. Waiting time at the end of December 2014 were 10 days.
- Over the six months reviewed, a total of 130 appointments were lost to none attendance, an average of 22 appointments per month.
- 12 % (6/50) contracted sessions were cancelled.

5.4 Optician

Figure 6 Optician Clinics

Optician clinics	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Number of patients expected to be seen	96	49	47	60	50	51
Number of patients actually seen in clinic	74	35	32	43	36	35
Clinic utilisation (%)	77	71	68	72	72	69
Waiting time for routine care (days)	32	44	49	39	9	10
Contracted sessions	5	4	4	5	4	4
Delivered sessions	5	4	4	5	4	4
Cancelled sessions	0	0	0	0	0	0

- One optician's clinic per week is held, with an additional session per month delivered for vulnerable prisoners if required.
- Between July and December 2014 a total of 255 appointments were delivered, giving a mean average of 43 appointments per month.
- Clinic utilisation ranged from 68% to 77%.
- Waiting times for routine appointments ranged from 9 to 49 days.
- Over the six months reviewed, a total of 98 appointments were lost to none attendance, an average of 16 appointments per month.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
 HMP Birmingham : Final Version April 2015

- No contracted sessions were cancelled.

5.5 Podiatry

Figure 7 Podiatry Clinics

Podiatry clinics	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Number of patients expected to be seen	57	65	68	91	68	83
Number of patients actually seen in clinic	41	46	39	57	45	55
Clinic utilisation (%)	72	71	57	63	66	66
Waiting time for routine care (days)	31	35	27	23	34	10
Contracted sessions	8	8	9	9	8	7
Sessions delivered	4	7	8	9	7	7

- There are two podiatry clinics per week. Between July and December 2014, a total of 283 appointments were delivered, giving a mean average of 47 appointments per month.
- Clinic utilisation ranged from 57% to 72%.
- Waiting times for routine appointments ranged from 10 to 35 days.
- Over the six months reviewed, a total of 149 appointments were lost to none attendance.
- 14% (7/49) of contracted sessions were cancelled.

5.6 Dentist

In 'Strategy for Modernising Dental Services for Prisoners in England'¹², it is recommended a minimum of one 3 hour dental session per week should be provided for every 250 prisoners and that appointments for routine care should not normally exceed six weeks. According to the guidance, six dental sessions per week would be required to meet need at HMP Birmingham.

- Nine sessions are delivered per week, with sessions each morning and afternoon (with the exception of Friday afternoons).
- It was reported that remand prisoners are only seen if need is urgent. Oral hygiene sessions are not provided.

Figure 8 Dental Clinics

Dental clinics	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Number of patients expected to be seen	176	137	234	183	209	200
Number of patients actually seen in clinic	121	100	153	131	146	148
Clinic utilisation (%)	69	73	65	72	70	74
Waiting time for routine care (days)	31	42	28 - 42	42	No data	No data
Contracted sessions	46	40	44	46	40	35
Sessions delivered	31	21	33	29	32	28
Cancelled sessions	15	19	11	17	8	7

¹² Department of Health (2003), Strategy for Modernising Dental Services for Prisoners in England 2003, HMSO, London

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

- Between July and December 2014, a total of 799 dental appointments were delivered, giving a mean average of 133 appointments per month.
- Clinic utilisation ranged from 65% to 74%, with an average monthly utilisation of 70%.
- Due to changes made in the reporting systems (from monthly performance dashboards to HJIPs), data relating to waiting times for routine appointments was not available for all months. Comments on the reporting spreadsheets indicate waiting times were between 4-6 weeks.
- Over the six months reviewed, a total of 340 appointments were lost to none attendance.
- 31% (77 /251) of contracted sessions were cancelled.

5.7 Appointments Lost to None-Attendance

The table below summaries the information in the above section regarding appointments lost to non-attendance

Figure 9 Summary of Appointments Lost to Non-Attendance

Clinic	Total no. of appointments July 1 st to Dec 31 st 2014	Total no. of DNA's July 1 st to Dec 31 st 2014	Overall % DNAs in this period
G.P	3537	1482	42%
Physiotherapist	325	130	40%
Optician	255	98	38%
Podiatry	283	149	53%
Dentist	799	340	43%
Total	5199	2199	Mean average 42%

The healthcare team are already taking a proactive approach to managing non-attendance at appointments. Meetings were held on 20th November and 16th December 2014 to discuss this issue. Actions include:

- Reminding prisoners of appointments the day before they are due for attendance
- Twice weekly wing based GP clinics to be held on B wing from January 2015.
- Plans to extend delivery of GP clinics to G and J wings in the near future.
- Night staff to deliver wing appointment slips day before appointment due.

Despite these measures, a very significant amount of routine appointment time is lost to non-attendance and it is essential that this is addressed. A number of recommendations have been made.

5.8 Recommendations: Clinics

High levels of DNA's reduce the number of appointments available for those who need them and can create inefficiencies and tensions within the prison healthcare system.

- A robust multi-faceted campaign to reduce DNAs should be planned and implemented (the author notes work on this has already commenced).
- DNA management should be on Senior Management Team agendas and regularly reviewed until DNA rates reduce and remain at less than 20%.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

- Clear definitions of what constitutes DNA need to be agreed as definitions across the cluster differ and this may result in inaccurate cross cluster comparisons.
- The healthcare department may wish to discuss whether non-attendance at clinic appointments without good reason can be linked to the Incentives and Enhanced Privileges system within the prison. This approach has been very successfully used at HMPYOI Drake Hall, where DNA rates are the lowest across the cluster.
- All prisoners should be given written information about the approach to non-attendance.
- The optician could deliver ocular triage training sessions and develop ocular triage algorithms to support nursing staff assessment and reduce unnecessary referrals to the optician.
- It is recommended that the healthcare team liaise with the prison provider to identify ways in which prisoners could purchase reading glasses as they might do in the wider community.
- Nursing staff could also be trained to undertake simple foot assessments to reduce podiatry referrals and, in conjunction with access to over the counter products such as corn plasters and bunion pads, this may reduce podiatry appointments and encourage self-management where appropriate.
- Innovative ways to deliver services such as mobile vaccination clinics could be considered. Mobile vaccination clinics (held within education and workshops for example) could:-
 - Reduce the overall number of appointments required
 - Increase vaccination uptake and vaccination coverage
 - Reduce DNA's
 - Reduce time spent out of purposeful activity
- In an award winning patient involvement initiative launched at HMP Leeds, DNA's were reduced by 30% though enrolling healthcare representatives / health champions to work with healthcare staff to relay messages to their peers about the importance of attendance at appointments. Working in liaison with the prison provider at HMP Birmingham, it is recommended that a similar initiative is launched to support communication of key messages around appointment attendance.
- Poster information and interactive awareness sessions held with families/visitors could help to engage them in communicating the importance of attendance at appointments.

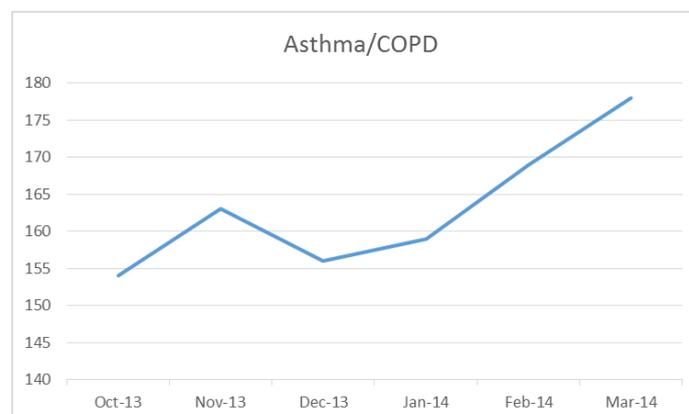
6. Prevalence of Physical Disease and Conditions

There is limited published UK data pertaining to the prevalence of non-communicable disease and physical illness amongst prisoner populations. This is summarised in Report 1 of this regional series.

A 2008 survey¹³ found that 25% of all newly sentenced prisoners had either a long-standing physical disorder or disability. Accurate prevalence data pertaining to prison populations is still in the process of being developed and it is anticipated that the newly introduced Health & Justice Indicators of Performance will help to support this aim and enable comparisons across segments of the prison population.

6.1 Asthma

Figure 10 Asthma: October 2013 to March 2014



The graph above illustrates the number of men on the asthma register from October 2013 to March 2014.

SystemOne QOF 'How Am I Driving?' report indicates that at the time of undertaking this HNA, there were 175 patients on the asthma register and 9 on the COPD register. Of these, it is evidenced that 37 have had an asthma review (including reversibility testing) within the last 12 months.

The actual reported prevalence of asthma (12.6% from SystemOne data) is much higher than national prevalence of 5.9%¹⁴ and also higher than prevalence estimates in the Birmingham toolkit (7%).

This is a significant change from the previous HNA (conducted in 2010), where a prevalence of 4.8% was reported. However, it is possible that this inconsistency may be a result of data recording and capture mechanisms as there are some indications in the previous HNA that data may not be accurate.

The SystemOne QOF asthma register excludes patients who have not been prescribed asthma-related drugs in the previous 12 months and therefore the reported prevalence is of treated asthma. It is recommended that as part of the ongoing SystemOne work at HMP Birmingham, asthma READ codes

¹³ Stewart, D, The problems and needs of newly sentenced prisoners: results from a national survey, Ministry of Justice 2008

¹⁴ Asthma prevalence by CCG area
<http://fingertips.phe.org.uk/search/ASTHMA#gid//pat/44/ati/19/page/0/par/E40000002/area>

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

are attached to reception screening and LTC templates are checked to ensure that data capture is as accurate as possible.

It is also noted that prevalence data extracted from national QOF data is not subject to prevalence modeling.

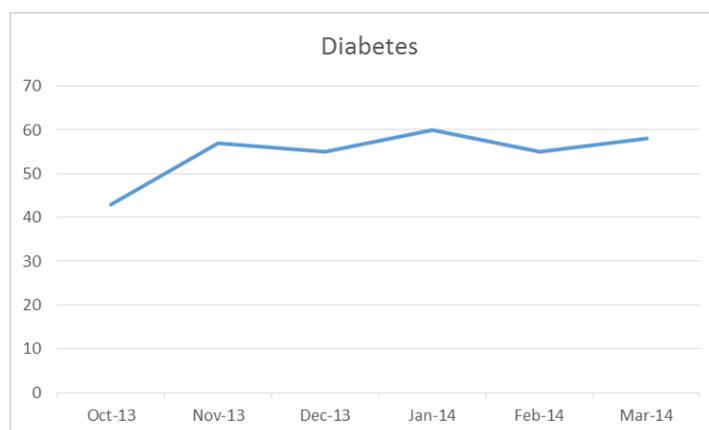
Factors such as under diagnosis and reporting diligence are not taken into consideration. In addition, it has been suggested that registers should be treated with caution in the first few years of reporting as they are still being established and validated and that apparent increases in prevalence may be due to improvement in recording and case finding, rather than a true increase in the prevalence in the population¹⁵.

Although SystemOne has now been used within prison healthcare for a few years, in many prisons, the use of READ codes to develop accurate clinical reports has only recently come into sharp focus with the advent of NHSE Health & Justice Performance Indicators. This could have a significant impact on future HNA data.

The 2010 HNA reports that there were no facilities to undertake Spirometry at the prison. There is now a weekly respiratory clinic held each Tuesday, by a nurse who holds a post registration qualification in COPD. There is access to Spirometry and reversibility testing utilising Spirometry is undertaken. A separate pulmonary rehabilitation clinic is also held on Thursdays.

6.2 Diabetes

Figure 11 Diabetes: October 2013 – March 2014



At the time of undertaking the Health Needs Assessment, there were 64 patients with diabetes (QOF DM017). However, the register does not differentiate between type 1 and type 2 diabetics and SystemOne reports were unable to provide accurate data.

Nationally, it is estimated that overall prevalence of diabetes the UK is 6%¹⁶ (with the exception of Wales where prevalence rates are 6.7%). Approximately 10% of people with diabetes have type 1 diabetes and 90% have type 2. Application of these estimates would suggest that out of the 64 men

¹⁵ http://www.dhsspsni.gov.uk/index/stats_research/stats-resource/stats-gp-allocation/gp_contract_qof/statistics_and_research-qof-prevalence.htm

¹⁶ HSCIC: National Diabetes Audit 2011/12: Report 1: Care Processes and Treatment Targets. <http://www.hscic.gov.uk>

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

on the diabetes register at HMP Birmingham, approximately 6 would have type 1 and 58 would have type 2 diabetes.

Statistically, the overall prevalence of diabetes within HMP Birmingham (4.6%) is lower than national expected prevalence (6%)¹⁷, although higher than the estimated prevalence of 3.1% reported in the 2010 HNA.

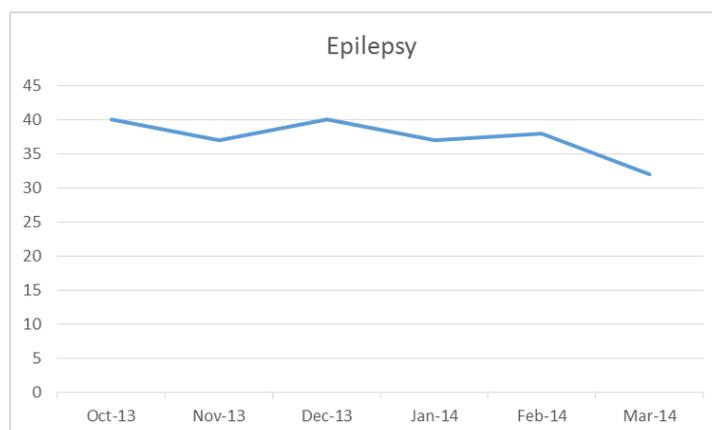
As noted in section 1.3 of this report, Black African, Black Caribbean, Indian, Pakistani and Bangladeshi men have a higher prevalence of type 2 diabetes than the general population and HMP Birmingham has a higher than national average of Black and Asian ethnicity prisoners. However, to counterbalance this, the prevalence of obesity in the prison population is much lower than the national average (see 6.4 below) and this will impact on diabetes prevalence.

Of the patients with diabetes, the QOF report indicates that 62 (96%) had had recent blood pressure recordings and 21 (33%) had received seasonal influenza vaccine. It is recorded that four men had received foot checks; however, the nurse with responsibility for Long Term Conditions felt this was possibly under-reported. Diabetic patients can be referred to the podiatrist for foot checks but nurses undertaking diabetes reviews have also been trained to undertake foot checks. A recommendation has been made regarding accurate capture and reporting of annual review activity.

It was stated that diabetic retinopathy screening was undertaken on site by the retinopathy screening team from Birmingham City Hospital. However, an analysis of the last three months of escort data (see section 15 of this report) indicates that three men went on escorted visits to the hospital for retinopathy screening.

6.3 Epilepsy

Figure 12 Epilepsy: October 2013 – March 2014



¹⁷ APHO Diabetes Prevalence model England Male over 16 at www.yhpho.org.uk/default.aspx?RID=81090

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

At the time of undertaking the Health Needs Assessment; there were 26 men on the epilepsy register (QOF EP001). This prevalence (1.8%) is almost twice the national prevalence of 9.7 per 1,000 (0.97%)¹⁸.

There is no nurse with specialist training in epilepsy.

Patients with recent seizures should have documented clinical management and care plans. In addition to this, consent should be sought to share information with wing officers to ensure staff who are first on scene in the event of a seizure are aware of what action to take whilst summoning healthcare support.

Epilepsy is currently reviewed by the GP as required.

6.4 Obesity

Figure 13 Obesity: October 2013 - September 2014



At the time of undertaking the Health Needs Assessment, there were 105 men on the obesity register (QOF OB001).

The current prevalence of obesity (7.5 %) is significantly below national prevalence (23%)¹⁹.

In a study of risk factors of non-communicable disease in prisoners by Herbert, Plugge & Foster²⁰ it was suggested that prisoners are less likely to be obese than the general population, as discussed in report number 1 of this regional series.

The healthcare team use an adapted model of MUST (Malnutrition Universal Screening Tool) to assess patients who are underweight and GPs, pharmacy and nursing staff liaise with community dieticians and the prison catering department to ensure appropriate care plans are in place.

¹⁸ Joint Epilepsy Council, 2005. Epilepsy prevalence, incidence and other statistics. <https://www.epilepsy.org.uk/> Accessed 23.01.15

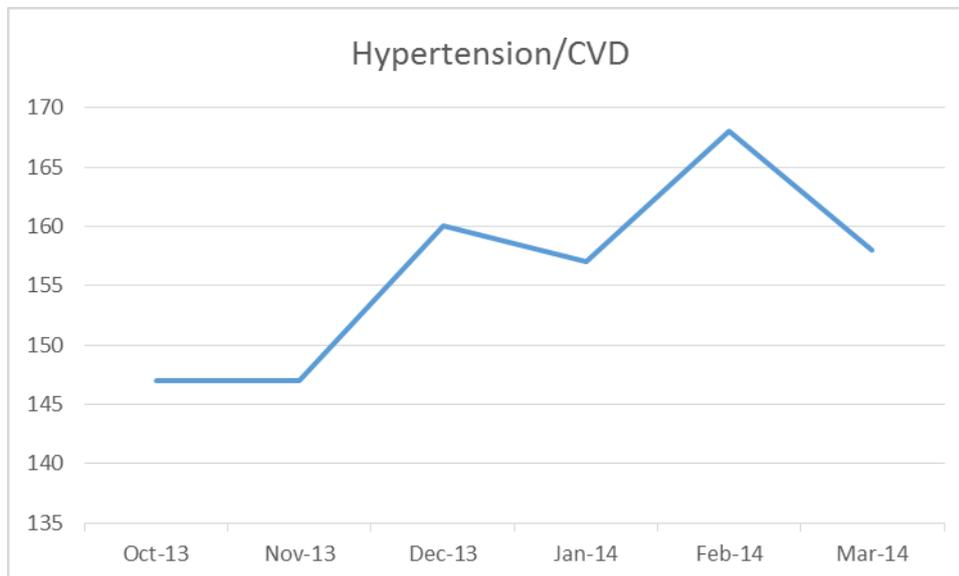
¹⁹ www.yhpho.org.uk/

²⁰ Herbert K, Plugge E, Foster C. (2012): Prevalence of risk factors for non-communicable diseases in prison populations worldwide: a systematic review, Lancet 379

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

6.5 Hypertension / CVD

Figure 14 Hypertension/CVD October 2013 - March 2014



At the time of undertaking the Health Needs Assessment, there were 168 men on the hypertension register (QOF HYP001), giving a prevalence of 12%. Plans for CVD risk assessment have been outlined in section 4.2.3.

6.6 Recommendations – Physical Health

There is a high level of awareness regarding the management of Long Term Conditions. Plans to commence CVD risk assessments are progressing well and the pulmonary rehabilitation clinic is an excellent initiative. There is the opportunity to further develop the management of Long Term Conditions and suggestions are made in the following recommendations:-

- The QOF ‘How Am I Driving?’ report suggests that 21% of asthmatics have had an asthma review in the last 12 months. This may be due to the rapid churn of the prison and that a proportion of prisoners are released prior to reviews being undertaken. However, it should be ensured that all activity is READ coded and captured accurately to reflect the work being undertaken.
- A local READ code formulary should be developed and READ codes assigned to screening templates, diabetes clinic templates and free text consultations that differentiate between type 1 and type 2 diabetes.
- It should be ensured that all activity associated with the review of Long Term Conditions is READ coded appropriately to accurately reflect activity undertaken.
- Plans to conduct diabetic retinopathy screening on site should be pursued to ensure accessibility and uptake and also reduce unnecessary hospital escorts.

7. Communicable Diseases

7.1 Tuberculosis

NICE guideline CG117 provides recommendations for the management of patients with tuberculosis.²¹

All prisoners at HMP Birmingham are screened for Tuberculosis and asked questions about symptomology and contact during the healthcare reception screening. If symptoms of Tuberculosis are identified, the patient is admitted to the inpatient ward pending review by the GP and advice from the chest clinic or Public Health England as appropriate.

There have been no cases of active TB at HMP Birmingham in the past 12 months. There have been no infectious / acquired infections during this time.

There is a communicable disease policy developed in liaison with Public Health England and an Infection Control Policy and plan.

7.2 Hepatitis

The reader is referred to report 1 of this series for review of the burden of disease in prisons.

The most recently published PHE Sentinel Report²² provides the following statistics:-

Number of individuals tested for anti-HCV in UK prisons January to December 2013 N= 4,242

Number of individuals in prisons tested positive for anti HCV N=400 (9.4%)

Number of individuals tested for HBsAg in prisons January to December 2013 N= 3,477

Number of individuals testing positive to HBsAg in prisons N= 51 (1.5%)

Figure 15 Hepatitis B & C Screening Uptake

	Total Receptions	No. of prisoners declining vaccination	No. Already Vaccinated	No. vaccinated within one month	Total Doses Given	% Vaccine Uptake*	% Declined	% Already Vaccinated	% Vaccine Coverage	Hep C Tests	% Hep C tests performed
HMP Birmingham	1,649	173	0	491	491	33%	10%	0%	30%	0	0%

Of the 1,649 men received into HMP Birmingham during the period January 1st – March 31st 2014, 10.5% of prisoners declined vaccination. 29.8% of new receptions were vaccinated within one month. Overall vaccination coverage was 30%, which is very low against the PHE target of 80%.

There is a Nursing Standard Operating Procedure in place detailing the READ codes to be used for recording the number of vaccinations offered, vaccinations declined, patients already vaccinated and vaccinations administered.

The results of SystmOne clinical reports for the HNA did not correlate with the figures in the table above and indicated that assignment of READ codes is inconsistent and data capture does not

²¹ NICE Guideline CG 117 Tuberculosis: Clinical diagnosis and management of tuberculosis, and measures for its prevention and control

²² PHE Annual report from the sentinel surveillance study of blood borne virus testing in England: data for January to December 2013 Infection reports Vol 8 (29) Published : 25 July 2014

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

currently accurately reflect activity. Recommendations have been made regarding data capture and collation.

A separately maintained spreadsheet indicates that between February 2014 and January 2015 there were 311 patients tested for Hepatitis C of whom 29 (9.32%) were positive.

There is a Hepatitis C pathway which details the steps to be taken for pre-test counselling, testing, post-test counselling, risk minimisation advice and referral for positive results. Patients testing positive are referred to the GP for the development of a patient plan, advice on transmission, prescription of Milton sterilising tablets and onward referral to the Hepatology Department at the Queen Elizabeth Hospital.

It was reported that there are plans to introduce dry spot blood testing to replace the oral swab testing currently employed.

Figure 16 HIV Testing (Source: HMP Birmingham HJIP spreadsheet)

HIV Screening	Sept-14	Oct-14	Nov-14	Dec-14
No. of patients eligible for testing	18	6	21	503
No. of patients tested	18	6	21	15
No. of confirmed diagnosis of HIV	0	0	0	1

Figure in red text is inconsistent with rest of data (erroneous entry).

Of the 60 patients tested for HIV between September 2014 and December 2014, one tested positive. Patients testing positive are referred to the GP for counselling, advice and onward referral to a HIV specialist.

7.3 Recommendations

- It is recommended that the current systems for data capture and collation are reviewed to ensure that activity associated with Hepatitis B and C screening, vaccinations and treatment is accurately reported and reflects the work undertaken. It is particularly important that vaccination coverage is accurately reported and this may have been under reported in previous data submissions.

8. Sexual Health

Figure 17 Sexual Health Clinics (Source: HMP Birmingham HJIP spreadsheet)

Sexual health clinics	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Number of patients expected to be seen	27	49	31	31	40	32
Number of patients actually seen in clinic	20	34	18	17	22	13
Clinic utilisation (%)	74	69	58	55	55	41
Waiting time for routine care (days)	No data	No data	No data	No data	31	7
Contracted sessions	4	5	4	5	4	3
Delivered sessions	3	5	3	5	4	3
Cancelled sessions	1	0	1	0	0	0

- A nurse led Sexual Health Clinic is held weekly.
- Between July and December 2014, a total of 124 appointments were delivered, giving a mean average of 21 appointments per month.
- Clinic utilisation ranged from 41% to 74%.
- Some data for routine waiting times was unavailable. The waiting time at the end of December 2014 was 7 days.
- Over the six months reviewed, a total of 90 appointments were lost to none attendance, an average of 15 appointments per month.
- The sexual health nurse undertakes screening and assessment including obtaining any swabs, blood samples or other biological samples required.
- Oral swabs have been used to date for Hepatitis C screening but a pilot using dry spot blood testing is to commence shortly.
- Pre-test counselling is offered for HIV and Blood Borne Virus screening.
- In 2014, 109 men were screened for HIV, of which 9 were positive.
- HIV positive patients are referred to a HIV specialist consultant who liaises with the prison healthcare team regarding treatment and care.
- Confidential advice and education is provided and condoms, lubricants and dental dams are available.

With the exception of HIV data, STI prevalence data wasn't available from HMP Birmingham. National prevalence data is shown below.

Figure 18 National and Regional Prevalence of Sexually Transmitted Infections

National and Regional Prevalence of STIs		
Prevalence	England	West Midlands
Syphilis diagnosis rate per 100,000	5.9	3
Gonorrhoea diagnosis rate per 100,000	52.9	43.2
Chlamydia detection aged 16-24 per 100,000	2016	1917
Chlamydia screened aged 16-24	24.9%	22%
Genital Herpes per 100,000	58.8	52
HIV aged 15-59 per 100,000	2.14	1.54

Public Health England report that of the 446,253 new STI diagnoses made in 2013, the most commonly diagnosed STIs were chlamydia (208,755; 47%), genital warts (73,418; 17%), genital herpes (32,279; 7%), and gonorrhoea (29,291; 7%).²³

9. Physical Disability

Although a question is asked during the screening reception regarding physical disabilities, the response to this question does not have a READ code and therefore data regarding specific disabilities is not collected. Accurate SystmOne reports on type of disability could not be generated.

In a patient survey undertaken as part of the March 2014 HMIP inspection; approximately 21% respondents regarded themselves as having some sort of disability, although type of disability is again not specified.

A recommendation regarding READ coding of physical disabilities has been made earlier in this report and is therefore not repeated in this section.

10. Health Promotion and Well-being

10.1 Health Promotion

There is a whole prison approach to health promotion and a Health Promotion Strategy. Regular meetings are held and health promotion events delivered. At the time of the HNA site visit, a health promotion event was taking place on B Wing for men who had been unable to attend an earlier event in the year. At the event there were several stalls presented by different departments within the prison (Primary Healthcare, Substance Misuse, Mental Health, Physical Education, Education, Catering etc.) and outside presenters are also invited to attend. A staff event was planned for later in the year.

There is an opportunity to link the visitors centre and family and friends to health promotion events and themes, which is explored further in Section 16 of this report.

10.2 Smoking

- There are three smoking cessation sessions per week.
- In the first quarter of 2015 (January 1st to March 25th), 790 appointments were booked and 514 appointments attended. The DNA rate was 34.9%, with 276 appointments being lost to non-attendance.
- Smoking cessation activity is not READ coded on SystmOne. Templates for smoking cessation are available on SystmOne but are not utilised, therefore it has not been possible to include quit rates and outcomes data.

²³ Public Health England: Health Protection Report: Weekly Infection report Volume 8 Number 24 published 17 June 2014 at:
www.gov.uk/government/uploads/system/uploads/attachment_data/file/345181/Volume_8_number_24_hpr_2414_AA_stis.pdf

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

10.3 Weight Management

- In exploring obesity as an emerging theme, a recent systematic review of international literature reviewed the prevalence of poor diet, inadequate physical activity and obesity in prisoner populations.
- A key finding was that male prisoners were less likely to be obese than males in the general population in the USA and Australia²⁴. As reported in section 6 of this report, 7.5% (N=105) of the current population are obese according to reception screening BMI.
- If required, weekly weight checks and weight management support are offered via nursing clinics.

Healthcare can liaise with the prison catering department where special diets are required.

Advice regarding healthy eating is incorporated into health promotion campaigns.

10.4 Physical Exercise

- There are two outside football pitches and a gymnasium at the prison.
- The GP and physiotherapist liaise with the prison Physical Education Department and prescription exercise can be requested where appropriate. There is specialist provision for prisoners aged over 50 years old.
- Level 2 Gym Instructorship, first aid and health and fitness courses are available for prisoners to attend.
- In a survey undertaken during the 2014 HMIP report, only 16% of prisoners reported they exercised outdoors. 10% stated they attended the gym three or more times a week and it was noted that gym attendance from BME and Muslim prisoners was very low.

10.5 Recommendations – Health Promotion and Well-being

- SystemOne smoking cessation templates are available but not utilised. Use of the templates would enable more accurate reporting of smoking cessation activity and outcomes.
- There is an opportunity to increase service user and family and carer engagement in health promotion activity. It is recommended that a designated member of the primary care team is identified to link with the visitors centre to develop an innovative and inclusive health promotion programme that maximises service user, family and carer engagement.

11. Social Care Needs

Social care is not an NHS commissioning responsibility and is therefore outside of the remit of this NHS England commissioned HNA. However, the following comments were noted whilst collating data for the report:

The most recent IMB report for HMP Birmingham describes how the prison ‘continues to operate a very successful Older Prisoner and Social Care Wing (J Wing)’ where ‘prisoners almost invariably report high levels of satisfaction’ due to the ‘hard work, caring attitude and dedication of staff’.

²⁴ Herbert K, Plugge E, Charles Foster C and Doll H. Prevalence of risk factors for non-communicable diseases in prison populations worldwide: a systematic review. *Lancet* 2012; DOI: 10.1016/S0140-6736(12)60319-5).

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

The 2014 HMIP²⁵ report for HMP Birmingham states,

‘Very good support arrangements were in place for prisoners on J wing, which accommodated older prisoners and those identified with social care needs and disabilities. Care plans were in place and prisoners’ everyday needs met. These prisoners could participate in work, education and association, and we saw some positive interaction between staff and prisoners. The prison held regular forums for older prisoners, and two joint health care and PE sessions a week were delivered to prisoners on the wing’.

The report also identified the promotion of continuity of health and social care on release.

However, provision for older prisoners and those with disabilities/care needs on other wings was described as being less consistent, detailing that there was no formal carer scheme and although care support plans were developed, they were not shared with prisoners.

Access for older/disabled prisoners was also identified as a problem. The IMB report commented,

‘Unfortunately there is a delay in providing a stair lift on the wing, because funding has not been agreed – the unit is on two floors and several occupants are wheelchair users’.

The IMB additionally commented that there had been a problem in resolving heating problems and hot water to some of the cells – an issue that had been identified in both the previous and most recent IMB reports.

11.1 Recommendation – Social care

- It is important that healthcare Commissioners and providers and HMPS and NOMS colleagues create strong communication pathways with the Local Authority (Adult Social Services) to identify opportunities for information sharing and joint commissioning to meet the health and social care needs of prisoners at HMP Birmingham.
- Healthcare has access to a range of population data that may be useful to those tasked with planning services to meet social care need within the prison. Information sharing agreements should be in place to ensure that a mutually supportive relationship between health and social care is generated that benefits patients and supports a holistic care approach.

²⁵ HMP Birmingham Unannounced Inspection by HMIP, 24th February-7th March 2014

12. Mental Health

The information in the box below is extrapolated directly from the Public Health England 'Health and Justice Health Needs Assessment Template: Adult Prisons, July 2014' and illustrates the breadth of mental health need identified in this population group.

- In a study of prisoners, 72% of male and 71% of female prisoners were found to suffer from two or more mental disorders (including personality disorder, psychosis, neurosis, and alcohol misuse and drug dependence)²⁶.
- 20% of prisoners suffered from four identifiable disorders.
- Male remand prisoners are 20 times more likely to suffer psychosis and 20 times more likely to entertain suicidal thoughts than the general population²⁷.
- Many people in contact with the criminal justice system have experience of interpersonal trauma²⁸.
- This has been linked to the onset of a range of mental health problems including post-traumatic stress disorder, depression, anxiety disorders and substance misuse.
- 29% of prisoners report having experienced emotional, physical or sexual abuse as a child²⁹.

12.1 Integrated Mental Health Services

At HMP Birmingham an integrated mental health service led by an experienced forensic psychiatrist is delivered by Birmingham and Solihull Mental Health Trust.

The team provides primary mental health, secondary mental health, dual diagnosis and forensic mental health services and liaises extensively with other health and justice mental health and diversion services.

The mental health team report an excellent working relationship with the prison and liaise closely with prison colleagues to support the ACCT process, completion of separation and care (segregation) unit algorithms and risk assessments, contribution to Good Order & Discipline reviews and constant watches and constant watch reviews. The ACCT process is a multi-disciplinary approach to the care of prisoners with vulnerabilities who require additional monitoring and support.

The Clinical Lead commented that he felt the team provide an excellent, experienced and responsive service within the confines of the environment.

²⁶ Singleton, N., Meltzer, H. & Gatward, R. (1998) Psychiatric Morbidity among Prisoners in England and Wales. London: Office for National Statistics

²⁷ Charles Cunniffe, Rik Van de Kerckhove, Kim Williams and Kathryn Hopkins Estimating the prevalence of disability amongst prisoners: results from the Surveying Prisoner Crime Reduction (SPCR) survey Ministry of Justice Research Summary 4/12

²⁸ Rose, S., Freeman, C. and Proudlock, S. (2012) Despite the evidence – why are we still not creating more trauma informed mental health services? Journal of Public Health. 11(1): 5-9.

²⁹ Williams, K., Vea Papadopoulou, V., & Booth, N. (2012) Prisoners childhood and family backgrounds: Results from the Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study of prisoners. London: Ministry of Justice

Staff resources are detailed in the table below

Figure 19 Mental Health Services Staff Resources

HMP Birmingham Mental Health Services Staff Resources		
Job title		Vacancies
Service manager mental health	1	0
Deputy Ward manager	3	1 – vacant post appointed to awaiting clearances
Staff Nurse	6	0
Psychiatrist	2	0
CPN	4.5	0
Forensic Psychiatrist	2 sessions	0

The team attend ACCT reviews and contribute to ACCT care maps. There is a Standard Operating Procedure in place detailing responsibilities for recording opening and closing of ACCT documents on patient records and communicating required information to the mental health duty nurse. This process was implemented following lessons learned from a previous serious incident.

Between implementation of the system and 31st December 2014, SystmOne reports indicate that there was a total of 312 ACCT documents opened, 169 closed and 236 reviews attended.

12.2 Screening and Referral

All men are screened for mental health concerns during the initial and secondary reception screen.

Pathways are in place for the management of men with mental health concerns.

Following the screening process, if no mental health concerns are identified, the prisoner will go the first night centre (D wing) and continue through the prison induction process.

If there are minor mental health concerns at reception, the reception nurse can complete a TAG (Threshold Assessment Grid) referral form and send a referral to the mental health team via the 'Task' electronic referral and messaging function on SystmOne.

The Task is sent to a group referral list and then followed up by the team. Tasks sent via the SystmOne electronic system are fully auditable.

An ACCT document may be opened to initiate the multi-disciplinary enhanced support process previously described.

If mental health concerns are identified at the reception screening stage, the duty mental health nurse is informed and may either attend reception to undertake a further initial assessment and discuss and agree an immediate care plan, or may arrange for the patient to be admitted from reception to the inpatient ward (Ward 2).

During a prisoners stay at HMP Birmingham, if mental health concerns are identified by healthcare staff, residential officers, education, chaplaincy or other personnel, referrals can be made via the TAG referral system or by telephone. There is a generic email box provided for referrals from prison

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

provider staff (G4S). In addition, outpatient mental health clinics are held for patients on wing location and a Community Psychiatric Nurse (CPN) model is used to provide outreach support.

Weekly multi-disciplinary team meetings are held to discuss all new referrals. Accepted referrals may then be allocated to specific primary mental health, secondary mental health, dual diagnosis or forensic caseloads.

The ward In Reach team can support men on normal location within the prison who are known to the services.

During the 12 months from 1st July 2013 to 30th June 2014, 1,500 new mental health assessments were undertaken, an average of 125 assessments per month.

During the same period, the secondary care caseload ranged from 77 - 124 patients per month, with an average monthly caseload of 112 clients.

A total of 1505 patients were managed via CPA (Care Programme Approach), including patients located on the inpatient ward.

A detailed breakdown of primary and secondary diagnoses was not available as the team utilise both SystemOne and RiO (a separate community based patient record system) and entries on SystemOne are not consistently READ coded.

There are plans to deliver Mental Health First Aid Training (MHFA) to officers and health trainers to increase mental health awareness and support them in their role.

The team rigorously pursue communication with Community Mental Health Teams and CPA Co-Ordinators for all clients who are released from prison whilst on their caseload.

12.3 Inpatient Care

There is a 15 bedded Mental Health Inpatient Unit (Ward 2) which is located on the second floor of the Healthcare Centre.

This section of the HNA describes the unit and general management of the facility. However, a regional Inpatient Unit analysis is being undertaken separately and in parallel to the HNA. Utilisation of inpatient beds and capacity and demand has therefore not been included.

There is a policy document which clearly outlines bed management pathways for both the physical and mental health wards.

The three pathways outlined are:

- Admission pathway for patients within the prison identified as having mental health issues
- Admission pathway for agreed period of assessment / observation to ascertain or negate presence of mental health issues
- External referrals to healthcare through the regional rota

Where external referrals are made, a member of the mental health team will visit the referring prison to assess the referred prisoner and discuss the need for admission. If admission is agreed, the patient will be transferred to Ward 2 at HMP Birmingham, with an agreement that the patient will be transferred back to the referring establishment once they are deemed fit to do so.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
 HMP Birmingham : Final Version April 2015

Weekly bed management meetings are held and attended by senior healthcare and prison managers, medical staff and clinicians.

The policy states that the purpose of the bed management meetings is to review the current bed state, clarify discharge locations for patients, discuss patients who may be difficult to place and prioritise waiting lists.

All cells on the unit are single cells. There are 2 gated cells to facilitate patients being observed constantly where required.

Figure 21 Healthcare Facilities Inpatient Unit: Ward 2 - second floor

HMP Birmingham Healthcare Facilities Inpatient Unit: Ward 2 - second floor		
	No. of Rooms	Comments
Single cells	15	Recently refurbished to address issues identified as the outcome of coroners' inquest into a previous death in custody and all cells now have fixed beds
Double cells	0	
Gated cells	2	Utilised as constant watch cells when required
CCTV cells	0	
Safer cells	0	
Association room / patient dayroom	1	Association area/ dining area Recess area with TV
Patient bathrooms		Communal shower block and bath.
Patient toilets		Each cell has its own toilet There is also a communal toilet
Facilities for those with physical disabilities / special adaptations	All	Individual assessment of prisoner needs
Offices	0	
Medicines administration room	1	Computer/printer access
Consulting rooms	1	Consulting room/group room
Group rooms	1	Utilised for ward round, external mental health assessments and training
Patient waiting rooms	0	
Other	3	Nursing Station (computer/printer access) Domestic store room/kit room

Patients are admitted to the ward for assessment and stabilisation. Where appropriate and required, the need for referral to a secure mental health bed is assessed, referrals made and transfers facilitated.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

There are weekly ward rounds to review patient care and progress and to inform bed management and discharge planning.

The ward is staffed by Registered Mental Health Nurses and Healthcare Officers. There are two nurses on duty during the day supported by three or four officers. There is a qualified nurse on duty at night.

Therapeutic interventions include:

- Psychology (4 sessions per week)
- A range of talking therapies
- Self-help strategies
- Massage (2 mornings per week)
- Therapeutic activity and engagement sessions

The team are in the process of recruiting an Occupational Therapist. It was suggested that a mental health social worker role would be advantageous to link with community and resettlement teams and enhance continuity of care arrangements and discharge planning.

Frustrations were expressed regarding restrictions on the time patients could be unlocked and out of their cell. In addition, it was felt that patients were sometimes disadvantaged by being on the healthcare unit and having reduced access to gym, employment and education opportunities.

12.4 Forensic Psychiatry

A multi-disciplinary forensic mental health meeting is held weekly and is separate to the general mental health MDT meeting. Index offences of murder, arson and designated serious arrestable offences trigger a forensic mental health review and, where appropriate, diversion to a medium secure mental health unit may be recommended. Input is provided by a visiting forensic psychiatrist with support from higher trainees in forensic psychiatry under supervision.

12.5 Transfers under Mental Health Act

A survey (conducted in 2011) by the Royal College of Psychiatrists³⁰ aimed to establish whether psychiatrists felt that a two week/14 day target (as initially recommended in The Bradley Report 2009³¹) for transferring acutely unwell clients out of prisons was reasonable and also to identify key barriers and possible solutions to timely prison transfers.

The survey concluded that:

- 14 days was a reasonable target to transfer a prisoner with acute, severe mental illness to an appropriate healthcare setting.
- Maximum waiting time for those not deemed to be in urgent need of treatment should not exceed more than approximately 2 months.

Barriers to timely transfers included:

³⁰ Prison transfers A survey from the Royal College of Psychiatrists December 2011 at www.rcpsych.ac.uk/pdf/GoodPracticeGuide.pdf - Accessed 07.012.15

³¹ The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system; London, Department of Health April 2009

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

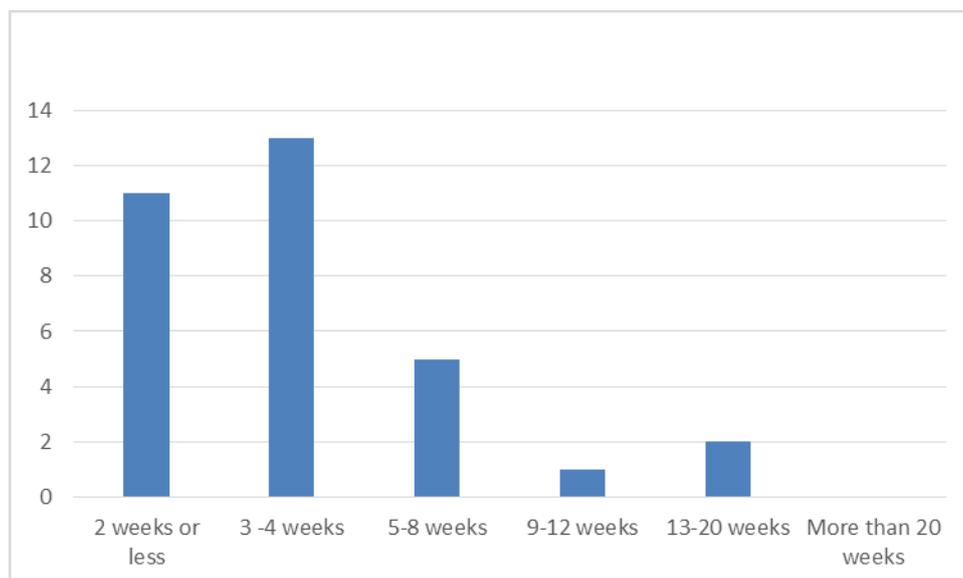
- Costly administration processes
- Difficulty in undertaking timely assessments due to accessing the prison estate
- Coordination of resources
- Information sharing
- Bed management
- Commissioning structures

In the 12 month period between July 1st 2013 and 30th June 2014, a total of 32 transfers were made under the Mental Health Act. 31 men were transferred to Medium Secure Units and one was transferred to a Psychiatric Intensive Care Unit (PICU).

None of the prisoners were managed in the Segregation Unit prior to transfer. Her Majesty’s Inspectorate of Prisons and the Prison Reform Trust have commented many times on the inappropriate care of acutely unwell mental health patients in segregation units, as in some prisons this is the default location for men with challenging behaviours, even if behaviours are a result of mental ill health. The approach adopted at HMP Birmingham is caring and responsive and denotes excellent practice.

A summary of the time elapsed from first assessment to transfer under MHA is provided below.

Figure 20 Time from First Assessment to Transfer under MHA



11 out of 32 (approximately 34%) transfers were made within 14 days.

A further 18 transfers were made within 8 weeks – the Royal College of Physicians recommendation for those not deemed as requiring urgent treatment.

3 transfers (9 %) exceeded 60 days, however no transfers exceeded 20 weeks.

The time taken to transfer out acutely unwell patients is concerning and an area where occasionally needs are not met. However, transfer times from HMP Birmingham compare favourably with those from some other establishments within the cluster.

12.6 Recommendations: Mental Health

The mental health services offered are comprehensive and well managed and the prison has the facilities and range of experienced staff required to appropriately manage some very challenging clients.

- The Mental Health First Aid Training (MHFA) planned for officers and health champions should be progressed.
- The Visitors Centre at HMP Birmingham is very proactive and their expertise could be leveraged to widen the audience for key mental health awareness messages. Opportunities for additional funding to include families and carers in Mental Health First Aid Training should be explored.
- The Healthcare Director and Clinical Lead should liaise with prison providers to ensure that time out of cell on the Inpatient Unit is not compromised and that patients are not disadvantaged by their location and have access to association time, gym and physical activities .
- The opportunity to utilise third sector organisations to provide alternative counselling services other than those offered by chaplaincy should be considered.

13. Learning Disabilities & Autistic Spectrum Disorders

The Bradley report suggests `the proportion of people in prison who have learning difficulties or disabilities that interfere with their ability to cope with the criminal justice system has been estimated at 20 to 30%'³².

In addition, with regard to Autistic Spectrum Disorders, NICE ³³states that `a significant proportion of adults with autism across the whole autistic spectrum experience social and economic exclusion. There is a wide variation in rates of identification and referral for diagnostic assessment, waiting times for diagnosis, models of multi- professional working, assessment criteria and diagnostic practice for adults with features of autism. These factors contribute to delays in reaching a diagnosis and subsequent access to appropriate services`.

Autistic individuals can become stressed by `a wide range of social situations, changes that interrupt their `safe` routines, or environmental triggers'³⁴, all of which are likely to occur within a prison environment. When stressed, they may adopt behaviours including self-harming, withdrawing and failing to communicate or resorting to physical violence. To others these behaviours may seem to be abnormal, unpredictable and intentional. It is arguable that the experience of prison for an individual

³² The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system; London, Department of Health April 2009

³³ Autism: Recognition, referral, diagnosis and management of adults on the autistic spectrum at www.nice.org.uk/guidance/cg142- Accessed 23.01.15

³⁴ https://www.birminghambeheard.org.uk/adults-communities/www-birminghamcitycouncil/supporting_documents/Adults%20with%20autism%20and%20the%20criminal%20justice%20system%20final%20report.pdf

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

on the autistic spectrum could 'affectively amount to mental torture if their special needs are not taken into account'³⁵.

The QOF performance report 'How am I driving?' (Indicator LD003) for this prison indicates that there are 14 patients with a learning disability. SystemOne reports also indicate that there are 5 patients with Autistic Spectrum Disorder. No patients were identified as having Asperger's Syndrome. However, there is no local READ code formulary or template assessment for Learning Disability and Autistic Spectrum Disorders and this is almost certainly a significant under-representation.

The first night screening reception has a question/prompt regarding learning disability but relies on individual self-reporting and answering of a yes/no question.

The healthcare team liaise with the Community Learning Disabilities Team for advice and support regarding patients with identified learning disabilities, however, there is an opportunity to raise and develop awareness.

A review of 'Autism: Recognition, Referral, Diagnosis and Management of Adults on the Autism Spectrum' may provide tools upon which to conduct an analysis of need in this area.³⁶

13.1 Recommendations: Learning Disabilities and Autistic Spectrum Disorder

- It is recommended that a Commissioner-led Steering Group is formed to review current learning disability and autism services and support across the West Midlands Prison Cluster.
- The Steering Group should link with any existing multi-agency autism strategy groups to review, develop, implement and evaluate local care pathways.
- It is recommended that funding is identified to develop a regional resource to support further research, identification, signposting and support services for the West Midlands Prisons cluster.
- It is recommended that the regional resource will comprise an appropriate cohort of professionals who are able to develop care pathways for children, young people transferring from children's to adult services and adults who have learning disabilities, ADHD or Autistic Spectrum Disorders.
- It is recommended that the regional resource is commissioned to provide:
 - assessment, treatment and support and referral services for service users whilst in prison
 - education and awareness raising for healthcare staff and HMPS and NOMS colleagues

³⁵ <https://autismandoughtisms.wordpress.com/2011/07/13/autism-in-prisons/>

³⁶ NICE: 'Autism: recognition, referral, diagnosis and management of adults on the autism spectrum' NICE Clinical Guideline 142, June 2012 available at www.nice.org.uk

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

- a through the gate service linking to Community Healthcare Teams, third sector agencies, peer support networks and Community Rehabilitation Companies to support resettlement on release

14. Substance Misuse

14.1 Substance Misuse Services

Clinical treatment of Substance Misuse in prisons is detailed in:-

Clinical Management of Drug Dependence in the Adult Prison Setting (DH 2006)³⁷

Prison Service Order 3550 – Clinical Services for Substance Misusers³⁸

Prison Service Instruction 45/2010 Integrated Drug Treatment System³⁹

Clinical Substance Misuse services (IDTS) are provided by Birmingham & Solihull Mental Health NHS Foundation Trust. Psychosocial Services are provided by the South Stafford and Shropshire NHS Foundation Trust Drug & Alcohol Recovery Team (DART). The two teams work very closely together and are co-located (see facilities table below).

At the time of the HNA, the IDTS Service Manager was new in post but was planning to meet regularly with the DART Team Leader to further develop integration and joint working.

Figure 9 Healthcare Facilities IDTS / DART

Healthcare Facilities: Healthcare Centre Ground floor – IDTS / DART		
	No. of rooms	Comments
Staff offices / work areas	5	IDTS Nurse office IDTS Admin office DART offices Managers office Computer and printer access
Group area/recess	1	Basic kitchen facilities
Group / therapy rooms	2	IDTS/DART training areas
Staff wash/ toilets	1	Male, female and disabled

Figure 21 IDTS & DART Staff Resources

IDTS & DART Staff Resources - Drug & Alcohol Clinical Services (IDTS)		
Job Title	WTE currently in post	Vacancies
Service manager, IDTS	1	0
IDTS team leader	1	1
Deputy team leader	4	0
Staff nurse	9	1
Support worker	6	0
IDTS & DART Staff Resources - Psychosocial Services		

³⁷ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_115004.pdf

³⁸ <https://www.justice.gov.uk/offenders/psos>

³⁹ <https://www.justice.gov.uk/offenders/psis>

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
 HMP Birmingham : Final Version April 2015

Job Title	WTE currently in post	Vacancies
Manager	1	0
Senior practitioner	1	0
DART Worker	9	1
Senior officer	1	0

As with the primary care team, the teams have experienced some staffing and recruitment difficulties but felt that this had improved recently. The teams felt that once all vacancies were filled they had appropriate resources to deliver against need.

A number of actions have been undertaken to work with the prison providers to reduce the time taken for prison security vetting to be completed to support the recruitment process. However, this remains a problem and requires continued focus.

14.2 Substance Misuse Need

Figure 22 Substance Use April 13-April 14 (Source: Adult Prisons Quarterly Treatment Report)

Substance Use Data 2013-2014									
HMP Birmingham	Q1		Q2		Q3		Q4		
	Total	%	Total	%	Total	%	Total	%	
New receptions:									
Number of new receptions (based on healthcare screenings)	1481	-	Not supplied	-	1492	-	Not supplied	-	
Number of new receptions beginning drug treatment episodes	521	35%	620	-	586	39%	623	-	
New treatment entrants (individuals):									
Total opiate user (OU) new treatment entries	269	-	345	-	343	-	369	-	
Total non-opiate user new treatment entries	98	-	63	-	67	-	78	-	
Total primary alcohol new treatment entries	153	-	188	-	152	-	151	-	
Total new entrants	520	-	596	-	562	-	598	-	
Treatment combinations for individuals:									
Opiate Users									
Clinical interventions only	45	16%	89	17%	95	16%	154	25%	
Non-clinical structured interventions	35	12%	31	6%	29	5%	20	3%	
Clinical and non-clinical structured interventions	206	71%	394	76%	459	78%	432	70%	
No modality started	4	1%	5	1%	8	1%	7	1%	
Total opiate users in treatment	290	-	519	-	591	-	613	-	
Non opiate users									
Clinical interventions only	18	15%	22	17%	19	16%	27	19%	
Non-clinical structured interventions	48	41%	42	33%	33	28%	21	15%	
Clinical and non-clinical structured interventions	47	40%	50	39%	53	46%	64	46%	
No modality started	5	4%	13	10%	11	9%	27	19%	
Total non-opiate users in treatment	118	-	127	-	116	-	139	-	
Primary Alcohol Users									
Clinical interventions only	44	26%	93	33%	99	35%	110	42%	
Non-clinical structured interventions	43	25%	38	14%	24	9%	12	5%	
Clinical and non-clinical structured interventions	75	44%	134	48%	145	52%	127	49%	
No modality started	8	5%	16	6%	11	4%	12	5%	
Total primary alcohol users in treatment	170	-	281	-	279	-	261	-	
Total individuals in treatment	578	-	927	-	986	-	1013	-	

HMP Birmingham is a big and busy local remand prison. Most of the receptions will have come via local courts and a high proportion of new receptions have substance misuse needs.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

From April 2013 to April 2014, a total of 2,350 receptions commenced new drug treatment episodes.

Of the total new treatment entrants, 58.26% (n=1326) were opiate users, 13.4% (n=306) were non-opiate new treatment entrants and 28.3% (n=644) were primary alcohol new treatment entrants.

For all treatment groups, the most common treatment combination was clinical and non-clinical structured intervention (70% opiate users, 46% non-opiate users and 49% primary alcohol users).

Additional data (the same data set from which the above table was extrapolated) indicates that heroin was cited as the primary drug of use by 40.34% (n=809) of men, followed by alcohol (28.5% n=572).

59% of those for whom injecting status was recorded had never injected, 18% had previously injected and 19% were injecting at the time of coming into custody. 4% declined to provide an injecting status.

37.5% of men reported having no second drug of use. The most common second drug of use was crack cocaine reported by 23.24% of men. The data suggests that primary heroin users tend to use crack cocaine as a secondary drug. Primary alcohol users tend to use cannabis as a second drug.

In addition to the substances detailed in the quarterly data submissions, the team are aware of increasing use of New Psychoactive Substances (NPS) and synthetic cannabinoids. There is particular concern regarding the use of Black Mamba amongst prisoners, causing a number of prisoners to become acutely unwell and require urgent transfer to hospital.

14.3 Services Delivered to Meet Need

Prisoners are asked questions about substance use at screening and if they declare substance misuse or have a positive urine drug screen they are referred to the substance use nurse or GP.

Consent is obtained to contact the patient's pharmacy, Community Drugs Team or prescribing GP for details of any ongoing prescribed medication regime. Once confirmed, the prescription will be continued within the prison (unless a break in treatment means that it is unsafe to do so). The SystemOne prescribing function is not yet utilised and paper prescription record sheets are used.

Unless severely withdrawing (when admission to the Inpatient Unit may be considered), men with substance misuse issues generally remain on the first night centre and go to B wing the following day.

On the day after reception, a full assessment takes place with input from the GP, IDTS nurse and DART worker. Joint care planning is initiated and a timetable of clinical and psychosocial reviews planned and agreed. A copy of the timetable is provided for the patient to enable them to follow their individual care plan.

The managers of the IDTS and DART teams have been working together to improve joint care planning. A previous system for joint care planning had not been successful as clients were allocated one IDTS and one DART worker to jointly okay and review care. However, due to shift patterns and annual leave joint planning had proved difficult to facilitate. An alternative system with two DART and IDTS workers allocated to each individual is now in place and joint care planning is now easier to facilitate.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

Care plans are individually tailored to suit need. Men who are on longer term sentences will be stabilised and then begin a reduction programme aiming to be opiate free. Those on short term sentences may be stabilised and maintained on methadone or Buprenorphine (Subutex) until released with arrangements for continuity of care via the Community Drugs Teams.

Prescribing reviews are undertaken by the GP and IDTS nurses. Evidence based tools are used to assess withdrawal (clinical opiate withdrawal scales, clinical alcohol withdrawal scales). There are comprehensive substance misuse policies and Standard Operating Procedures.

Prisoners can engage in a range of group and 1:1 support including:-

- Motivational interviewing
- Cognitive Behavioural Therapy (CBT)
- Brief solution focused therapy
- Relapse prevention
- Harm reduction
- Overdose prevention
- Advice & information
- Sign posting
- Referral for housing and resettlement
- Group work
 - Inclusion recovery (8 sessions over one week)
 - Relaxation
 - Reading Group (in partnership with library and music groups)
 - Alcohol Awareness
 - Self-esteem group

Comments identified that there had been a lack of capacity to consistently run groups and that no groups had been held in August or December, due to high levels of staff sickness.

DART undertake a full assessment within 5 days for all opiate users and within 15 days for non-opiate users. It was commented that work with alcohol users has increased and improved.

Peer support is provided and promoted by Wing Based Recovery Champions, however there is scope to improve and extend this initiative. The DART manager is currently exploring the possibility for recovery champions to undertake a peer mentoring qualification programme.

There is a Band 7 Dual diagnosis nurse and dual diagnosis pathways are in place to support those with complex co-existing mental health and substance use issues.

Staff commented on the duplication of information gathering from patients by the DART and IDTS teams and it is recommended that a process mapping and pathways review exercise is undertaken to identify areas of duplication and to streamline processes.

In addition, DART do not have access to SystemOne and keep separate records to the IDTS team. It would be beneficial if an information sharing agreement could be agreed and endorsed by Information Governance to facilitate the two teams having access to the same SystemOne patient record.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
 HMP Birmingham : Final Version April 2015

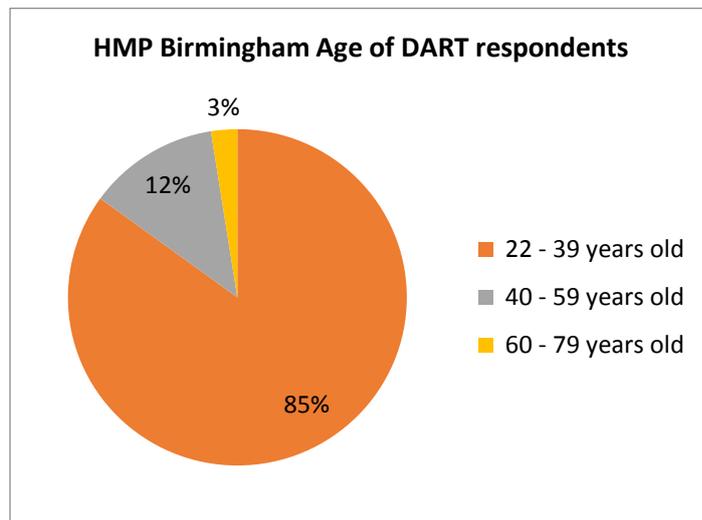
An additional comment was that moving men from B wing (on completion of detoxification) could be difficult. It was felt that there is a need to provide an appropriate environment to move to on completion of detoxification.

Discharge planning was good. There are strong links with community drug services and continuity of prescribing and care. Where required, meetings with DIP workers are arranged pre-release to encourage post release attendance and engagement.

14.1 Stakeholder feedback

To illicit the views of DART service users 60 DART questionnaires were distributed. 40 questionnaires were returned giving a 66 % response rate.

Figure 23 Age of Respondents DART Questionnaires



The majority (85%, n=34) of respondents to DART questionnaires were between the ages of 22-39 years old. 12% (n=5) of respondents fell into the 40-59 age bracket and 3% (n=1) were above the age of 60.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
 HMP Birmingham : Final Version April 2015

Figure 24 Respondents Receiving Prescribed Medicines for Drug and Alcohol Problems

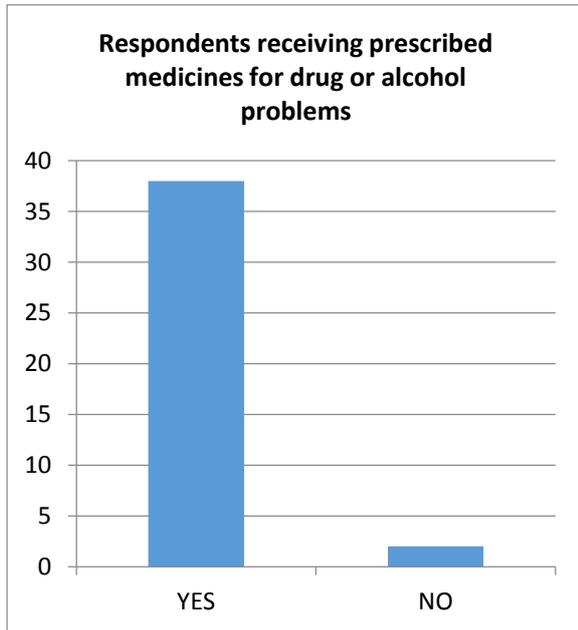
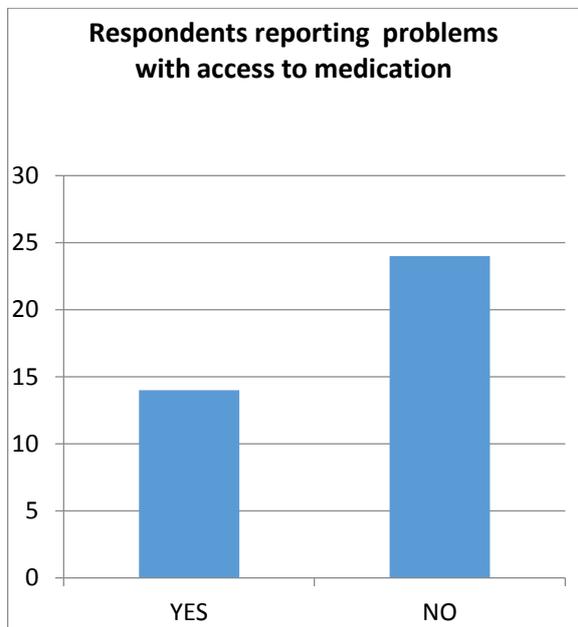


Figure 25 Respondents Reporting Problems with Access to Medication

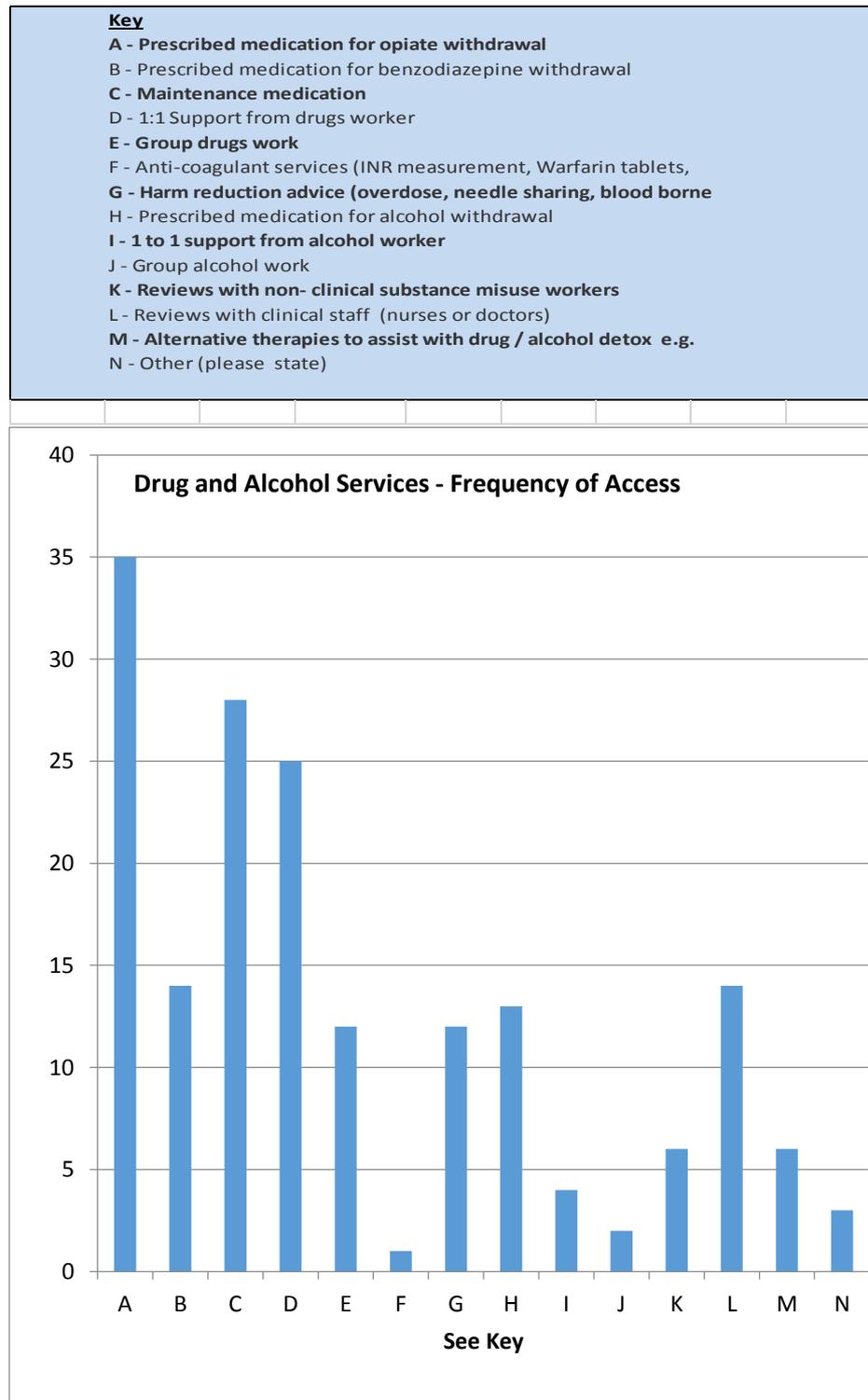


95% of respondents (n=38) were receiving prescribed medication for drug or alcohol problems and 36.8% (n=14) of these men reported experiencing problems accessing their medication. Problems

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

included perceived delays in continuance of prescribed medications and also the perception that medications that had been prescribed in the community were stopped upon admission to prison.

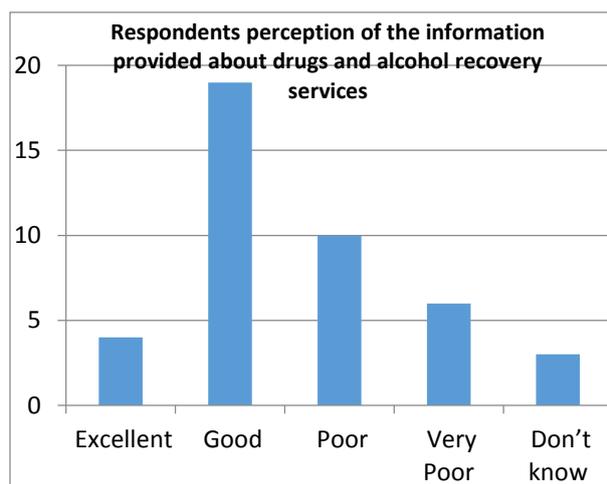
Figure 26 Drug and Alcohol Services – Frequency of Access



West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

'A' was the most frequently accessed service with 35 respondents receiving prescribed medication for opiate withdrawal (see key above). 28 respondents were receiving maintenance medication. 1:1 support from drugs workers was also frequently accessed.

Figure 27 Respondents Perception of Information Received about Substance Misuse Services



The majority of respondents (54.8%, n=23) had a positive perception of the information provided to them about drug and alcohol recovery services within HMP Birmingham. 38% (n=16) perceived it negatively.

The table below summarises service user comments about the service. It should be noted that although some comments are not factually accurate, all comments have been included as they represent service user perceptions.

Figure 28 Service User Comments Drug and Alcohol Services

Service User Questionnaire Comments Drug and Alcohol Services	
What are the best things about drug and alcohol services in this prison?	Are there any things about drug and alcohol services that you think could be improved?
The nurses are very helpful	Let people be on the meds they're on outside
Get you on the road to recovery	Maintain people
Prescribed medication for withdrawal	They could let us detox at our own pace not just drop us as soon as we get a sentence
Helps you clean your act up	I think you should have a care plan which suits the person because its better all round on both parties and then people wouldn't get into debt and stuff
Gives you time to get clean from drugs and helps you recover	Give the meds to people that need them
I am very happy – once again, doctors and nurses are the best and service is at excellent speed. Once again thank you for your support and services	If you come into the prison on a Friday you are left till Monday before you get your medication
They maintained me on methadone so when I get out I will be on a script in the community	Something needs to be done about weekends when first in prison

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

<p>They are well run and the nurses do their best for you</p> <p>I'm maintained on a methadone script and will continue to pick up my script when I get released</p> <p>They help a lot They do give methadone</p> <p>Being maintained on Subutex helps me a lot and got me out of the fragile state of mind of using or wanting to use</p> <p>That they medicate you for these problems</p> <p>Helps you understand about your addiction and gets you help</p> <p>We are given what we need to stop withdrawing</p> <p>X and Y (names removed) work with a lot of services to get you help as soon as you get out which is important – housing, job drug support and mentors to guide you who are already in recovery themselves</p> <p>They do get to all the patients</p> <p>We are given what we need to stop withdrawing</p> <p>If keeps you from using drugs</p> <p>Getting my medication on time everyday</p> <p>There is more than enough help from all concerned, a real good team overall, thank you</p> <p>Not being pushed into coming off your meds</p> <p>That you don't have to do a forced withdrawal where we would suffer for a weeks or even months when it comes to sleep</p> <p>They quickly dealt with proving my methadone when I came into the prison</p> <p>Good nurses and doctors very understanding</p> <p>That they have to provide a service because if it was down to choice I don't think people would do it</p> <p>I am serving few weeks and since last time I was in (more than 2 years ago) the drug service has improved a lot and I am happy as they are faster than ever and I thank you for all support</p> <p>I was asking our family for a lot of money what they haven't got...so it's good I get help from healthcare if not I would be in a lot of trouble owing money out to lads and I can't pay it</p> <p>I'm happy with the situation here</p>	<p>Easier access to getting appointments with the detox doctor</p> <p>Getting to see my drug worker would be a start. See him on wing sometimes I ask to see him he tells me yeh yeh I'll touch base with you tomorrow but he never comes so that could improve in my eyes</p> <p>Need to see the doctors more often</p> <p>Add a drug and alcohol course or education department for the inmates on remand and short sentences. Two times I came here in last three years and I was not able to study about drugs with is my main issue because I have had only 2-4 months which I think even 2 weeks will be enough to get to know the damage about the drugs</p> <p>You should be maintained for as long as you feel you are ready</p> <p>Being told exactly what's happening with your detox and not just going to the medical hatch one day to find that your medication that you thought was maintained is actually being reduced and detoxed</p> <p>Lots of things</p> <p>The first night you come into prison as you are at your worst</p> <p>Take you off pain killers when you've been on them for years for serious health issues. This is wrong</p> <p>More help for alcohol detox would be better as I came here from HMP Notts with a bad alcohol problem and was given three days diazepam and it didn't help at all</p> <p>People who are on medication should get the same as they get outside</p> <p>You should be getting what you get outside, no questions</p> <p>Try and get a doctor in on Saturday so people do not rattle all weekend</p> <p>Nothing except I'm receiving my medication</p> <p>Get to see the doctor quick as possible</p> <p>Your initial medication is and can be tantamount to torture. I suffered on induction for about a month until I got somewhere near my normal meds</p> <p>A closer understanding of the service users reasoning and background which led them to use drugs or alcohol in the first place</p>
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West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

<p>As healthcare here are always willing to listen and help and improve their services, overall I'm happy and so are many of the other prisoners</p>	<p>Giving prisoners a more adequate drug screening test when they first come in because the test they give you now is inadequate most of the time even when you do have opiates in your system</p>
<p>I think I'm starting to see small changes that are common sense – maintaining people who need that safety net because I've seen many times where people have been taken off their methadone too quickly and have gone back to using heroin again.</p>	<p>The prisoner should have more say in how long he is treated</p> <p>Nobody should have to withdraw even for a single day as all the facilities are available when you arrive on induction, painkillers don't do anything at all - would save prisoners and staff a lot of hassle</p>

Overall, there is a balance of comments. Areas of service user frustration appear to be predominantly around the continuance of medications prescribed by their community GP and detoxification regimes. It is important when considering this to differentiate between demand and need and to acknowledge that clinically robust and evidence based approaches may not always be accepted by the service user group.

The continuance or non-continuance of previously prescribed medication reflects the rationalised approach to the prescribing of tradable medications (such as Pregabalin, Tramadol & Gabapentin) that GPs at the prison have adopted in accordance with NICE and safer prescribing guidance⁴⁰.

14.3 Recommendations Substance Misuse

- It is recommended that implementation of electronic prescribing via SystmOne is considered and that all prescribers utilise this single electronic prescribing system as there is an inherent clinical risk when multiple prescribers (e.g. Primary care GPs, Substance Misuse, Psychiatry) separately prescribe. This has been evidenced in several death in custody reviews where poly-pharmacology is cited as a causative factor.
- A process mapping exercise should be undertaken to identify and remove duplication in IDTS and DART pathways.
- Advice should be sought from service providers Corporate Information Governance Teams regarding DART staff having access to SystmOne, enabling use of one electronic patient record to facilitate patient centred joint care planning approaches.
- Development of a recovery wing to support men post detoxification should be explored by IDTS and DART services in liaison with Commissioners and the prison provider.
- The service should continue to liaise closely with prison colleagues regarding use of NPS and misuse of prescribed medications, ensuring that appropriate information sharing and intelligence sharing policies are in place to facilitate a cohesive approach to creating a safer substance environment.
- It is suggested that a multi-disciplinary regional task force comprising commissioners, providers, prison colleagues and representatives from local A&E and police custody

⁴⁰ RCGP Safer Prescribing in Prisons Guidance for clinicians RCGP Secure Environments Group

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

healthcare providers is formed to develop a prisons healthcare approach to the management of New Psychoactive Substances. This is further discussed in the regional report.

- It would be useful to capture more specific statistical data for use of New Psychoactive Substances and misuse associated with prescribed medication to inform strategies for addressing these areas of misuse.
- It may be useful for DART to develop a bank of suitably qualified security cleared group facilitators to enable group work to be delivered consistently.
- The extension of the Recovery Champion role and peer led initiatives to support recovery should be explored. Examples of good practice within the region (e.g. Recovery Champion Initiative at HMYOI Brinsford) could be used to further develop the role at HMP Birmingham.

15. Planned and Unplanned Secondary Care

The management of planned and unplanned visits to secondary care facilities requires close liaison with prison colleagues within secure environments.

With recent benchmarking exercises and the efficiencies required across all public sector services, it has become essential that this element of healthcare service provision is robustly managed and that innovations to reduce hospital escorts and bed watches are considered in order to continue to meet healthcare needs.

The healthcare department are currently allocated 5 appointment slots per week day for hospital escorts. There are three escort slots in the morning and two in the afternoon. The team reported that on occasions they struggle to manage the number of patient appointments required within the number of escort slots available. If more than five patients have appointments in a day, the GP reviews appointments and advises which appointments may be postponed, providing a clinical overview to the process.

G.P referrals are faxed to the hospital and appointments are then made via the healthcare administration department. All appointments are entered on to the SystmOne appointments ledger and also on to a spreadsheet detailing the department / speciality.

An analysis of appointments by speciality for the first three months of 2015 was undertaken and is summarised in the table below:-

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
 HMP Birmingham : Final Version April 2015

Figure 29 Appointments by Speciality 2014

Department / Speciality	Jan-15	Feb-15	Mar-15	Totals
Accident & Emergency	10	5	11	26
Breast Clinic	1	0	1	2
Cardiology	0	1	0	1
Clinical trials	3	2	2	7
CT Scan	1	2	1	4
Dermatology	1	0	1	2
Dialysis	12	10	12	34
Dressings clinic	3	0	0	3
Endoscopy	1	1	0	2
ENT	0	1	1	2
Eye Clinic	2	0	1	3
Fracture clinic	7	0	8	15
Hand clinic	0	1	1	2
MRI	6	1	5	12
Neurophysiology	3	0	1	4
Oral surgery	0	5	2	7
Oral / Maxillo- facial	0	0	5	5
Outpatients (general - not specified)	20	27	17	64
Pre-assessment clinic	0	3	2	5
Respiratory outpatients	0	1	0	1
Retinopathy screening	0	0	3	3
Surgical outpatients	3	0	2	5
Trauma and orthopaedics	4	2	2	8
Ultrasound	5	9	8	22
X-Ray	29	11	6	46
Miscellaneous other	0	1	3	4
Totals	111	83	95	289

- The specific department and speciality are not recorded for all appointments, therefore in the period studied 64 appointments were attributed to 'general outpatients'. If the department or speciality of all appointments is recorded this will enable a more detailed analysis to be undertaken to inform action plans to reduce escorts and bed watches.
- The highest number of specifically identified escorts were for x- rays (n=46).
- Projection of the three month figures suggest approximately 184 appointments per year for x-rays.
- At the time of writing this report, HMP Birmingham have begun to utilise on site x-ray facilities supported by radiography staff from Birmingham City Hospital and have already seen a marked reduction in the number of hospital escorts.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

- Dialysis, Accident & Emergency, Ultrasound and Fracture Clinic were also specialities accounting for higher numbers of escorts. Recommendations have been made regarding each of these at the end of this section.
- Outpatient visits to the most frequently accessed specialities combine to account for approximately 49.48% of all appointments. Rigorous targeting of the reduction of escorts in these areas could significantly reduce numbers and costs and improve patient experience.

The majority of patients from the prison attend Birmingham City Hospital which is located close by. However, occasionally patients also attend appointments at other local hospitals (Birmingham Heartlands, Sandwell, Russells Hall Hospital, & Queen Elizabeth Hospital).

It would be beneficial for the Healthcare Department to develop strong links with Directorate Leads at Birmingham City Hospital and to develop ongoing dialogue to identify and address actions that can be taken to reduce the numbers of hospital escorts and duration of bed watches.

15.1 Recommendations – Planned and Unplanned Secondary Care

- The healthcare department should liaise with Birmingham City Hospital to enable pre-operative assessments to be conducted by nursing staff at the prison.
- The potential for undertaking minor oral surgery procedures on site should be explored.
- An on-site x-ray facility has recently become operational. It is recommended that consideration is given to expanding this to incorporate ultrasound scans.
- Telemedicine has significantly reduced hospital escorts within the North East Cluster of prisons. It is recommended that Commissioners undertake a regional cost-benefit analysis for the introduction of telemedicine facilities. This is discussed further in the regional analysis. At HMP Birmingham, a combination of on-site x-ray and telemedicine consultations could be used to reduce fracture clinic and orthopaedic appointments.
- Unplanned visits to hospital (Accident & Emergency) should be analysed and a training needs analysis undertaken to identify training that would support on site management - for example minor illness / injuries training and suturing wound adhesions.
- A SystemOne template with background READ codes should be used to record all unscheduled hospital visits (escorts and bed watches) to enable accurate future analysis.
- Continue to review all EBW data on a regular and on-going basis to identify any areas for development.

16. Stakeholder Analysis

16.1 Methodology

The HNA comprised both qualitative and quantitative approaches, combining interviews, focus groups and service user and visitor questionnaires.

Semi-structured face to face interviews were conducted with the Director of Healthcare, Forensic Psychiatrist, Mental Health Manager Clinical Co-ordinator, Appointments Co-Ordinator and the manager of the Drug & Alcohol Recovery Team (DART). In addition, discussions were held with the Lead GP and Primary Care Lead. A service user focus group was held with seven participants.

120 service user questionnaires were distributed in total (60 x general healthcare questionnaires and 60 x DART questionnaires). Feedback from the DART questionnaire is incorporated into section 14 of this report.

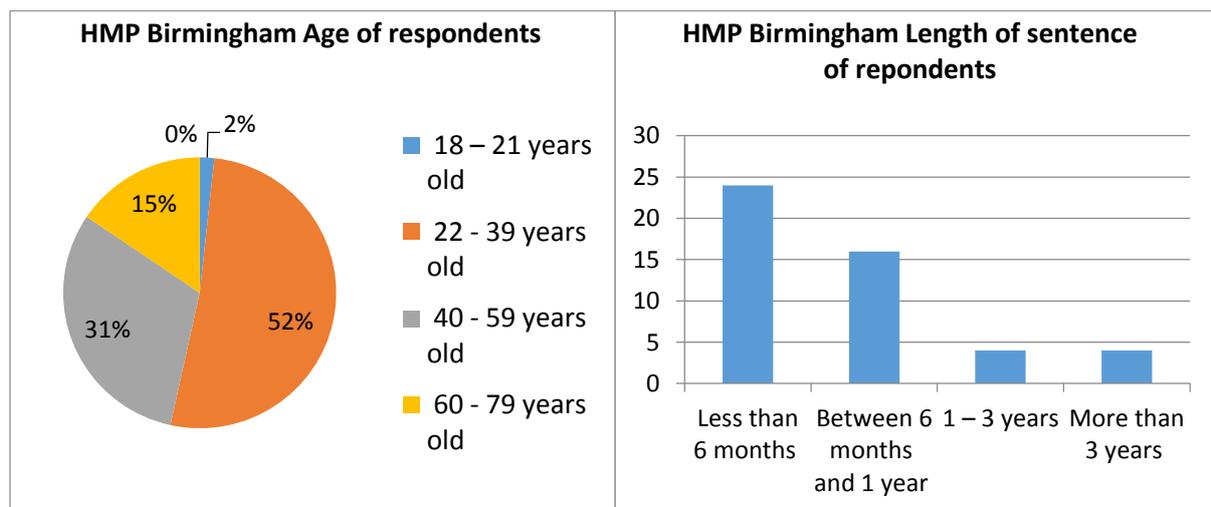
16.2 Questionnaires

50 general questionnaires were distributed and 47 returned, giving an excellent response rate of 94%. However, it should be noted that not all responses were complete and therefore rates of responses to individual questions varied slightly.

Collated general questionnaire results are illustrated in the figures below. Feedback from individual wings and wards can be found in Appendix 1.

Figure 30 HMP Birmingham General Questionnaires Age of Respondents

Figure 31 HMP Birmingham General Questionnaires Length of Sentence of Respondents

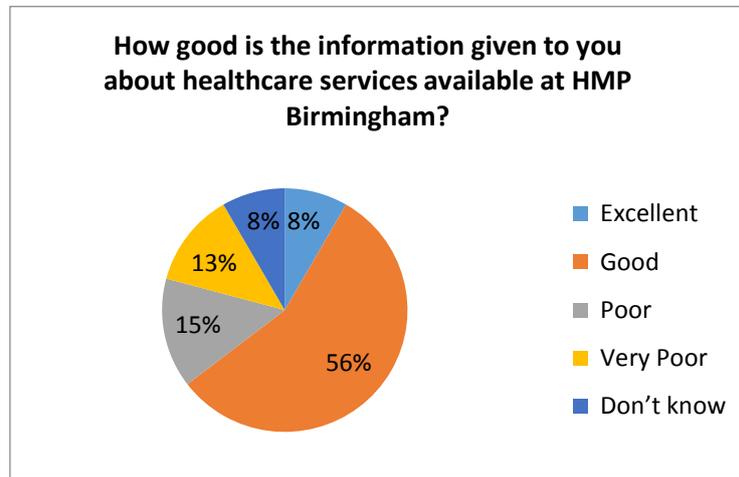


The majority of respondents (52%, n=30) fell into the 22-39 year age bracket. 46% (n=27) of respondents were above the age of 40 and 2% (n=1) were under the age of 22. There were no respondents aged 80 years or more.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

50% (n=24) of men were serving sentences of less than 6 months, 33% (n=16) were serving between 6 months and 1 year, 8.3% (n=4) between 1 and 3 years and 8.3% (n=4) more than 3 years.

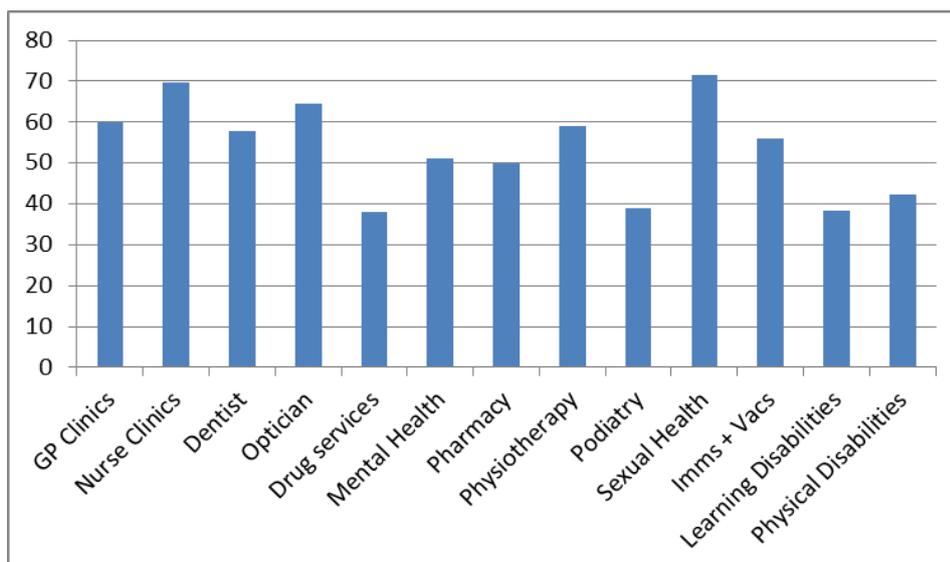
Figure 32 HMP Birmingham General Questionnaires Information about Healthcare Services



The information provided to prisoners about healthcare at HMP Birmingham was rated 'good' by 56% (n=27) of respondents. A further 8% (n=4) deemed it to be 'excellent'. 28% (n=13) of respondents gave negative feedback.

Perception of the quality of services was measured via Likert scale responses (Excellent, Good, OK, Poor, Very Poor) which were assigned numerical scores and collated to produce an overall rating. An additional (non-rateable) response of 'Don't know' was included and overall scores for each service were adjusted according to the number of rateable responses to reduce bias for services not accessed by all respondents.

Figure 33 HMP Birmingham Service User Perception of Quality of Services



West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

GP Clinics, Nurse Clinics, Optician and Sexual Health Services were all perceived favourably by service users and scored 60% or more. Drug Services, Podiatry and Learning Disability Services were less positively viewed.

16.3 Qualitative feedback

The table below summarises service user comments about the prison healthcare service. As with comments from DART service user questionnaires, it should be noted that although some comments are not factually accurate, all comments have been included as they represent service user perceptions.

Figure 34 HMP Birmingham Comments from General Questionnaires

Service User Comments from General Questionnaire	
What are the best things about healthcare services in this prison?	Are there any things about healthcare services that you think could be improved?
I get my meds mostly on time and all the doctors on healthcare are very good. I do find that they do have time for me	Takes too long for what I want. Only good thing is at healthcare unit you get to play on the computer
There are a lot of staff about and they are there if you need them	Optician: I would like reading glasses and can't get an appointment. I don't care if I have to pay for glasses as my others have been lost in court. Boots glasses will do but I must have something for work and reading
I have found it to be as good as it can be	Waiting time for dentist and optician
Everyone in this prison is treated very well	The time medication is ordered – seems nurses and pharmacy do not work together on this service leaving delays on medication reaching wings (I.Ps)
The nurses and doctors are always available to give you advice and information and also in my view are caring and do a very good job	If medication at meds time could not already be made up (in container/glass) for service at hatch as this would speed up medication on wing rather than waiting till person has got to hatch then going through all guys to admin medication
At least we have them though it takes a while to see everyone	Give medicines on time
At least we have all the facilities even if it takes a while to book	See prisoners who need urgent care
If you need some medication you could ask at the hatch and if they have it they give it to you	Improve dentist services
Pharmacy	Poor attention to requirements, very unreliable, spasmodic! Nobody pays attention to particular requirements. Everything is slow – appointments etc
It's clean	Listen to patient
Quick appointments	Get prescription right
Doctors are quite good and easy to get to see	Medication times are inconsistent, maybe 3pm one day then 11pm. Pharmacy are very slow, sometimes requests for I.P meds go missing.
I've only had 2/3 hep jabs haven't used any other service	
Staff are very helpful	
Positive	
Good and quick service	

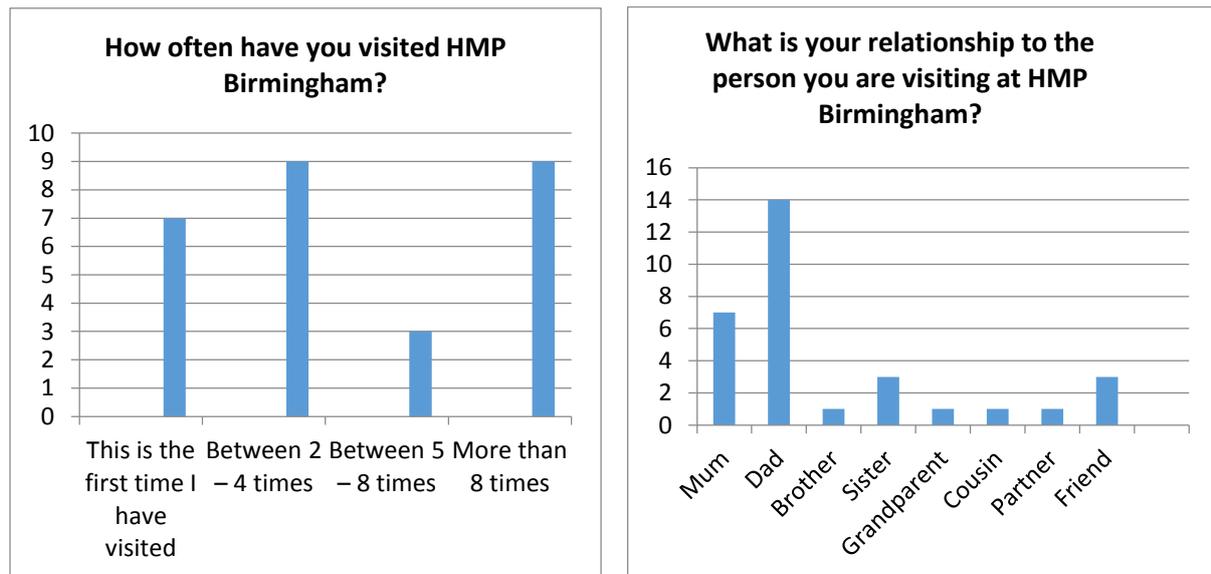
West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

<p>Easy access via kiosk machine</p> <p>It's free</p> <p>Better environment, few people, less interaction with other people. That is what I need at the moment (Ward 2 patient)</p> <p>Near to home</p> <p>Free meds</p> <p>Polite, helpful staff</p> <p>The opticians were very good</p> <p>It is a very good nurse clinic and good nurses and medicines</p>	<p>The whole system for medication needs totally upgrading – e.g. medication arrives while food being served, plus many more problems</p> <p>To be seen quicker and with the dentist it would be nice if you could have what needs to be done even if you are on remand</p> <p>I.P drugs – so we can take them at the proper time, it's no good taking sleeping tablets at 3pm on Fri, Sat, Sun and 6pm Mon to Thurs. Enhanced and red band prisoners should be trusted with I.P drugs knowing they will be withdrawn forever if abused. Even if it's dealt out once a day but you are allowed to take at the appropriate time</p> <p>We should be told as soon as we come into the prison that there are vaccinations available</p> <p>Quicker service / appointments (x5 comments)</p> <p>Physiotherapy (x2 comments)</p> <p>Everything needs improving</p> <p>Dentist appointments take too long</p> <p>If you didn't have to wait so long for your creams – issue them on the day you visit healthcare, usually get them a few days later</p> <p>Get new doctors that will listen to patients needs</p> <p>Doctors don't listen to you</p> <p>Correct medication prescribed for illnesses</p> <p>I think that taking people for bloods at the same time as doctors' appointments is not good practice as the nurse does not arrive till approx. 10am so people are waiting a long time</p> <p>Be quicker for appointments</p> <p>More psychology and psychotherapy depending on what you need</p> <p>More tobacco</p> <p>Not received any information about healthcare</p> <p>Waiting times and knowing prisoner needs</p> <p>Everything – most people I speak to (i.e. friends on the wing or other inmates) always put the service down</p>
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16.4 Visitor Questionnaires

Figure 35 Visitors Questionnaire Frequency of Visits

Figure 36 Visitors Questionnaire Relationship to Service User



The majority of respondents to the visitors questionnaire had visited HMP Birmingham either 2-4 times (32%, n=9) or more than 8 times (32%, n=9). For a quarter of visitors (25%, n=7) this was the first time they had visited the establishment.

66.6% (n=20) of visitors were parents, with exactly twice as many fathers (46.7%, n=14) as mothers (23.3%, n=7) visiting on the day questionnaires were distributed. 13% (n=4) of visitors were siblings and 10% (n=3) were friends.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
 HMP Birmingham : Final Version April 2015

Figure 37 Visitor Questionnaires Perception of Healthcare Services

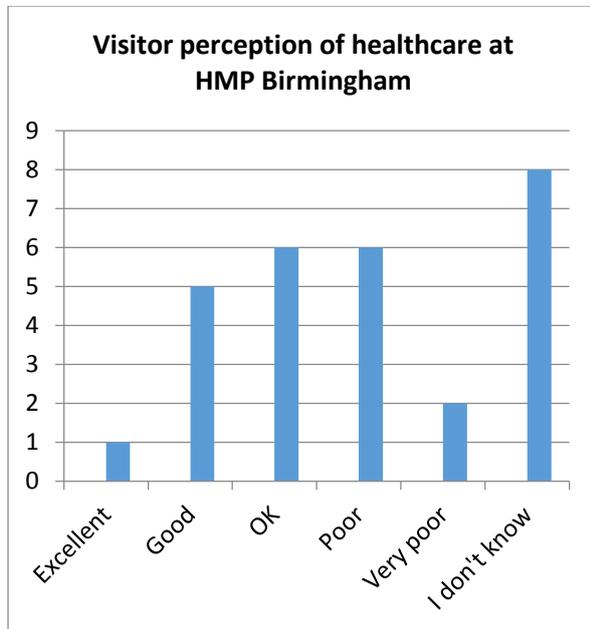
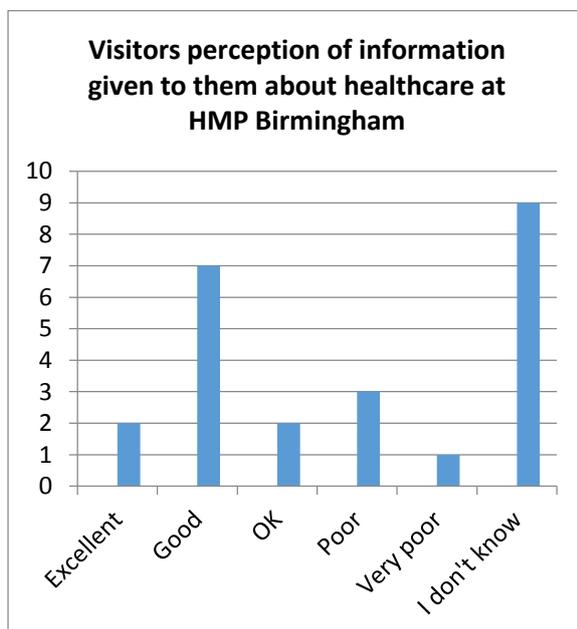


Figure 38 Visitor Questionnaires Perception of Information about Healthcare Services



The majority (28.6%, n=8) of visitors answered ‘I don’t know’ when asked what their perception of healthcare at HMP Birmingham was. 42.9% (n=12) perceived healthcare favourably, rating it either ‘Ok’ (21.4%, n=6), ‘Good’ (17.9%, n=5), or ‘Excellent’ (3.6%, n=1).

29.2% (n=7) of respondents viewed the information given to them about healthcare services at this prison favourably, rating it ‘Good’, while 12.5% (n=3) deemed it ‘Poor’. However, as with the previous question, the majority of visitors (37.5%, n=9) answered ‘I don’t know’. An opportunity

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

therefore exists to include the visitors' centres and families in health promotion initiatives to enhance patient and family involvement and also extend the reach and communication of key public health and health promotion messages.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

Figure 39 Comments from Visitors

Visitor Questionnaire Comments	
What healthcare issues do you think are important to men in this prison?	What healthcare issues are important to you as friends and family of men in this prison?
General checks Dentist (2 x comments) Sexual health Doctors (2 x comments) Mental health (3 x comments) Physical health Stop smoking All food/toilets/beds/work/eat/showers DART (4 x comments) Drugs (2 x comments) Hospital Wellbeing (2 x comments) Healthcare is important but my dad needs his medication on time To make sure they're ok General healthcare Antibiotics Co-codamol Counselling (2 x comments)	DART (2 x comments) I want my partner to come home better Stop smoking My partner requested to see a dentist and it took over a week, also when he came to prison he had hurt is foot, he was on crutches and they couldn't take him to his follow up appointment Drugs (2 x comments) Hospital Regular checks Access to appropriate people in health sectors When I am trying to ring the prison I can never get through, the only answer I get is either from legal or the visit centre who try to help me Just that the best healthcare is provided in all areas while inside That my partner gets the best healthcare possible More reliable service Counselling (2 x comments) Mental health (3 x comments) Needs to be better advertised what help is available Unware of what healthcare services are available More help with rehab There are a lot of people who need more help than they are getting I think families need to know things available so we can support our partners on the outside

16.5 Recommendations: Stakeholder Feedback

- The healthcare department could include the visitors' centres and families in health promotion initiatives to enhance patient and family involvement and also extend the reach and communication of key public health and health promotion messages.
- Waiting times for services could be displayed in the visitors centre.

17. Independent Scrutiny

Independent inspections of HMP Birmingham were encouraging, although several areas of need were identified.

HMP Birmingham was subject to an unannounced inspection by HMIP in March 2014.

The HMIP report stated that within HMP Birmingham ‘prisoners were generally satisfied with health services, although they were unhappy with access to the dentist. Governance systems were robust. Health services were good, although some failure to attend rates were too high and daytime activities for inpatients needed improvement. Pharmacy services were good, but some prisoners on night-time medication were still not receiving them at prescribed times. Dental services were adequate but far too many prisoners were waiting to receive non-urgent treatment. Mental health services were impressive’⁴¹.

In a survey undertaken by HMIP during this inspection, 47% of prisoners said the overall quality of health care was good against a comparator of 38% and 34% in 2011⁴².

HMP Birmingham was inspected against the following CQC outcomes in November 2011

Outcome 1	People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run
Outcome 4	People should get safe and appropriate care that meets their needs and supports their rights
Outcome 6	People should get safe and coordinated care when they move between different services
Outcome 14	Staff should be properly trained and supervised, and have the chance to develop and improve their skills
Outcome 16	The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The service was assessed as meeting standards for outcomes 1, 6 and 14. HMP Birmingham failed to meet the standard for outcomes 4 and 16. The CQC report documents this was because

- Initial access to the healthcare services was difficult.
- Discipline staff were not always available to escort patients to appointments.

⁴¹ HMP Birmingham Unannounced Inspection by HMIP, 24th February-7th March 2014, p37

⁴² HMP Birmingham Unannounced Inspection by HMIP, 24th February-7th March 2014, p38

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

- There was a lack of information and/or communication about healthcare⁴³.

A follow up inspection was therefore undertaken in December 2012 to make sure the improvements required had been made. The service was assessed as meeting both standards⁴⁴.

The CQC report found that 'the trust was now working more closely with the prison service to resolve the issues identified [and] had implemented a number of systems to improve people's access to the healthcare services. Information provided by the trust demonstrated that monitoring of the service was much improved. Issues were identified and addressed in a more timely fashion. A new system had been implemented in the reception area of the healthcare wing to allow people to give feedback on the service they received directly'⁴⁵.

The Annual IMB report identified some issues which remained unresolved despite being acknowledged in previous reports. These included the use of a forensic psychologist for prisoners displaying bizarre behaviour, the use of the x-ray machine in reception and unacceptable responses to prisoner complaints⁴⁶.

18. Compliments and Complaints

In the period April to October 2014, the prison healthcare department received an average of 72.3 complaints each month.

4 compliments were received during this time (April, May, August and October).

19. Incidents & Serious Untoward Incidents

Figure 40 Incidents and Serious Untoward Incidences

⁴³ HMP Birmingham Care Quality Commission Report, November 2011, <http://www.cqc.org.uk/location/RXTC4/reports>

⁴⁴ HMP Birmingham Care Quality Commission Report, December 2012, <http://www.cqc.org.uk/location/RXTC4/reports>

⁴⁵ HMP Birmingham Care Quality Commission Report, December 2012, <http://www.cqc.org.uk/location/RXTC4/reports>

⁴⁶ HMP Birmingham The Annual Report of the Independent Monitoring Board, 1st July 2012-30th June 2013, p8

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
 HMP Birmingham : Final Version April 2015

	Clinical Incident	Violence, Abuse And Harassment	Ill Health	Security	Other (Estates, Facilities & C	Total
Medication (Administration)	8					8
Self Harm (Actual)	5					5
Verbal Abuse		3				3
Medication (Management)	5					5
Threats To Harm Other(S)		6				6
Ill Health (Patient)			4			4
Staffing Issues	3					3
Assault (Physical)		1				1
Aggressive Behaviour		1				1
Medication (Prescription)	1					1
Assault (Sexual)		1				1
Medication (Dispensing)	3					3
Death	1					1
Inappropriate Behaviour	1					1
Safeguarding/Privacy & Dignity	1					1
Complaint / Potential Complain					2	2
Ill Health (Other)			1			1
Intrusion / Trespassing / Brea				1		1
Total	28	12	5	1	2	48

The majority of incidents reported were clinical incidents. Incidents relating to medication administration were the most common, followed by incidents of actual self harm.

5 serious incidents were recorded (1 for each of the months April, August and October 2014 and 2 in September 2014) but data has been suppressed due to low numbers. However, there is evidence to suggest that lessons learned from serious incidents are communicated to staff and that amendments are made to systems, policies and practice as a result of these, which is excellent practice.

20. Deaths In Custody

There were 4 deaths in custody at HMP Birmingham between the months of April 2014 and October 2014 - 3 of these occurred in April and 1 in October.

As the coroners inquests for these deaths have not yet been held and the Prison and Probation Ombudsman reports not published, details are suppressed.

The Prison and Probation Ombudsman's archive of fatal incidents indicates:

In 2010, there were 11 deaths at the prison of which 6 were from natural causes and 5 self- inflicted.

In 2011, there were 4 deaths, all from natural causes.

In 2012, there were 2 deaths, one from natural causes and one self- inflicted.

2013 and 2014 are incomplete as reports are not published until after the coroner's inquest.

There are no specific themes in healthcare recommendations from the six deaths in 2011 & 2012. Actions have been taken to meet the requirements of all accepted recommendations.

Recommendations include:

- Ensuring contemporary record keeping
- Implementing palliative care pathways and end of life care planning
- Follow up of blood test and results
- Ensuring urgent access to GP is available

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

- Medication and food supplements to be prescribed in accordance with Trust formularies
- Implementation of specific medication audits
- Ensuring access to supplies of emergency stock medication
- Effective communication regarding risk status of patients

21. Local Summary and Gap Analysis

At HMP Birmingham, a range of healthcare services and interventions are delivered to meet the needs of the population.

The key areas where gaps in meeting need have been identified are:

- Management of non-attendance at appointments (DNAs) to facilitate optimum use of available appointment time and improve access to healthcare
- Offer and uptake of national screening programmes
- Hepatitis B vaccination coverage
- Management of New Psychoactive Substances
- Identification, referral, assessment, diagnosis and support for those with learning disabilities, Autistic Spectrum Disorders and conduct disorders

The reader is referred to the synopsis of findings in the executive summary at the beginning of the report for a broader summary.

22. Local recommendations

The following recommendations are based upon information that has been made available to the Health Needs Assessment Team at the time of writing this report.

No.	Area	Recommendation
1	Facilities	The pharmacy work space requires refitting to optimise working space to accommodate volume of work required.
2	Facilities	The nurses consulting room in reception requires upgrading to meet clinical standards.
3	Facilities	It is recommended that a review is undertaken of space available for IDTS & DART screening consultations to enable all consultations to be undertaken confidentially.
4	Reception screening	The current reception screening template should be reviewed and back ground READ codes assigned to ensure that all data is captured and able to be reported through the SystemOne reporting functionality.
5	National screening programmes	SystemOne and the reception screening template should be utilised to identify patients eligible for Abdominal Aortic Aneurysm screening, bowel cancer screening and NHS CVD Risk national screening programmes.
6	National screening programmes	Aligned with HJIP reporting requirements, SystemOne READ codes should be allocated within a local READ code formulary to assign when the above screening is offered, accepted or declined and negative or positive results recorded. This will provide local evidence of implementation of screening programmes and may also contribute to regional and national data sets.
7	National screening programmes	All men eligible for bowel cancer screening should be identified through SystemOne clinical reporting function and an awareness programme and screening 'catch up' programme launched to ensure all those eligible have been offered screening.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

No.	Area	Recommendation
8	National screening programmes	Bowel cancer screening should then be offered as a rolling programme.
9	National screening programmes	Many elements of CVD screening for over 40's are already incorporated into the screening template. A mapping exercise should be undertaken to identify any additional referral prompts required to ensure initial and CVD risk screening dovetail and are undertaken as efficiently as possible and without unnecessary duplication of effort. A rolling programme of screening should utilise healthcare assistants and health trainers to provide lifestyle advice and information.
10	National screening programmes	SystemOne should be utilised to auto-generate flags when men reach the age of 65 and become eligible for AAA screening.
11	National screening programmes	All patient records should detail NHS numbers to facilitate inclusion and continuation of national screening programmes.
12	National screening programmes	The generation of quarterly reports detailing the age and ethnicity of those accessing national screening programmes (utilising SystemOne clinical reporting functionality) would enable evaluation of equality of access.
13	Primary Care Clinics	A robust multi-faceted campaign to reduce DNAs should be planned and implemented (the author notes that work on this has already commenced).
14	Primary Care Clinics	DNA management should be on Senior Management Team agendas and regularly reviewed until DNA rates reduce and remain at less than 20%.
15	Primary Care Clinics	Clear definitions of what constitutes 'DNA' need to be agreed, as definitions across the cluster differ and may result in inaccurate cross cluster comparisons.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

No.	Area	Recommendation
16	Primary Care Clinics	The healthcare department may wish to discuss whether non-attendance at clinic appointments without good reason can be linked to the Incentives and Enhanced Privileges system within the prison. This approach has been very successfully used at HMPYOI Drake Hall, where DNA rates are the lowest across the cluster.
17	Primary Care Clinics	All prisoners should be given written information about the approach to non- attendance.
18	Primary Care Clinics	The optician could deliver ocular triage training sessions and develop ocular triage algorithms to support nursing staff assessment and reduce unnecessary referrals to the optician. It is recommended that the healthcare team liaise with the prison provider to identify ways in which prisoners could purchase reading glasses as they might do in the wider community.
19	Primary Care Clinics	Nursing staff could also be trained to undertake simple foot assessments to reduce podiatry referrals, and in conjunction with access to over the counter products such as corn plasters and bunion pads, this may reduce podiatry appointments and encourage self-management where appropriate.
20	Primary Care Clinics	Innovative ways to deliver services such as mobile vaccination clinics could be considered. Mobile vaccination clinics (held within education and workshops for example) could:- <ul style="list-style-type: none"> • Reduce the overall number of appointments required • Increase vaccination uptake and vaccination coverage • Reduce DNA's • Reduce time spent out of purposeful activity
21	Primary Care Clinics	In an award winning patient involvement initiative launched at HMP Leeds, DNA's were reduced by 30% though enrolling healthcare representatives / health champions to work with healthcare staff to relay messages to their peers about the importance of attendance at appointments. Working in liaison with the prison provider at HMP Birmingham, it is recommended that a similar initiative is launched to support communication of key messages around appointment attendance.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

No.	Area	Recommendation
22	Primary Care Clinics	Poster information and interactive awareness sessions held with families and visitors could help to engage them in communicating the importance of attendance at appointments.
23	Long Term Conditions	The QOF 'How Am I Driving?' report suggests that 21% of asthmatics have had an asthma review in the last 12 months. With the rapid churn of the prison it may be that a proportion of prisoners are released prior to reviews being undertaken, however it should be ensured that all activity is READ coded and captured accurately to reflect the work being undertaken.
24	Long Term Conditions	A local READ code formulary should be developed and READ codes assigned to screening templates, diabetes clinic templates and free text consultations that differentiate between type 1 and type 2 diabetes.
25	Long Term Conditions	It should be ensured that all activity associated with the review of Long Term Conditions is READ coded appropriately to accurately reflect activity undertaken.
26	Long Term Conditions	Plans to conduct diabetic retinopathy screening on site should be pursued to ensure accessibility and uptake and also reduce unnecessary hospital escorts.
27	Vaccinations	It is recommended that the current systems for data capture and collation are reviewed to ensure that activity associated with Hepatitis B and C screening, vaccinations and treatment is accurately reported and reflects the work undertaken, and in particular reflects vaccination coverage, which may have been under reported in previous data submissions.
28	Health Promotion	SystemOne smoking cessation templates are available but not utilised. Use of the templates would enable more accurate reporting of smoking cessation activity and outcomes.
29	Health Promotion	There is an opportunity to increase service user and family and carer engagement in health promotion activity. It is recommended that a designated member of the primary care team is identified to link with the visitors centre to develop an innovative and inclusive health promotion programme that maximises service user, family and carer engagement.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

No.	Area	Recommendation
30	Social care	It is important that healthcare commissioners and providers and HMPS and NOMS colleagues create strong communication pathways with the Local Authority (Adult Social Services) to identify opportunities for information sharing and joint commissioning to meet the health and social care needs of prisoners at HMP Birmingham.
31	Social Care	Healthcare has access to a range of population data that may be useful to those tasked with planning services to meet social care need within the prison. Information sharing agreements should be in place to ensure that a mutually supportive relationship between health and social care is generated that benefits patients and supports a holistic care approach.
32	Mental health	The Mental Health First Aid Training (MHFA) planned for officers and health champions should be progressed.
33	Mental health	The visitors centre at HMP Birmingham is very proactive and their expertise could be leveraged to widen the audience for key mental health awareness messages. Opportunities for additional funding to include families and carers in Mental Health First Aid Training should be explored.
34	Mental health	The Healthcare Director and Clinical Lead should liaise with prison providers to ensure that time out of cell on the impatient unit is not compromised and that patients are not disadvantaged by their location and have access to association time, gym and physical activities .
35	Mental health	The opportunity to utilise third sector organisations to provide alternative counselling services other than those offered by chaplaincy should be considered.
36	Learning Disabilities	It is recommended that a Commissioner led Steering Group is formed to review current Learning Disability and Autism services and support across the West Midlands Prison Cluster.
37	Learning Disabilities	The Steering Group should link with any existing multi-agency autism strategy groups to review, develop, implement and evaluate local care pathways.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

No.	Area	Recommendation
38	Learning Disabilities	It is recommended that funding is identified to develop a regional resource to support further research, identification, signposting and support services for the West Midlands Prisons cluster.
39	Learning Disabilities	It is recommended that the regional resource will comprise an appropriate cohort of professionals who are able to develop care pathways for children, young people transferring from children's to adult services and adults who have learning disabilities, ADHD or Autistic Spectrum Disorders.
40	Learning Disabilities	It is recommended that the regional resource is commissioned to provide: <ul style="list-style-type: none"> ○ assessment, treatment and support and referral services for service users whilst in prison ○ education and awareness raising for healthcare staff and HMPS and NOMS colleagues ○ a through the gate service linking to Community Healthcare Teams, third sector agencies, peer support networks and Community Rehabilitation Companies to support resettlement on release
41	Substance Misuse Services (IDTS / DART)	It is recommended that the implementation of electronic prescribing via SystemOne is considered and that all prescribers utilise this single electronic prescribing system as there is an inherent clinical risk when multiple prescribers (e.g. Primary Care GPs, Substance Misuse, Psychiatry) separately prescribe. This has been evidenced in several death in custody reviews where poly-pharmacology is cited as a causative factor.
42	Substance Misuse Services (IDTS / DART)	A joint process mapping exercise should be undertaken to identify and remove duplication in IDTS and DART pathways.
43	Substance Misuse Services (IDTS / DART)	Advice should be sought from each service providers Corporate Information Governance Teams regarding DART staff having access to SystemOne, enabling use of one electronic patient record to facilitate patient centred joint care planning approaches.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

No.	Area	Recommendation
44	Substance misuse services (IDTS / DART)	Development of a recovery wing to support men post detoxification should be explored by IDTS and DART services in liaison with commissioners and the prison provider.
45	Substance Misuse Services (IDTS / DART)	The service should continue to liaise closely with prison colleagues regarding use of NPS and misuse of prescribed medications, ensuring that appropriate information sharing and intelligence sharing policies are in place to facilitate a cohesive approach to creating a safer substance environment.
46	Substance Misuse Services (IDTS / DART)	It is suggested that a multi-disciplinary regional task force comprising Commissioners, providers, prison colleagues and representatives from local A&E and police custody healthcare providers is formed to develop a prisons healthcare approach to management of New Psychoactive Substances. This is further discussed in the regional report.
47	Substance Misuse Services (IDTS / DART)	It would be useful to capture more specific statistical data for use of New Psychoactive Substances and misuse associated with prescribed medication to inform strategies for addressing these areas of misuse.
	Substance Misuse Services (IDTS / DART)	It may be useful for DART to develop a bank of suitably qualified security cleared group facilitators to enable group work to be delivered consistently.
48	Substance Misuse Services (IDTS / DART)	The extension of the Recovery Champion role and peer led initiatives to support recovery should be explored. Examples of good practice within the region (e.g. Recovery Champion Initiative at HMYOI Brinsford) could be used to further develop the role at HMP Birmingham.
49	Hospital Appointments & Secondary Care	The healthcare department should liaise with Birmingham City Hospital to enable pre-operative assessments to be conducted by nursing staff at the prison.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

No.	Area	Recommendation
50	Hospital Appointments & Secondary Care	The potential for undertaking minor oral surgery procedures on site should be explored.
51	Hospital Appointments & Secondary Care	An on-site x-ray facility has recently become operational. It is recommended that consideration is given to expanding this to incorporate ultrasound scans.
52	Hospital Appointments & Secondary Care	Telemedicine has significantly reduced hospital escorts within the North East Cluster of prisons. It is recommended that Commissioners undertake a regional cost- benefit analysis for the introduction of telemedicine facilities. This is discussed further in the regional analysis. At HMP Birmingham a combination of on-site x-ray and telemedicine consultations could be used to reduce fracture clinic and orthopaedic appointments.
53	Hospital Appointments & Secondary Care	Unplanned visits to hospital (Accident & Emergency) should be analysed and a training needs analysis undertaken to identify training that would support on site management - for example minor illness / injuries training and suturing wound adhesions.
54	Hospital Appointments & Secondary Care	A SystemOne template with background READ codes should be used to record all unscheduled hospital visits (escorts and bed watches) to enable accurate future analysis.
55	Hospital Appointments & Secondary Care	Continue to review all EBW data on a regular and on-going basis to identify any areas for development.
56	Families and Carers	The healthcare department could include the visitors' centre and families in health promotion initiatives to enhance patient and family involvement and also extend the reach and communication of key public health and health promotion messages.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

No.	Area	Recommendation
57	Families and Carers	Waiting times for services could be displayed in the visitors centre.

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 2 of 11
HMP Birmingham : Final Version April 2015

Appendix 1