

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 4 of 11  
HMP Dovegate Final Version April 2015

# HMP Dovegate

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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 at HMP Dovegate (Healthcare, ISMS, Integrated Mental Health Team, contracted service providers, HMPS and NOMS colleagues) and to the men who participated in focus groups and completed questionnaires.

Thanks are also 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

## 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 1 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.<sup>1</sup>

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.

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[www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/331628/Health\\_Needs\\_Assessment\\_Toolkit\\_for\\_Prescribed\\_Places\\_of\\_Detention\\_Part\\_2.pdf](http://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 Dovegate opened in 2001 and is situated on the Staffordshire/Derbyshire border. The prison is operated by Serco Home Affairs. It has a total operational capacity of 1060 and holds adult male prisoners serving a range of sentences including trial, remand, awaiting sentence and convicted men serving over 4 years to life. The prison is designated to operate as a resettlement prison, serving the catchment area of Staffordshire and the West Midlands.

The prison consists of 3 house blocks. Original house blocks 1 and 2 were designed for single occupancy, with the exception of some 20 cells which can accommodate 2 prisoners. Cells in the newer house block (house block 3, built in 2009) are larger and have integral showers. In addition to this, HMP Dovegate has the only privately-run Therapeutic Community (TC) for repeat serious offenders. This is separate from the main prison and has a 200 bed capacity. Within the TC there is also a small specialised unit (TC plus) with places for up to 20 prisoners with learning difficulties.

The Healthcare Centre comprises inpatient and outpatient facilities. A range of outpatient clinics are provided from the Healthcare Centre and from wing based treatment rooms. The Inpatient Unit has 12 beds (one which is a gated cell) and accommodates patients with both mental and physical health conditions. The unit is also used as a regional resource and receives referrals from other adult male prisons within the area for patients that require inpatient care.

HMP Dovegate has a large education and training facility, 4 workshops, a recycling centre, a gymnasium and a multi-faith centre, as well as gardens and vegetable growing areas.

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 February 2015. At the time of undertaking the HNA there were 1,104 prisoners in the establishment.

Following a competitive tendering process, Care UK were awarded a prime provider healthcare contract commencing on October 1<sup>st</sup> 2014. As this is a new contract, some historic data has not been available; therefore some of the HNA recommendations are based upon very recent data.

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 gaps are identified as described.

### *Population & Demography*

- HMP Dovegate has an operational capacity of 1060 and a population turnover suggesting a churn of 1.02 times per year.
- On 31<sup>st</sup> December 2014, approximately 46% of prisoners at the prison were serving sentences of more than 4 years to less than life. 36% were serving indeterminate sentences. Only 2% of the sentenced population were serving sentences less than or equal to 6 months.
- Approximately 10% of the population are on remand.
- This suggests that healthcare services at HMP Dovegate need to be able to have efficient reception screening processes for rapid referral and meeting of immediate healthcare needs for the remand and short term sentenced prisoners, alongside a structured and systematic

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approach to meeting the longer term health needs of the medium to long term sentenced population.

- SystmOne patient and QOF alert systems should be used to optimise care planning to meet this 2 tier level of need.
- At the time of undertaking the HNA, 28.7% of the population were over the age of 40 (and therefore of the age for which NHS CVD risk assessment screening is recommended).
- 3% of men were 60 years or older.
- 91% of men at HMP Dovegate were UK nationals.
- On 31st December 2014, 75.5% of the prison population was of White ethnicity.
- The percentage of Black / Black British men (11%) accurately reflects the national prison average and is therefore proportionate to the 2.8% of Black Britons in the general population.
- The percentage of Asian / Asian British prisoners (8.1%) is higher than the national prison average of 6%.
- The Health Survey for England 2004<sup>2</sup> indicates increased risk and prevalence of long term conditions in Black and Asian minorities, impacting on the health needs of the population at the prison.

#### Screening

- All men received in to HMP Dovegate receive a health screening assessment.
- 10% of prisoners at HMP Dovegate are on remand. Prisoners remanded directly from court will have a higher level of immediate health need.
- As a resettlement prison, it is essential that the healthcare teams at HMP Dovegate identify those eligible for national screening programmes and ensure that all eligible men are offered the opportunity of taking part in screening prior to their release, requiring some refinements to the current screening processes.
- National screening programmes for bowel cancer screening, Abdominal Aortic Aneurysm and CVD risk assessment have yet to be commenced.
- Some 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.
- All screening templates should be reviewed to ensure that they identify resettlement prisoners and link them in to referral and appointment systems that efficiently address all health and wellbeing needs prior to release whilst providing 'through the gate' information for continued engagement with healthcare services post release.
- A number of additional recommendations have been made to support the implementation of national screening programmes.

#### Primary Care

- The primary care services delivered appear to meet the needs of the population; however, the issue of none attendance (DNAs) is a concern. This has already been highlighted at Clinical Governance meetings and is on the healthcare risk register.

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<sup>2</sup> Health Survey for England 2004: The Health of Minority Ethnic Groups– headline tables at [www.hscic.gov.uk](http://www.hscic.gov.uk)

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- A robust multi-faceted campaign to reduce DNAs should be planned and implemented. Reduction of DNAs should be addressed through:
  - Reducing actual number of appointments through wing based triage, teleph1 triage, reduction of inappropriate / unnecessary referrals
  - Enabling attendance
  - Promoting appropriate self-care and management
  - Liaison with prison provider to improve prisoner attendance at scheduled appointments
  - Consideration of innovative and alternative ways to deliver services (e.g. mobile clinics to visit workshops and education)
- DNA management should be regularly reviewed until DNA rates reduce to an agreed and acceptable level.
- Recommendations have been made to support approaches to DNA management with the acknowledgement that work is already ongoing in this area.

*Management of Physical Disease and Long Term Conditions*

- The actual prevalence of asthma (9.1%) within the prison population at HMP Dovegate is higher than national prevalence of 5.9%<sup>3</sup> and also higher than prevalence estimates in the Birmingham toolkit (7%).
- Since the previous HNA, the prevalence of asthma has risen from 7.5% (n=78) to 9.1% (SystemOne data).
- Since the previous HNA, the prevalence of diabetes within HMP Dovegate has decreased marginally from 3.5% to 3.35%. This is lower than the national expected prevalence of 6%<sup>4</sup> and may be attributable in part to the lower levels of obesity seen in the prison population.
- Prevalence of epilepsy (1.55%) is above national general population prevalence (0.9%)<sup>5</sup> and is twice the prevalence (0.77%) reported in the 2013 HNA.
- Current prevalence of obesity (12.1%) is significantly below national prevalence (23%).<sup>6</sup>
- At the time of the HNA, 11 patients at HMP Dovegate suffered from COPD, giving a prevalence rate of 0.99%. 88.8% of these men had received a flu vaccination, which is good practice.
- At the time of the HNA, prevalence rates for cancer within the prison population at HMP Dovegate were 0.36% (n=4).
- There are 30 men on the Coronary Heart Disease register, giving the same rate of prevalence (2.7%) as that recorded in the previous HNA.
- 0.9% (n=10) of this prison population suffer from stroke/TIA.
- A more structured approach to the management of Long Term Conditions is required if it is to be ensured that all eligible men have been offered the required reviews prior to release and resettlement.

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<sup>3</sup> Asthma prevalence by CCG area

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

<sup>4</sup> APHO Diabetes Prevalence model England Male over 16 at [www.yhpho.org.uk/default.aspx?RID=81090](http://www.yhpho.org.uk/default.aspx?RID=81090)

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

<sup>6</sup> [www.yhpho.org.uk/](http://www.yhpho.org.uk/)

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- It is recommended that a nurse with specific experience and qualification in the management of long term conditions is recruited, or that a development opportunity is offered for an existing member of the nursing team to undertake training and qualification.

#### *Sexual Health*

- It has not been possible to obtain data regarding prevalence of sexually transmitted conditions for this Health Needs Assessment. It is therefore recommended that this is either the subject of a separate sexual health needs assessment or has specific focus when the next HNA is undertaken.

#### *Communicable disease*

- The healthcare provider should liaise with Public Health England Health Protection Team to develop the training identified as an action plan requirement in the Public Health England 'West Midlands Prison Health Protection Report' (2014).
- A systematic approach to Hepatitis B vaccinations and to the data capture of vaccinations offered and declined and the numbers of men already vaccinated needs to be implemented in order to increase vaccination coverage to meet important PHE targets.
- An urgent review of Hepatitis C pathways needs to be undertaken to ensure that:
  - Screening is coordinated and all screening data is accurately collated and captured
  - Patients identified as Hepatitis C have access to specialist consultant review
  - A system is implemented and resources identified to ensure that hospital appointments for those requiring Hepatitis C treatment are not cancelled and treatment continuity can be assured.
- A review of the data collected for HJIP indicators is required to ensure that data is consistent and accurate.

#### *Lifestyle, Health Promotion and Well-being*

- There is a joint (whole prison) Health Promotion Action Plan. Health promotion activities are planned to reflect national health promotion and education initiatives.
- The 2013 HNA reports a decline in the number of self-reported smokers from 2012 to 2013. However, smoking appears to have increased by approximately 9% since 2013.
- Smoking cessation services at HMP Dovegate are delivered by 'Time to Quit' - the Staffordshire and Stoke on Trent Partnership NHS Trust smoking cessation service.
- The service provides 2 full days of support each week. The QOF 'How Am I Driving?' report indicates that 93.8% of men have been offered support and 80.8% have been referred to a specialist service within the reporting period.

#### *Social Care Needs*

Social care is not an NHS commissioning responsibility and is therefore outside of the remit of this NHS England commissioned HNA.

A separate NOMs data collection exercise regarding social care factors is currently being undertaken and it is recommended that this is reviewed by prison providers, healthcare commissioners and healthcare provider services to identify the implications for healthcare services and any areas where joint working is required.

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### *Mental Health*

- Whilst other prisons within the cluster are covered by 2 sub teams, HMP Dovegate has a separate delivery model and provides an Integrated Mental Health Service.
- Within the integrated model, 4 full time primary care mental health nurses are employed by Care UK (as detailed in section 3 of this report) who also employ a Band 7 mental health nurse team leader.
- South Staffordshire & Shropshire Healthcare NHS Foundation Trust (SSSFT) provide the staff for the severe/enduring (traditionally secondary care) element of the service.
- The team are currently working towards an integrated mental health pathway with the vision of single line management with a single lead and team lead.
- It is anticipated that the model will have many advantages for both patients and team members
- As this is a new service, limited information was available regarding need and it may be useful to undertake a focused mental health needs assessment a year after service commencement to support ongoing development.

### *Learning Disability & Autistic Spectrum Disorders*

- The QOF performance report 'How am I driving?' Indicator LD003 for this prison indicates that there are 30 patients with a learning disability.
- This is higher than for other prisons within the cluster and possibly reflects an increased awareness of learning disability, which may be partially attributed to the specialist Therapeutic Unit (TC+) for those with learning disabilities.
- There does not appear to be a system for annual LD reviews for men in the main prison.
- As there is no actual prevalence data for learning disabilities reported in the 2013 HNA therefore comparison with previous years has not been possible.
- A regional recommendation has been made regarding disability support services for the prisons cluster.

### *Substance Misuse*

- An Integrated Substance Misuse Service (ISMS) comprising clinical and psycho-social support services is provided by Care UK as part of the overarching integrated healthcare model.
- From April 2013 to April 2014 there was a total of 2,727 new receptions 351 (12.9%) of whom commenced new drug treatment episodes.
- Of the total new treatment entrants, 36.2% (n=165) were opiate users, 24.3% (N=111) were non-opiate new treatment entrants and 39.5% (n=180) were primary alcohol new treatment entrants.
- Comparatively, in December 2013, 46.5% of new treatment entrants were opiate users, 13% were non opiate users and 40.5% were primary alcohol clients.
- The number of new treatment entrants who are opiate users appears to be decreasing, reflecting national trends.
- Prisoners with a history of drug or alcohol use are identified by the primary care team during first night reception screening.
- There is no on site GP cover for evening receptions, although staff reported that there were plans to recruit an evening GP.

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- Currently there is no provision for first night prescribing of methadone or other opiate substitutes and prisoners are provided with symptomatic relief until they can be seen by the GP the following day.
- A GP clinic is held on Saturdays to review men who have arrived on a Friday evening.
- Frustration with lack of first night prescribing was a recurrent theme in staff and service user feedback.
- It is recommended that an evening GP is recruited as soon as possible. Pending recruitment, locum cover by an experienced substance misuse clinician should be secured so that first night prescribing for both alcohol and opiate dependant patients can be initiated.

*Planned & Unplanned Secondary Care*

- Hospital escorts and bedwatches were identified as a concern in interviews with the clinical lead, head of healthcare and prison governor.
- The issue has been raised at partnership meetings and identified as a risk to patient care.
- Between July and December 2014, a total of 620 outpatient appointments were booked. 50.8% (N=315) of these were subsequently cancelled either on the day of the appointment or prior to the appointment date.
- This high cancellation rate inevitably limits patient access and impacts on care quality and patient experience.
- The commissioner led Health & Justice Secondary Care Activity Report analysed escort and bedwatch activity for all prisons across the cluster from August 2013 to August 2014 and found that the highest costs for scheduled care appointments across the region was incurred by HMP Dovegate (£76,355), attributing to 16.37% of the total costs of outpatient activity .
- It would be beneficial for the healthcare providers at HMP Dovegate to foster links with Directorate Leads at Queens Hospital and to develop ongoing dialogue to identify and address local actions to reduce cancellations of hospital escorts and improve patient experience.

A full list of recommendations made can be found in section 20 of the HNA report.

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## Table of Abbreviations

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<b>ACCT</b>	Assessment, Care, Custody and Teamwork
<b>A&amp;E</b>	Accident and Emergency
<b>CCG</b>	Clinical Commissioning Group
<b>CVD</b>	Cardio Vascular Disease
<b>COPD</b>	Chronic Obstructive Pulmonary Disease
<b>CPA</b>	Care Programme Approach
<b>CQUIN</b>	Commissioning for Quality and Innovation
<b>CT</b>	Computerised Tomography
<b>DDA</b>	Disability Discrimination Act
<b>DNA</b>	Did Not Attend
<b>DRSS</b>	Diabetic Retinopathy Screening Service
<b>EBW</b>	Escorts and Bed watches
<b>EDR</b>	Expected Date of Release
<b>ENT</b>	Ears Nose and Throat
<b>HIA</b>	Health Impact Assessment
<b>HIV</b>	Human Immunodeficiency Virus
<b>HJIP</b>	Health and Justice Indicators for Performance
<b>HMIP</b>	Her Majesty's Inspectorate of Prisons
<b>HMP</b>	Her Majesty's Prison
<b>HMPYOI</b>	Her Majesty's Prison Youth Offending Institute
<b>HMYOI</b>	Her Majesty's Youth Offending Institute
<b>HNA</b>	Health Needs Assessment
<b>ISMS</b>	Integrated Substance Misuse Services
<b>LTC</b>	Long Term Conditions
<b>MAX-FAX</b>	Maxillo Facial
<b>MDT</b>	Multi-Disciplinary Team
<b>MHA</b>	Mental Health Act
<b>MSK</b>	Musculo-skeletal
<b>NHSE</b>	National Health Service England
<b>NICE</b>	National Institution for Health and Care Excellence
<b>NOMS</b>	National Offender Management Service
<b>OHRN</b>	Offender Health Research Ne2rk
<b>ONS</b>	Office for National Statistics
<b>PALS</b>	Patient Advice and Liaison Services
<b>PEO</b>	Physical Education Officer
<b>PHE</b>	Public Health England
<b>QOF</b>	Quality Outcomes Framework
<b>SSOTP</b>	Stafford and Stoke-on-Trent Partnership NHS Trust
<b>TAG</b>	Threshold Assessment Grid
<b>UDA</b>	Units of Dental Activity

## 1. HMP Dovegate - Prison Population & Demographics

HMP Dovegate opened in 2001 and is situated on the Staffordshire/Derbyshire border. The prison is operated by Serco Home Affairs. It has a total operational capacity of 1060 and holds adult male prisoners serving a range of sentences including trial, remand, awaiting sentence and convicted men serving over 4 years to life. The prison is designated to operate as a resettlement prison, serving the catchment area of Staffordshire and the West Midlands.

The prison consists of 3 house blocks. Original house blocks 1 and 2 are designed for single occupancy, with the exception of some 20 cells which can accommodate 2 prisoners. Cells in the newer house block (house block 3, built in 2009) are larger and have integral showers. In addition to this, HMP Dovegate has the only privately-run Therapeutic Community (TC) for repeat serious offenders. This is separate from the main prison and has a 200 bed capacity. Within the TC there is also a small specialised unit (TC plus) with places for up to 20 prisoners with learning difficulties.

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HMP Dovegate has a large education and training facility, 4 workshops, a recycling centre, a gymnasium and a multi-faith centre, as well as gardens and vegetable growing areas.

At the time of undertaking this Health Needs Assessment there were 1,104 prisoners in the establishment.

The narrative 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.'

## 1.1 Age

Figure 1 Age Distribution of Population 30<sup>th</sup> June 2013-31<sup>st</sup> December 2014

Population by Age Group	30 Jun 2013	30 Jun 2014	31 Dec 2014
18-20	0	0	0
21-24	127	149	151
25-29	225	260	249
30-39	336	378	387
40-49	205	214	212
50-59	76	79	72
60 +	42	42	33
<b>All</b>	<b>1,011</b>	<b>1,122</b>	<b>1,104</b>

From June 2013 to December 2014 there has been an overall population increase of 9.19%.

In December 2014, 13.7% (n=151) of the prison population at HMP Dovegate were aged 21-24 years old and 22.6% (n=249) were aged 25-29. The majority (35.1%, n=387) of prisoners were between the ages of 30-39 years old, with 19.2% (n=212) between the ages of 40-59, 6.5% (n=72) between the ages of 50-59 and 3% (n=33) aged 60 or above.

These figures are comparative to those recorded in June 2013, when 12.6% (n=127) of the population were less than 25 years of age and the majority of prisoners (33.2%, n=336) fell into the 30-39 age bracket. Proportionately, there are now slightly less prisoners aged 60 years and above than there were in June 2013.

## 1.2 Nationality

Figure 2 Population by Nationality 30<sup>th</sup> June 2013-31<sup>st</sup> December 2014

Population by Nationality	30 Jun 2013	30 Jun 2014	31 Dec 2014
Not Recorded	8	*	11
Foreign National	75	*	83
UK National	928	1,031	1,010
<b>All</b>	<b>1,011</b>	<b>1,122</b>	<b>1,104</b>

On 31<sup>st</sup> December 2014, 91% of prisoners at HMP Dovegate were UK nationals. 8% were foreign nationals. A similar figure (92% UK nationals) is recorded 18 months previously, in June 2013.

### 1.3 Ethnicity

Figure 3 Population by Ethnicity 30<sup>th</sup> June 2013-31<sup>st</sup> December 2014

Population by Ethnicity	30 Jun 2013	30 Jun 2014	31 Dec 2014
Unrecorded	*	*	*
Asian or Asian British	74	76	89
Chinese or Other	*	7	7
Black or Black British	106	114	125
Mixed	28	34	45
Not Stated	0	*	*
White	792	889	834
All	1,011	1,122	1,104

In December 2014, the majority of prisoners at HMP Dovegate (75.5%, n=834) were White males.

11% were of Black or Black British ethnicity and 8.1% were (n=89) Asian or Asian British. This is similar to figures represented in June 2013 when 78.3% (n=792) of the prison population were White, 10.5% (n=106) Black or Black British and 7.4% (n=74) Asian or Asian British.

The percentage of Black / Black British men is an absolute reflection of the national prison average of 11%, and, as with the national average, remains disproportionate to the 2.8% of Black Britons in the general population.

The percentage of Asian / Asian British prisoners (8.1%) is higher than the national prison average of 6%.

In December 2014, there were 3.3% more prisoners of mixed ethnicity than in June 2013 (n=28 June 2013, n=45 December 2014). There were also more prisoners of Chinese ethnicity (n=7) but this still accounted for less than 1% of the total prison population.

### 1.4 Length & Type of Sentence

Figure 4 Population by Sentence Length 30<sup>th</sup> June 2013-31<sup>st</sup> December 2014

Population by Sentence Length	30 Jun 2013	30 Jun 2014	31 Dec 2014
Less than or equal to 6 months	44	64	23
More than 6 months to 12 Months	12	13	9
More than 12 months to 4 years	60	79	92
More than 4 years to less than life	380	450	462
Indeterminate	347	372	361
Recalls	43	53	50
All	886	1,031	997

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On 31<sup>st</sup> December 2014, 46% of prisoners at HMP Dovegate were serving sentences of more than 4 years to less than life. 36% were serving indeterminate sentences, 9% were serving more than 12 months to 4 years and 2% less than or equal to 6 months.

Comparatively, in June 2013, there were slightly less (42.9%, n=380) prisoners serving sentences of more than 4 years to less than life and slightly more (39.2%, n=347) were serving indeterminate sentences. From June 2013-December 2014, prisoners serving sentences of less than or equal to 6 months had fallen by 3% (n=44 June 2013, n=23 December 2014) and prisoners serving sentences of more than 12 months to 4 years had risen by 2.2% (n=60 June 2013, n=92 December 2014).

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	*	*	107
Sentenced	887	1,033	997
Non-criminal	*	*	0
<b>All</b>	<b>1,011</b>	<b>1,122</b>	<b>1,104</b>

Of 1104 prisoners serving at HMP Dovegate in December 2014, 90% (n=997) of prisoners were sentenced, with the remaining 10% (n=107) of prisoners on remand. There were no prisoners serving non-criminal sentences. This is comparative to figures recorded in June 2013 when 88.7% (n=887) of the prisoner population were sentenced adults.

### 1.5 Movements In & Out of Prison

The table below shows the numbers of first and sentenced receptions for the 12 months from 1<sup>st</sup> October 2013 to 30<sup>th</sup> September 2014.

Figure 6 Receptions October 2013 to September 2014

First Receptions <sup>(1)</sup>	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
All	39	39	30	23	20	26	..	..	..	31	21	18
Untried	*	*	*	*	*	*	16	43	12	26	13	17
Convicted Unsented <sup>(1)</sup>	0	0	0	0	0	*	..	..	..	*	*	*
Sentenced	*	*	*	*	*	0	*	*	0	*	*	*
Non Criminal	0	0	0	0	0	0	0	0	0	0	0	0

Sentenced Receptions <sup>(2)</sup>	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
All	79	68	49	63	49	65	73	52	64	47	54	35
Less than or equal to 6 months	40	32	26	27	14	32	25	19	24	12	18	11
More than 6 months to less than 12 months	*	6	*	*	*	*	*	8	*	*	*	*
12 months to less than 4 years	17	23	16	20	18	23	26	14	26	21	17	15
4 years and more	*	7	*	*	*	*	13	11	9	*	*	*
Life	0	0	*	0	0	0	*	0	*	0	0	0

Figure 7 Releases October 2013 to September 2014

	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Total
Dovegate	45	40	37	39	29	23	32	34	31	30	19	25	384

#### Notes from Ministry of Justice regarding above data:

(1) The data supply used for the statistical reporting of convicted unsentenced remand receptions was disrupted between 1 April to 30 June 2014. This meant that for this period some convicted

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unsentenced remand receptions were not recorded and also meant that first receptions could not be accurately calculated. For the period 1 July to 30 September 2014 this problem has been rectified and figures have been published. Figures for the previous period will be published in due course subject to the result of ongoing investigations.

(2) The number of Sentenced Receptions does not equal First Sentenced Receptions. This is because First Receptions counts the first time a prisoner was received to prison - a prisoner may have been received as a remand prisoner, before being sentenced and received as a sentenced prisoner. Furthermore, some prisoners who are sentenced will have been first received on remand to a different prison.

On average, (providing a mean estimate for months where data is missing) there were approximately 86 receptions per month at HMP Dovegate (1032 per year). This estimates to a population a churn rate of 1.02, indicating that the prison 'turns over' its population about once per year.

## 1.6 Key Findings – Population & Demographics

The population profile suggests a number of health needs considerations which are introduced here and referred back to and expanded upon in relevant sections within this report : -

- HMP Dovegate has an operational capacity of 1060 and a population turnover suggesting a churn of 1.02 times per year.
- On 31<sup>st</sup> December 2014, approximately 46% of prisoners at the prison were serving sentences of more than 4 years to less than life. 36% were serving indeterminate sentences. Only 2% of the sentenced population were serving less than or equal to 6 months.
- Approximately 10% of the population are on remand.
- This suggests that healthcare services at HMP Dovegate need to be able to have efficient reception screening processes for rapid referral and meeting of immediate healthcare needs for the remand and short term sentenced prisoners, alongside a structured and systematic approach to meeting the longer term health needs of the medium to long term sentenced population.
- SystmOne patient and QOF alert systems should be used to optimise care planning to meet this 2 tier level of need.
- At the time of undertaking the HNA, 28.7% of the population were over the age of 40 (and therefore of the age for which NHS CVD risk assessment screening is recommended).
- 3% of men were 60 years or older.
- 91% of men at HMP Dovegate are UK nationals.
- On 31<sup>st</sup> December 2014, 75.5% of the prison population was of White ethnicity.
- The percentage of Black / Black British men (11%) accurately reflects the national prison average and is therefore proportionate to the 2.8% of Black Britons in the general population.
- The percentage of Asian / Asian British prisoners (8.1%) is higher than the national prison average of 6%.
- The Health Survey for England 2004<sup>7</sup> indicates increased risk and prevalence of long term conditions in Black and Asian minorities, impacting on the health needs of the population at the prison.

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<sup>7</sup> Health Survey for England 2004: The Health of Minority Ethnic Groups– headline tables at [www.hscic.gov.uk](http://www.hscic.gov.uk)

## 2. Overview of Health Services Provided

At HMP Dovegate 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.

Following a competitive tendering process in 2014, a prime provider service provision contract was awarded to Care UK and the new health provision contract commenced on 1<sup>st</sup> October 2014.

GP, Primary Care, Integrated Substance Misuse and administration staff at HMP Dovegate are directly employed by Care UK.

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

There is also a 12 bedded 'Inpatient Unit' enabling enhanced levels of healthcare monitoring and support for patients with both physical and mental health conditions where required.

Integrated Mental Health Services are delivered by Care UK and South Staffordshire & Shropshire Healthcare NHS Foundation Trust.

A number of regular primary healthcare clinics are held.

- Physiotherapy & podiatry services are subcontracted to Premier Physical Healthcare Ltd.
- Dental services are subcontracted to Time for Teeth Ltd.
- Optician services are subcontracted to Evington Eyecare Ltd.
- Smoking cessation services are subcontracted to Time to Quit.

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.

Care UK have already begun the process of adapting data collection systems to provide evidence for future reporting against Health & Justice Performance Indicators.

### 3. Facilities & Resources

Staff resources are outlined in the table below.

Figure 8 HMP Dovegate Staff Resources

<b>Primary Physical Healthcare Services</b>		
<b>Job Title</b>	<b>WTE currently in post</b>	<b>Vacancies</b>
Clinical Lead	1.0	0
Team Leader	1.7 (temporary in post)	1
Nurses	10.	0
Healthcare Assistant	8.0	0
<b>Mental Health Services</b>		
Mental Health Lead	1.0	0
Mental Health Nurses	4.0	0
<b>ISMT Clinical Services</b>		
ISMT Lead Nurse	0.9	0
ISMT Nurses	2.0	0
<b>ISMT Psychosocial Services</b>		
ISMT Lead	1.0	0
Practitioners	8.0	0
ISMT Admin	1.6	0
<b>Administration</b>		
Senior Admin- HR	1.0	0
Administration	2.0	1
Medical Secretary	1.00	1
<b>Pharmacy</b>		
Pharmacy Technician	2.0	0
Pharmacy Assistant	1.6	0

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### 3.1 Outpatient Areas

Healthcare Centre Facilities		
	No. of rooms	Comments (e.g. access to computer, equipment, space etc)
Reception area/ reception office	1	Access to computer with SystmOne. Medication storage cupboard and grab bag.
Staff offices / work areas	7	Some rooms with computer access. Tables with draws
Consulting rooms	7	(1 small room without a computer, all other rooms with computer for SystmOne access). 1 x A and E room with ECG machine, dressing trolley, cupboards for equipment. Grab bag.
Patient waiting rooms / areas	2	
Patient toilet facilities	3	(1 of the toilets is for disabled access)
Dental Suite	1	Fully equipped with dental bed, chair and x ray facilities.
Pharmacy	1	
Medicines administration areas ( Healthcare centre medicines hatches or treatment rooms)		This is combined with pharmacy
Others (please specify)	1	Store room
	2	Archive rooms

HMP Dovegate Wing Based Rooms / Other Facilities		
	No. Rooms	Comments
Wing based medicines administration areas / treatment rooms	5	This includes the reception room
Wing based consulting rooms	1	Converted cell on L wing
Wing based group rooms	4	
Wing based healthcare offices	0	
Wing based day care facilities	0	
Other ISMT	4	Offices
	1	Filing room
	1	Shared archive room
	1	Classroom

### 3.2 Inpatients

The table below details the Inpatient Unit Facilities.

Figure 9 Healthcare Facilities

HMP Dovegate Inpatient Unit Facilities		
	No. Rooms	Comments
<b>Total patient capacity</b>	11	
<b>Single cells</b>	11	
<b>Double cells</b>	0	
<b>Gated cells</b>	1	For the use of constant supervision (ACCT process)
<b>CCTV cells</b>	9	
<b>Safer cells</b>	11	All cells within inpatients are classed as safer custody cells, all containing anti ligature points
<b>Association room, patient dayroom</b>	1	
<b>Patient bathrooms</b>	1	
<b>Patient toilets</b>	11	
<b>Facilities for those with physical disabilities / special adaptations</b>	1	1 x hospital bed
<b>Palliative care facilities</b>	1	
<b>Offices</b>	1	Prison officers office situated on the inpatient unit.
<b>Medicines administration room</b>	0	Combined use within pharmacy.
<b>Consulting rooms</b>	0	
<b>Group rooms</b>	1	Combined use with the association room/dayroom
<b>Patient waiting rooms</b>	0	Patient waiting room is situated within the outpatient department only

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.

## 4. Screening

### 4.1 Reception screening

All new receptions received into HMP Dovegate have an initial reception screen followed by comprehensive secondary health screen. Transfers in from other establishments also have a transfer health screen.

The first night reception screening comprises the following:

- Identification of any immediate physical, mental health or substance use health concerns (observed, assessed or self-reported) or injuries
- Self-harm history, exploration of any intent to self-harm, prompt for consideration of opening ACCT (Assessment Care Custody & Teamwork Document)
- Identification of any outstanding doctors /hospital appointments, ongoing treatment and plans for continuity of care
- Identification of any currently prescribed medications and plans for continuity
- First night risk assessments completed
- Any immediate actions or referrals required identified
- Consent for information sharing obtained

Secondary screening comprises:

- Further information gathering regarding medications
- TB screening questions and follow up /referral to GP if indicated
- Vaccination history
- Sexual health and Blood Borne Virus history and offer of screening /referral if required
- Men's health screening questions (prostate & testicular cancer, testicular lumps)
- Offer of Chlamydia screening
- Lifestyle questions regarding smoking and exercise, offer of smoking cessation support
- Further mental health questions
- A question is also asked regarding any known physical or learning disabilities

### 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 65<sup>th</sup> birthday.

Figure 10 AAA Screening Oct 14-Feb 15

AAA Screening	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15
No. eligible	2	1	1	1	2
No. screened	0	0	0	0	0

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In the months October 2014 – February 2015, between 1 and 2 men were eligible for AAA screening. HMP Dovegate is yet to commence an AAA Screening Programme therefore no patients were screened during this period.

#### 4.2.2 NHS Bowel Cancer Screening Programme (NHSBCP)

The NHS Bowel Cancer Screening Programme (NHSBCP) offers screening every 2 years to all men and women aged 60 to 69 and to people over 70 years old on request.

Figure 11 Eligibility for NHS Bowel Cancer Screening Programme

<b>Bowel Cancer Screening</b>	<b>Oct 14</b>	<b>Nov 14</b>	<b>Dec 14</b>	<b>Jan 15</b>	<b>Feb 15</b>
<b>No. eligible</b>	37	34	33	34	34
<b>No. screened</b>	0	0	0	0	0

SystemOne reports indicate that 34 men are currently eligible for NHSBCP; however no patients have been screened to date.

#### 4.2.3 NHS CVD Risk Assessment Screening (NHS Health Checks)

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<sup>2</sup> assessment tool and advice and support provided to reduce CVD risk (lifestyle measures such as weight loss, smoking cessation and 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.

SystemOne reports indicate that at HMP Dovegate, approximately 265 men are eligible for NHS Health checks, although none have been offered screening to date.

Figure 12 NHS Health Checks Oct14-Feb 15

<b>NHS Health Check</b>	<b>Oct 14</b>	<b>Nov 14</b>	<b>Dec 14</b>	<b>Jan 15</b>	<b>Feb 15</b>
<b>No. eligible</b>	269	261	266	265	265
<b>No. screened</b>	0	0	0	0	0

As 11% of the population at HMP Dovegate are Black / Black British and 8.1% are Asian /Asian British , it is worth noting that the Health Survey for England 2004<sup>8</sup> reports 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)

<sup>8</sup> Health Survey for England 2004: The Health of Minority Ethnic Groups– headline tables at [www.hscic.gov.uk](http://www.hscic.gov.uk)

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- 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 (11.5%) of stroke

It may therefore be appropriate for healthcare teams to extend the eligibility criteria for screening to those identified at particularly increased risk who fall slightly below the 40 year age limit.

#### 4.2.4 Key findings - Screening

As detailed in section 1.4 of this report, approximately 10% of prisoners at HMP Dovegate are on remand. Prisoners remanded directly from court will have a higher level of immediate healthcare need. The current reception screening process efficiently identifies immediate need and actions required.

As a resettlement prison, it will be essential that the healthcare teams at HMP Dovegate also identify those eligible for national screening programmes and ensure that all eligible men are offered the opportunity of taking part in screening prior to their release. This will require refinement of the screening process and recommendations have been made regarding this (see below).

#### 4.3 Recommendations: Screening

- All men eligible for bowel cancer screening should be identified through the SystemOne clinical reporting function. Awareness sessions and a screening 'catch up' programme should be launched to ensure all those eligible have been offered screening.
- The screening template should be adapted to capture new receptions / transfers eligible for bowel cancer screening and screening should be offered as a rolling programme.
- SystemOne should be used to flag men who become eligible for bowel cancer screening and those due for repeat screens during the duration of their prison sentence.
- Some 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.
- SystemOne should be utilised to auto-generate flags when men reach the age of 65 and become eligible for Abdominal Aortic Aneurysm 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 SystemOne clinical reporting functionality) would enable evaluation of equality of access.
- All screening templates should be reviewed to ensure that they identify resettlement prisoners and link them in to referral and appointment systems that efficiently address all

health and wellbeing needs prior to release whilst providing ‘through the gate’ information for continued engagement with healthcare services post release.

## 5. Primary Care Clinics

### 5.1 GP Clinics

Figure 13 GP Clinics October 14-February 15

GP Clinics	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
<b>Number of patients expected to be seen</b>	529	452	252	61	197
<b>Number of patients actually seen in clinic</b>	352	345	184	45	140
<b>Clinic utilisation (%)</b>	67	76	73	74	71
<b>Waiting time for routine care (days)</b>	11	10	16	8	10
<b>Contracted sessions</b>	50	45	29	47	32
<b>Delivered sessions</b>	50	45	22	45	35
<b>Cancelled sessions</b>	0	0	7	2	0

- GP services are provided by Care UK.
- The GPs have prescribing responsibility for the primary care and Integrated Substance Misuse elements of the service.
- There is a GP clinic each weekday afternoon and on Saturday mornings and an additional Controlled Drugs Clinic on Mondays.
- There is no GP cover for evening receptions.
- Between October 2014 and February 2015 a total of 1066 appointments were delivered, giving a mean average of 213.2 appointments per month.
- Clinic utilisation ranged from 67-76%.
- Waiting times for routine appointments ranged from 8 to 16 days.
- Over the five months reviewed, a total of 425 appointments were lost to non-attendance.
- 4.4% (99/203) of the contracted sessions were cancelled.
- The highest waiting times coincided with seven GP sessions being cancelled.

### 5.2 Nurse Clinics

Applications to see a nurse are made via the electronic kiosks (ATM's) for the following clinics:-

Daily nurse triage

Twice weekly blood sampling (venepuncture) clinics

Three times weekly dressings clinic

4 (2 full days) smoking cessation support

Nurse led Diabetes; Epilepsy and Asthma Long Term Conditions (LTC) clinics are held. However, there are no directly-employed specialist nurses at present - GPs and the hospital based Diabetes Nurse Specialist Team are relied upon to provide LTC support.

### 5.3 Physiotherapy

The Physiotherapist delivers 2 sessions per week.

Figure 14 Physiotherapy Clinics October 14-February 15

Physiotherapy Clinics	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Number of patients expected to be seen	48	61	56	61	70
Number of patients actually seen in clinic	39	39	36	39	48
Clinic utilisation (%)	81	64	64	64	69
Waiting time for routine care (days)	28	126	133	75	98
Contracted sessions	8	8	8	8	8
Sessions delivered	8	8	8	8	10

- Between October 2014 and February 2015 a total of 296 appointments were delivered, giving a mean average of 59.2 appointments per month.
- Clinic utilisation ranged from 64-81%.
- Waiting times for routine appointments ranged from 28 to 133 days.
- Over the five months reviewed, a total of 95 appointments were lost to non-attendance.
- No contracted sessions were cancelled and 2 additional sessions were delivered.

GPs refer to physiotherapy for musculo-skeletal pain as part of an overall management plan and as a considered alternative to the prescription of strong and potentially tradable analgesics where appropriate.

The physiotherapist liaises with prison Physical Education Officer for prescribed exercise programmes and also, particularly in the case of men complaining of bilateral joint pain (e.g. shoulder & knee pain), to consider causality linked to gym activity.

### 5.4 Optician

Optician services are provided by Evington Eyecare Ltd. Service provision incorporates

- Eye examination & visual acuity
- Prescription & dispensing of spectacles
- Fitting & repair of spectacles
- Continuation of advice and prescribing to support young adults already wearing contact lenses on reception into the prison
- Checks on ocular hygiene compliance for contact lens wearers
- Detection of ocular disease
- Assessment of ocular trauma where required

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- Eye care advice
- Referral to GP/ emergency services as necessary

Figure 15 Optician Clinics October 14-February 15

Optician Clinics	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Number of patients expected to be seen	48	0	0	61	80
Number of patients actually seen in clinic	39	0	0	45	55
Clinic utilisation (%)	81			74	69
Waiting time for routine care (days)	28	0	0	13	17
Contracted sessions	6	0	0	8	8
Delivered sessions	6	0	0	6	8
Cancelled sessions	0	0	0	2	0

- Between October 2014 and February 2015 a total of 189 appointments were delivered, giving a mean average of 37.8 appointments per month.
- Clinic utilisation ranged from 69-81%.
- Waiting times for routine appointments ranged from 13 to 28 days.
- Over the five months reviewed, there were no optician sessions in November and December 2014. A total of 50 appointments were lost to non-attendance.
- 9.1% (2/22) contracted sessions were cancelled.

- 

## 5.5 Podiatry

Figure 16 Podiatry Clinics October 14-February 15

Podiatry Clinics	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Number of patients expected to be seen	0	39	21	20	56
Number of patients actually seen in clinic	0	21	16	14	43
Clinic utilisation (%)		54	76	70	77
Waiting time for routine care (days)	77	77	98	13	48
Contracted sessions	0	2	2	2	2
Sessions delivered	0	4	2	2	6

- Between October 2014 and February 2015 a total of 136 appointments were delivered, giving a mean average of 21.6 appointments per month.
- Clinic utilisation ranged from 54-77%.
- Waiting times for routine appointments ranged from 13-98 days.
- Over the 6 months reviewed, a total of 42 appointments were lost to non-attendance.
- No contracted sessions were cancelled.
- Additional sessions were delivered to reduce the lengthy waiting times inherited by the new service provider on commencement of the contract on 1<sup>st</sup> October 2014.
- At the time of the HNA, waiting times had reduced significantly from a peak of 98 days in December 2014 to 48 days at the end of February 2015.
-

## 5.6 Dentist

In 'Strategy for Modernising Dental Services for Prisoners in England'<sup>9</sup>, it is recommended a minimum of 1.3 hour dental session per week should be provided for every 250 prisoners and that appointments for routine care should not normally exceed 6 weeks.

The dental service is subcontracted to Time for Teeth Ltd, a company specialising in the delivery of prison dental services.

Figure 17 Dental Clinics October 14-February 15

Dental Clinics	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Number of patients expected to be seen	270	260	255	227	238
Number of patients actually seen in clinic	202	195	194	165	162
Clinic utilisation (%)	75	75	76	73	68
Waiting time for routine care (days)	35	44	42	17	18
Contracted sessions	36	32	34	32	32
Delivered sessions	33	36	36	32	32
Cancelled sessions	3	0	0	0	0

- Between October 2014 and February 2015 a total of 1250 appointments were delivered, giving a mean average of 250 appointments per month.
- Clinic utilisation ranged from 68-76%.
- Waiting times for routine appointments ranged from 17-44 days.
- Over the 6 months reviewed, a total of 332 appointments were lost to non-attendance.
- 1.8% (3/169) contracted sessions were cancelled.

## 5.7 Recommendations: Clinics

The issue of non-attendance (DNAs) is a concern and has already been highlighted at Clinical Governance Meetings and is on the healthcare risk register. Recommendations made below are made to support approaches to DNA management and acknowledge that work is already ongoing in this area.

- A robust multi-faceted campaign to reduce DNAs should be planned and implemented. Reduction of DNAs should be addressed through:
  - Reducing actual number of appointments through wing based triage, telephone triage, reduction of inappropriate / unnecessary referrals
  - Enabling attendance
  - Promoting appropriate self-care and management

<sup>9</sup> Department of Health (2003), Strategy for Modernising Dental Services for Prisoners in England 2003, HMSO, London

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- Liaison with prison provider to improve prisoner attendance at scheduled appointments
- Consideration of innovative and alternative ways to deliver services (e.g. mobile clinics to visit workshops and education)
- DNA management should be regularly reviewed until DNA rates reduce to an agreed and acceptable level
- A clear definition of what is recorded as an appointment DNA need to be agreed as definitions across the cluster differ and may result in inaccurate cross cluster comparisons.
- 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 if in the wider community.
- Nursing staff could be trained to undertake simple foot assessments 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.
- At HMP Leeds, DNA's were reduced by 30% through 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 Dovegate, 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 and visitors could help to engage them in communicating the importance of attendance at appointments.
- A '1 stop shop' for nursing appointments could be trialled whereby each time men attend an appointment their vaccination status, BBV status, CVD risk assessment eligibility and chlamydia screening eligibility are checked and any actions required taken immediately rather than necessitate further 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 one of this regional series.

A 2008 survey<sup>10</sup> 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

The SystemOne QOF 'How Am I Driving?' report indicates that at the time of undertaking this HNA there were 101 patients on the asthma register.

Of these, it is evidenced that 8.8% (8/91) have had an asthma review (including reversibility testing) within the last 12 months.

The actual prevalence of asthma (9.1%) within the prison population at HMP Dovegate is higher than national prevalence of 5.9%<sup>11</sup> and also higher than prevalence estimates in the Birmingham toolkit (7%). Since the previous HNA, the prevalence of asthma has risen from 7.5% (n=78) to 9.1% (SystemOne data).

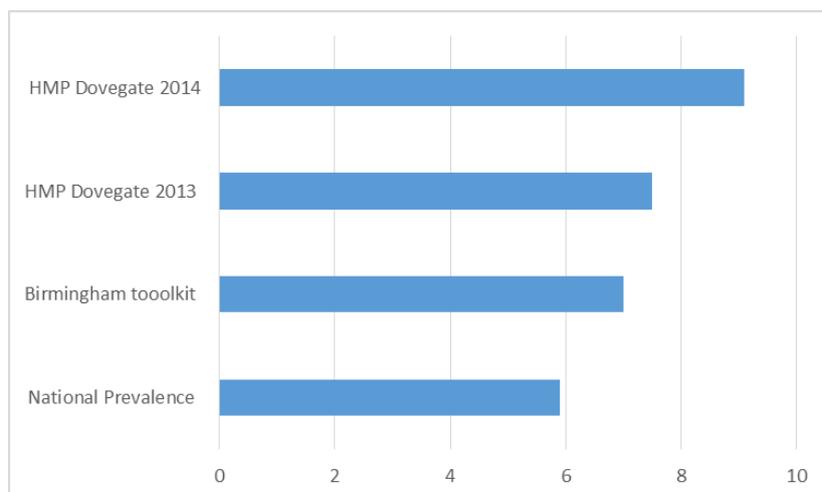
*Figure 18 Prevalence of Asthma at HMP Dovegate Compared to National Prevalence*

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<sup>10</sup> Stewart, D, The problems and needs of newly sentenced prisoners: results from a national survey, Ministry of Justice 2008

<sup>11</sup> Asthma prevalence by CCG area

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



The 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 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 population<sup>12</sup>.

This will be of particular consideration as more prison healthcare services begin to adopt NHSE Health & Justice Performance Indicators and data collection and collation is standardised nationally.

## 6.2 Diabetes

At the time of undertaking this HNA, there were 37 patients (3.35%) with diabetes (QOF DM017). Statistically, this is lower than the national expected prevalence of 6%<sup>13</sup>. Studies have suggested that 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.

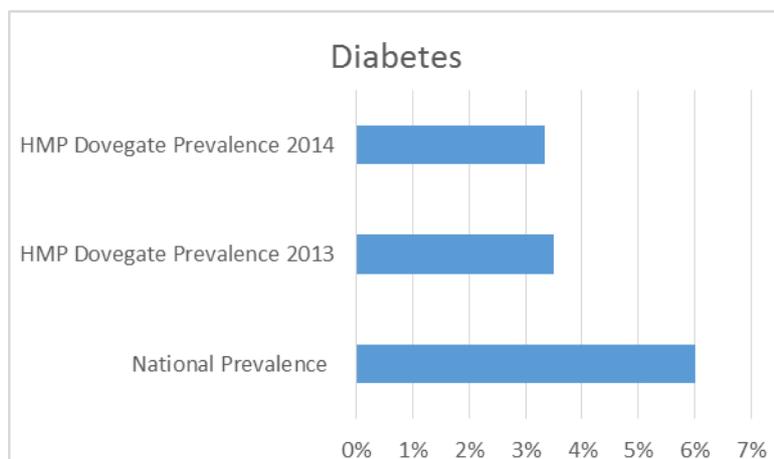
Since the previous HNA, the prevalence of diabetes within HMP Dovegate has decreased marginally from 3.5% to 3.35%.

*Figure 19 Prevalence of Diabetes at HMP Dovegate Compared to National Prevalence*

<sup>12</sup> [http://www.dhsspsni.gov.uk/index/stats\\_research/stats-resource/stats-gp-allocation/gp\\_contract\\_qof/statistics\\_and\\_research-qof-prevalence.htm](http://www.dhsspsni.gov.uk/index/stats_research/stats-resource/stats-gp-allocation/gp_contract_qof/statistics_and_research-qof-prevalence.htm)

<sup>13</sup> APHO Diabetes Prevalence model England Male over 16 at [www.yhpho.org.uk/default.aspx?RID=81090](http://www.yhpho.org.uk/default.aspx?RID=81090)

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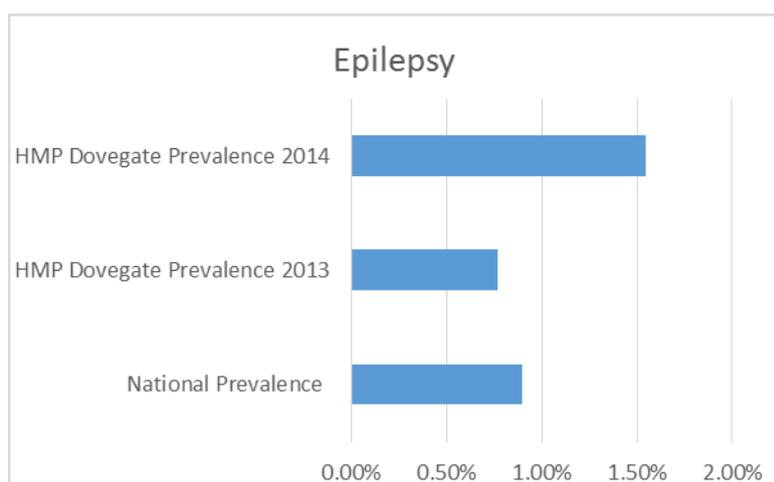


Of the 37 patients with diabetes, 90.3% had received seasonal influenza vaccine and 72.7% had received a foot examination, which is good practice.

Retinopathy screening clinics are held every 6 months. It is suggested that recording of this is linked to QOF indicators so that this good practice can be evidenced via the QOF How Am I Driving Dashboard.

### 6.3 Epilepsy

At the time of undertaking this HNA, there were 16 patients on the epilepsy register (QOF EP001). Prevalence of epilepsy (1.55%) is above national general population prevalence (0.9%)<sup>14</sup> and is twice the prevalence (0.77%) reported in the 2013 HNA.



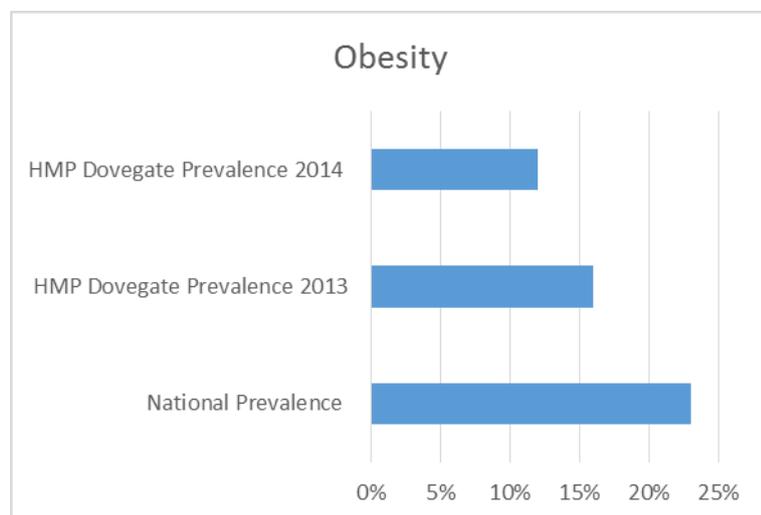
Epilepsy is currently reviewed by the GP as required.

<sup>14</sup> Joint Epilepsy Council, 2005. Epilepsy prevalence, incidence and other statistics. <https://www.epilepsy.org.uk/> Accessed 23.01.15

## 6.4 Obesity

Current prevalence of obesity (12.1%) is significantly below national prevalence (23%).<sup>15</sup>

Figure 20 Prevalence of Obesity at HMP Dovegate Compared to National Prevalence\*



\*Prevalence of 16% was estimated in the 2013 HNA. Actual prevalence could not be determined due to a SystmOne reporting anomaly at that time.

In a study of risk factors of non-communicable disease in prisoners by Herbert, Plugge & Foster<sup>16</sup>, 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.<sup>17</sup>

## 6.5 Other Long Term Conditions

At the time of the HNA, 11 patients at HMP Dovegate suffered from COPD, giving a prevalence rate of 0.99%. 88.8% of these men had received a flu vaccination, which is good practice.

Prevalence rates for cancer were 0.36% (n=4).

At the time of the HNA, there were 30 men on the Coronary Heart Disease register, giving the same rate of prevalence (2.7%) as that recorded in the previous HNA.

0.9% (n=10) of this prison population suffer from stroke/TIA.

## 6.6 Recommendations

A more structured approach to the management of Long Term Conditions is required if it is to be ensured that all eligible men have been offered the required reviews prior to release and resettlement.

<sup>15</sup> [www.yhpho.org.uk/](http://www.yhpho.org.uk/)

<sup>16</sup> Herbert K, Plugge E, Foster C. (2012): Prevalence of risk factors for non-communicable diseases in prison populations worldwide: a systematic review, Lancet 379

<sup>17</sup> Herbert K, Plugge E, Foster C. (2012): Prevalence of risk factors for non-communicable diseases in prison populations worldwide: a systematic review, Lancet 379

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- It is recommended that a nurse with experience in the management of Long Term Conditions is recruited or that a development opportunity is offered for an existing member of the nursing team to undertake appropriate training and qualification.
- All eligible asthma and COPD patients should have annual reviews.
- Retinopathy screening clinics are held every 6 months. It is suggested that recording of this is linked to QOF indicators so that this good practice can be evidenced via the QOF How Am I Driving Dashboard.
- Nursing staff may find it useful to access the resources for professionals produced by Epilepsy Action in 2013 (DVD 'Epilepsy in Prison' and accompanying leaflets and resources). The DVD is aimed at professionals working in prisons and will help raise awareness of the issues associated with living with epilepsy in a prison setting. In addition, there are a number of information booklets available to help aid prison staff.

## 7. Communicable diseases

### 7.1 Tuberculosis

All prisoners are asked questions about symptomology and contact during healthcare reception screening.

There have been no recent cases of active TB at HMP Dovegate.

There have been no infectious / acquired infections.

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

The Public Health England 'West Midlands Prison Health Protection Report 2014' suggests that the Public Health England Health Protection Team should support HMP Dovegate in the provision of training in communicable disease awareness, the role of PHE, vaccination awareness and infection control. Recent training was delivered in February 2015 on 'Principles of Infection Prevention' and 'Control and the Role of PHE in Prison Outbreak training'.

### 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 Report<sup>18</sup> 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%).

The most recent data forwarded by PHE was for the period January to March 2014, in which vaccination coverage was extremely low. However, the West Midlands Prison Health Protection

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<sup>18</sup> 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

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Report comments that there was an issue with the vaccination Patient Group Direction and therefore vaccinations were suspended for a period.

Figure 21 HMP Dovegate Hepatitis B & C Vaccination Coverage January to March 2014

	Total Receptions	Declined	Already Vaccinated	Vaccinated within 30 days	Total Doses Given	% Vaccine Uptake*	% Declined	% Already Vaccinated	% Vaccine Coverage	Hep C Tests	% Hep C tests performed
Dovegate	580	198	164	6	6	0.03	0.48	0.28	0.29	0	0

More recent data from the HJIP performance dashboards continues to report low levels of screening and recommendations have been made regarding this.

Figure 22 Hepatitis B Screening October 13-February 15

Hepatitis B Screening	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15
No. eligible	187	140	155	166	0
No. offered screening	0	0	0	0	7
No. screened (pathfinder only)	5	15	0	13	0

Figure 23 Hepatitis C Screening October 14-February 15

Hepatitis C Screening	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15
No. eligible	153	120	109	139	114
No. screened (pathfinder only)	0	15	0	0	0
No. offered screening	0	0	5	10	11
No. referred to specialist service	1	1	4	0	0

In the months October 2014 – February 2015, 4.1% (n=26) of the 635 men eligible for Hepatitis C screening were offered screening and 0.9% (n=6) were referred to a specialist service.

The Clinical Lead reported that the consultant hepatologist to whom Hepatitis C patients are referred has raised concerns about the number of patients for whom hospital appointments are cancelled due to lack of escorts. The consultant hepatologist is now reluctant to commence new treatment regimes due to concerns about continuity of care. This needs to be addressed through resolution of the hospital escorts issue and discussion with the hepatologist. A number of recommendations have been made later this report regarding hospital escorts which may support this important objective.

### 7.3 Recommendations

- The healthcare provider should liaise with Public Health England Health Protection Team to develop the training identified as an action plan requirement in the Public Health England 'West Midlands Prison Health Protection Report' (2014).
- A systematic approach to Hepatitis B vaccinations and to the data capture of vaccinations offered and declined and the numbers of men already vaccinated needs to be implemented in order to increase vaccination coverage to meet important PHE targets.
- An urgent review of Hepatitis C pathways needs to be undertaken to ensure that:

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- Screening is coordinated and all screening data is accurately collated and captured
- Patients identified as Hepatitis C have access to specialist consultant review
- A system is implemented and resources identified to ensure that hospital appointments for those requiring Hepatitis C treatment are not cancelled and treatment continuity can be assured.
- A review of the data collected for HJIP indicators is required to ensure that data is consistent and accurate.

## 8. Sexual Health

Figure 24 Sexual Health Clinics October 14-February 15

Sexual Health Clinics	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Number of patients expected to be seen	10	16	2	0	80
Number of patients actually seen in clinic	7	5	1	0	55
Clinic utilisation (%)	70	31	50	0	69
Waiting time for routine care (days)	8	11	14	5	0
Contracted sessions	2	2	0	0	0
Delivered sessions	2	2	0	0	0
Cancelled sessions	0	0	0	0	0

- Between October 2014 and February 2015 a total of 108 appointments were delivered, giving a mean average of 21.6 appointments per month.
- Clinic utilisation ranged from 31-70%.
- Waiting times for routine appointments ranged from 0 to 14 days.
- Over the five months reviewed, a total of 40 appointments were lost to non-attendance.
- Data relating to service provision is very variable.

Figure 25 Chlamydia Screening October 14-February 15

Chlamydia Screening	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15
No. eligible	31	38	28	27	27
No. screened	8	10	0	4	5

In the months October 2014 – February 2015, 17.9% of those eligible were screening for Chlamydia.

Figure 26 HIV Screening October 14-February 15

HIV Screening	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15
No. eligible	185	186	135	154	161
No. screened	4	15	4	8	0
No. confirmed cases	3	1	0	0	0

In the months October 2014 – February 2015, 3.8% of those eligible were screened for HIV. Of these 31 men, 12.9% (n=4) were confirmed HIV positive.

HIV positive patients are referred to a specialist HIV consultant for treatment.

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%).<sup>19</sup>

### 8.1 Recommendations: Sexual Health

- It has not been possible to obtain data regarding prevalence of sexually transmitted conditions for this Health Needs Assessment. It is therefore recommended that this is either the subject of a separate sexual health needs assessment, or has specific focus when the next HNA is undertaken.

## 9. Physical Disability

In the patient survey undertaken as part of the 2011 HMIP Inspection, approximately 12.2% of respondents regarded themselves as having some sort of disability, although type of disability is not specified.

SystemOne reports indicate that of the current prison population:-

- 39 men have mobility problems
- 28 have impaired hearing
- 13 are visually impaired
- There is 1 prisoner with a prosthetic

Healthcare areas and the Inpatient Unit have been assessed and aids are in place to assist access where required.

## 10. Health Promotion and Well-being

### 10.1 Health Promotion

There is a joint Health Promotion Action Plan. Health promotion activities are planned to reflect national health promotion and education initiatives.

### 10.2 Smoking

Figure 27 No. of Self-Reported Smokers

	Number of Self reported smokers over 24 months			
	2011	2012	2013	2014
QOF SM004	1081	1930	809	884

The 2013 HNA reports a decline in the numbers of self-reported smokers from 2012 to 2013. However, smoking appears to have increased by approximately 9% since 2013.

<sup>19</sup> 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](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/345181/Volume_8_number_24_hpr_2414_AA_stis.pdf)

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The Offender Health Research Network<sup>20</sup> cites research by MacAskill et al ( 2008) who found that 'prisoners who quit smoking whilst in prison experienced many positive outcomes: these included increased enjoyment of exercise; a sense of freedom, control and independence; gaining respect from significant figures within the prison and from family members, and valued financial benefits'.

Smoking cessation services at HMP Dovegate are delivered by 'Time to Quit', the Staffordshire and Stoke on Trent Partnership NHS Trust smoking cessation service.

The service provides 2 full days of support each week. The QOF 'How Am I Driving?' report indicates that 93.8% of men have been offered support and 80.8% have been referred to a specialist service within the reporting period.

NHS monitoring reveals that quit rates in prison-based stop-smoking services are unusually high. Experimental data from the NHS Information Centre (2010) suggests that quitters in the prison setting have a higher 4 week success rate (56%) than almost any other group<sup>21</sup>.

Quit rates were not available for this HNA. It is recommended that all smoking cessation activity is captured on SystemOne READ coded templates to enable readily available data for future HNAs.

### 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 Australia<sup>22</sup>. As reported in section 6 of this report, 12.1% (n=134) 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 in to health promotion campaigns.

## 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. A separate NOMs data collection exercise regarding social care factors is currently being undertaken and it is recommended that this is reviewed by prison

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<sup>20</sup> <http://www.ohrn.nhs.uk/resource/policy/NoSmokingPrisonGuide.pdf>

<sup>21</sup> [www.ohrn.nhs.uk/resource/policy/NoSmokingPrisonGuide.pdf](http://www.ohrn.nhs.uk/resource/policy/NoSmokingPrisonGuide.pdf)

<sup>22</sup> 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).

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providers, healthcare commissioners and healthcare provider services to identify the implications for healthcare and any areas where joint working is required.

Social care needs will clearly need to be factored into discharge and resettlement plans with strong links developed between prison resettlement workers, CRCs and local authorities in the West Midlands and Staffordshire areas.

### 11.1 Recommendations – Social Care

- Communication pathways should be developed 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 Dovegate.
- Healthcare has access to a range of population data that may be useful to those tasked with planning services to meet social care need. 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.

## 12. Mental Health

### 12.1 Integrated Mental Health Service

Whilst other prisons within the cluster are covered by 2 sub teams, HMP Dovegate has a separate delivery model and provides an Integrated Mental Health Service.

Within the integrated model, 4 full time primary care mental health nurses are employed by Care UK (as detailed in section 3 of this report) who also employ a Band 7 mental health nurse team leader.

South Staffordshire & Shropshire Healthcare NHS Foundation Trust (SSSFT) provide the staff for the severe/enduring (traditionally secondary care) element of the service.

SSSFT are commissioned to provide RMN cover for the Inpatients Unit with 3.5 WTE band 5 RMNs.

The team are currently working towards an integrated mental health pathway with the vision of single line management with a single lead and team lead.

<b>HMP Dovegate Prison Integrated Mental Health Team Staff Resources</b>			
<b>Job Title /Grade</b>	<b>WTE currently in post</b>	<b>Vacancies</b>	<b>Additional explanatory notes</b>
<b>Service Manager 8b</b>	1WTE	0	Covers 7 prisons
<b>Clinical Lead 8a</b>	1WTE	0	In post
<b>Clinical Psychologist 8a</b>	0.5 WTE	0	
<b>Assistant psychologist 4</b>	0.5WTE	0	Recruited Jan 2015 Awaiting start date
<b>Social Worker 6</b>	0.8 WTE	0	Recruited awaiting start date
<b>Occupational therapist 5</b>	1WTE	0	In post
<b>RMN 6</b>	2 WTE	0	In post
<b>Consultant Forensic Psychiatrists</b>	0.3 WTE	0	In post
<b>Forensic registrar</b>	On a training basis		In post
<b>Team secretary 3</b>	0.67WTE	0	Covers all 7 prisons from a central base in Stafford
<b>Medical Secretary 4</b>	1 WTE	0	Covers all 7 prisons from a central base in Stafford

Primary mental health nurses provide low level brief interventions and are trained in CBT, mindfulness and psychological therapies but are not yet set up as Dovegate IAPT. The stepped care approach underpins the integrated model and care plans are flexible and patient led.

CPA meetings are held weekly and there is also a weekly inpatient operational meeting.

The integrated team is beginning to offer group sessions delivered within a compassion focused therapy framework and are employing an assistant psychologist to develop group work.

This is a new and evolving service and staff reported that they were developing new ways of working as they move forward with the integrated service. It was commented that there are no Health & Justice Indicators of Performance (HJIPs) for the primary mental health element of the service.

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It was felt that being part of the wider SSSFT network was beneficial for staff training and supervision. HMP Dovegate has a designated Learning Disability Nurse who is also dually trained as a mental health nurse.

### 12.2 Screening and Referral

All men are screened for mental health concerns during the initial and secondary reception screen. The team operates a Stepped Care Model approach with a single point of access used alongside joint triage to allocate to appropriate intervention.

Referrals are made using the TAG (Threshold Assessment Grid) referral form. Referrals are then assessed and prioritised according to TAG score and are designated a priority rating of urgent (seen within 72hours), moderate (seen within 14 days) or standard (seen within 28 days).

TAG referral forms can be sent electronically via SystemOne task function.

Tasks are sent to a group task list rather than individually named members of staff, which is good practice.

There is a weekly meeting to discuss new referrals and any clients who are presenting concerns.

Clients already known to secondary care services or on CPA are automatically picked up by the In-Reach team.

### 12.3 Mental Health Need

As this is a new service, data relating to actual prevalence is currently sparse and data collection systems will require building over the forthcoming months.

To provide an evidence based estimation of need, the table below illustrates the prevalence of mental health disorders in adult male prisons<sup>23</sup> applied to the population of HMP Dovegate.

For calculation purposes, this has been calculated on an estimation of 100 remand prisoners and 1000 sentenced prisoners.

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[www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/331628/Health\\_Needs\\_Assessment\\_Toolkit\\_for\\_Prescribed\\_Places\\_of\\_Detention\\_Part\\_2.pdf](http://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

	National Prevalence England	Remand Prisoners	Sentenced Prisoners	HMP Dovegate estimate
Functional Psychoses	0.30%	10%	7%	80
Personality Disorder	Data not provided	78%	64%	718
Mild Anxiety and Depression	6.90%	26%	19%	216
Generalised Anxiety Disorder	3.40%	11%	8%	91
Depressive Episode	1.90%	17%	8%	97
Phobias	0.80%	10%	6%	70
Obsessive Compulsive Disorder	0.90%	10%	7%	80
Panic Disorder	1.00%	6%	3%	36

Figure 28 HMP Dovegate- Estimated Mental Health Need

The above table clearly illustrates the high numbers of men with personality disorder in prison and this often contributes significantly to the caseload of mental health teams.

Data from the Carer Engagement Report suggests that there were 35 referrals to the SSSFT team in November 2014.

In January 2014 there were 47 patients on CPA, 43 of whom had received annual reviews and 4 of whom were on the waiting list for review.

Data from the HJIP reporting framework suggests that in October 2013 there were 58 open ACCTS. In January this had reduced to 41, increasing again to 46 in February.

The duty nurse attends ACCT reviews where mental health issues are present. The ACCT planner used on the prisons system was reported as being ineffective due to records not being regularly updated. A joint review of the current process within the prison is required in order to raise the priority of careful, effective and timely management of ACCTS.

#### 12.4 Patient records

The team use SystmOne as their primary recording database with all secondary work – including risk assessments – recorded on RiO.

CARE UK does not currently have access to RiO but plans are in place to install unified templates onto SystmOne to reflect RiO, alongside caseloads and waiting lists.

RiO is the system used by South Staffordshire & Shropshire NHS Foundation Trust and enables the In Reach team to access community records and hospital inpatient records of clients from the local areas into which they provide services, enabling more accurate acquisition of mental health history and facilitating continuity of care.

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The team transferred to RiO from their previous recording system approximately 6 months ago.

There has been some loss of reporting functionality in the transfer from the previous electronic system to RiO - of which commissioners are aware - and therefore the In Reach team were unable to provide extensive historical data for the Health Needs Assessment.

As this is an embryonic service, no data was available on the incidence of newly occurring acute mental health episodes or on prevalence of specific diagnoses.

### 12.5 Transfers under Mental Health Act

A survey conducted in 2011 by the Royal College of Psychiatrists<sup>24</sup> aimed to establish whether psychiatrists felt that a 2 week/14 day target (as initially recommended in The Bradley Report 2009<sup>25</sup>) 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:

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

The time taken to transfer out acutely unwell patients is a concern across the secure estate and was expressed as a specific concern for HMP Dovegate by the Prison Director. The Integrated Mental Health Lead explained that while internal systems were in place, external barriers and lengthy waits hindered the successful transfer/discharge of mentally ill patients, echoing the governors concerns. Recommendations have been made regarding data collection for future HNAs.

### 12.6 HMP Dovegate Therapeutic Community

Dovegate Therapeutic Community (TC) has an operational capacity for 200 adult men. It is based on the concept that democratic therapeutic communities, run by both staff and prisoners, should be central to the way the prison operates. The unit is described here as a distinct and separate

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<sup>24</sup> Prison transfers A survey from the Royal College of Psychiatrists December 2011 at [www.rcpsych.ac.uk/pdf/GoodPracticeGuide.pdf](http://www.rcpsych.ac.uk/pdf/GoodPracticeGuide.pdf) - Accessed 07.012.15

<sup>25</sup> 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

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provision within HMP Dovegate. Psychologists and staff working on the unit are separate to the Integrated Mental Health Team.

In order to be considered for relocation to the TC, prisoners must be Category B or below and have at least 21 months to serve. Prisoners must also admit to and take responsibility for their offence and be prepared discuss their offending behavior within a group setting. They must be open about their offending and related institutional behavior and be prepared to be challenged by peers and staff within therapy and community groups. Offenders referred to the TC often have a history of serious violent offending, poor institutional behavior and prolific self-harm.

Within the TC at HMP Dovegate, morning support groups take place 3 times a week, immediately followed by reflection time. Residents spend afternoon sessions either at work or in education. Larger community groups are called twice weekly, with the opportunity to arrange special group meetings should an important issue requiring immediate discussion arise.

The Therapeutic Community at HMP Dovegate was subject to inspection by HMIP in February 2014. It was reported that:-

- Dovegate TC remained a safe prison, with very few incidents and most day-to-day safety problems dealt with by the communities rather than by more formal processes.
- Support for the small number of men vulnerable to self-harm was good, as was support for men with substance misuse issues.
- Staff-prisoner relationships were very good, which underpinned much of the work being done.
- Time out of cells was good, but sometimes affected by problems in the main prison.
- Leadership of learning and skills was developing, but some elements of quality improvement needed to be fully embedded,
- Resettlement support was good and men were encouraged to address their risks of re-offending.
- Some very good work was being done during therapy, but problems in delivering some key aspects of therapy risked undermining effectiveness.

However, inspectors also reported the following concerns:

- Men spent their first few months on the assessment unit and they had little to do that was purposeful.

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- The lack of experienced TC members in the unit was affecting the transfer of some key elements of the TC's ethos.
- Prisoners needed to feel confident enough to raise concerns in therapy about other prisoners' behavior, and this was not fully embedded, which needed to be addressed.
- The focus of learning skills as complementing therapy needed to be better understood and supported by staff.
- The promise of the national integrated personality disorder pathways strategy had not yet been realised, which was a wasted opportunity to ensure men arrived at the prison at the right time, and that there was a structured plan for them to progress after completion of the programme.

### 12.7 Recommendations: Mental Health

As this a new and developing Integrated Mental Health Service, the recommendations made relate to future data collection and collation and service evaluation.

- The SystemOne and RiO templates being developed by the team should be designed to efficiently capture data for HJIP reporting and performance and clinical outcomes monitoring.
- A local READ code formulary should be developed for the Integrated Mental Health Team so that accurate prevalence data for mental health conditions can be collated to accurately assess need and inform service developments.
- The team should liaise with the prison provider to review the ACCT planner process and ensure that accurate and timely information is provided to enable support of the ACCT process.
- As this is a new service, it may be useful to undertake a focused mental health needs assessment a year after service commencement to support ongoing development.

## 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%'<sup>26</sup>.

In addition to this, NICE <sup>27</sup>states 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-

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<sup>26</sup> 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

<sup>27</sup> Autism: Recognition, referral, diagnosis and management of adults on the autistic spectrum at [www.nice.org.uk/guidance/cg142](http://www.nice.org.uk/guidance/cg142)- Accessed 23.01.15

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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’.

The QOF performance report ‘How am I driving?’ Indicator LD003 for this prison indicates that there are 30 patients with a learning disability. This is significantly higher than for other prisons within the cluster and possibly reflects an increased awareness of learning disability, which may be partially attributed to the specialist Therapeutic Unit (TC+) for those with learning disabilities. Residents on the TC+ unit have scores of between 60 and 80 on WAIS (Wechsler Adult Intelligence Scale) assessment. As an ongoing element of their therapeutic engagement, residents receive regular support through a psychology led multi-disciplinary approach.

There does not appear to be a system for annual LD reviews for men in the main prison.

As there is no actual prevalence data reported in the 2013 HNA, comparison with previous years has not been possible.

### 13.1 Recommendations: Learning Disabilities and Autistic Spectrum Disorders

The recommendations below are made as a regional recommendation rather than specifically for HMP Dovegate and as such have been included in the regional HNA report.

- 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
  - a through the gate service linking to Community Healthcare Teams, third sector agencies, peer support ne2rks and Community Rehabilitation Companies to support resettlement on release

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## 14. Substance Misuse

### 14.1 Substance Misuse Need

The Data below is extrapolated from the national Adult Prisons Quarterly Treatment report.

Figure 29 Substance Use April 13-April 14 (Source: Adult Prisons Quarterly Treatment Report)

Substance Use Data 2013-2014									
HMP Dovegate	Q1		Q2		Q3		Q4		
	Total	%	Total	%	Total	%	Total	%	
<b>New receptions:</b>									
Number of new receptions (based on healthcare screenings)	661	-	616	-	491	-	959	-	
Number of new receptions beginning drug treatment episodes	106	16%	87	14%	57	12%	101	11%	
<b>New treatment entrants (individuals):</b>									
Total opiate user (OU) new treatment entries	55	-	40	-	20	-	50	-	
Total non-opiate user new treatment entries	27	-	21	-	25	-	38	-	
Total primary alcohol new treatment entries	44	-	52	-	41	-	43	-	
<b>Total new entrants</b>	<b>126</b>	<b>-</b>	<b>113</b>	<b>-</b>	<b>86</b>	<b>-</b>	<b>131</b>	<b>-</b>	
<b>Treatment combinations for individuals:</b>									
<b>Opiate Users</b>									
Clinical interventions only	22	9%	21	13%	21	12%	20	11%	
Non-clinical structured interventions	119	59%	124	74%	130	76%	147	81%	
Clinical and non-clinical structured interventions	30	26%	19	11%	16	9%	11	6%	
No modality started	4	6%	3	2%	5	3%	4	2%	
<b>Total opiate users in treatment</b>	<b>175</b>	<b>-</b>	<b>167</b>	<b>-</b>	<b>172</b>	<b>-</b>	<b>182</b>	<b>-</b>	
<b>Non opiate users</b>									
Clinical interventions only	1	1%	1	1%	1	1%	0	0%	
Non-clinical structured interventions	66	96%	71	96%	89	96%	118	98%	
Clinical and non-clinical structured interventions	0	0%	0	0%	1	1%	1	1%	
No modality started	2	3%	2	3%	2	2%	1	1%	
<b>Total non-opiate users in treatment</b>	<b>69</b>	<b>-</b>	<b>74</b>	<b>-</b>	<b>93</b>	<b>-</b>	<b>120</b>	<b>-</b>	
<b>Primary Alcohol Users</b>									
Clinical interventions only	2	1%	3	2%	2	1%	2	1%	
Non-clinical structured interventions	121	88%	136	93%	146	95%	162	96%	
Clinical and non-clinical structured interventions	10	7%	3	2%	1	1%	1	1%	
No modality started	4	3%	4	3%	5	3%	4	2%	
<b>Total primary alcohol users in treatment</b>	<b>137</b>	<b>-</b>	<b>146</b>	<b>-</b>	<b>154</b>	<b>-</b>	<b>169</b>	<b>-</b>	
<b>Total individuals in treatment</b>	<b>381</b>	<b>-</b>	<b>387</b>	<b>-</b>	<b>419</b>	<b>-</b>	<b>471</b>	<b>-</b>	

From April 2013 to April 2014 there was a total of 2,727 **new** receptions of whom 351 (12.9%) commenced new drug treatment episodes.

Of total new treatment entrants, 36.2% (n=165) were opiate users, 24.3% (N=111) were non-opiate new treatment entrants and 39.5% (n=180) were primary alcohol new treatment entrants.

Comparatively, in December 2013, 46.5% of new treatment entrants were opiate users, 13% were non opiate users and 40.5% were primary alcohol clients.

The number of new treatment entrants who are opiate users appears to be decreasing, reflecting national trends.

Data from the same source (not illustrated in the table above) also shows that:

- Of the opiate user treatment entrants, 70% had been taken in to custody and commenced on treatment within 3 weeks, 10% had been transferred from other prisons and 20% commenced treatment after three weeks in the prison.
- Of the non-opiate user treatment entrants, 50% had been taken in to custody and commenced on treatment within 3 weeks, 11% had been transferred from other prisons and 39% commenced treatment after three weeks in the prison.

- Of the primary alcohol user treatment entrants, 69% had been taken in to custody and commenced on treatment within 3 weeks, 7% had been transferred from other prisons and 24% commenced treatment after three weeks in the prison.

Alcohol was reported as the primary main drug (38% of those declaring their primary drug of use), followed by heroin (28%) and cannabis (11%).

The December 2013 Substance Misuse HNA<sup>28</sup> also reported alcohol and heroin as the 2 most common primary substances, with 39% of men reporting alcohol as the primary drug of use and 32% heroin.

58% of those for whom injecting status was recorded had never injected, 28% had previously injected and 14% were injecting at the time of coming into custody. This is a reduction from the 19% who reported currently injecting in the 2013 Substance Misuse HNA.

The 2013 Substance Misuse HNA reported that staff felt that the use of heroin had declined within the prison, but that the use of illicit Subutex, prescribed medications (including Tramadol, Gabapentin and Pregabalin), legal highs, alcohol and steroids had increased.

#### 14.2 The Integrated Substance Misuse Service

An Integrated Substance Misuse Service (ISMS) comprising clinical and psycho-social support services is provided by Care UK as part of the overarching integrated healthcare model.

Staff resources are as below, with the team also being supported by general administration and pharmacy services.

Figure 30 ISMS Staff Resources

ISMT Clinical Services		
ISMT Lead Nurse	0.9	0
ISMT Nurses	2.0	0
ISMT Psychosocial Services		
ISMT Lead Practitioners	1.0	0
ISMT Admin	8.0	0
	1.6	0

Prisoners with a history of drug or alcohol use are identified by the primary care team during first night reception screening.

There is no on site GP cover for evening receptions, although staff reported that there were plans to recruit an evening GP.

Currently there is no provision for first night prescribing of methadone or other opiate substitutes and prisoners are provided with symptomatic relief until they can be seen by the GP the following day.

A GP clinic is held on Saturdays to review men who have arrived on a Friday evening.

<sup>28</sup> Halliday, K HMP Dovegate Drug and Alcohol Needs Assessment December 2013

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It was indicated that a previous PGD for Chlordiazepoxide has been withdrawn and prescribing for alcohol dependant patients was reliant on the Out of Hours GP service.

Prisoners are not given Buscopan for symptomatic relief of abdominal cramps due to recent national intelligence that this can be used illicitly.

N Wing is the first night wing at H.M.P Dovegate. In addition to this M Wing is the designated ISMT wing where substance misuse patient reside for the first 28 days of treatment. M wing (ISMS wing) has cells with door hatches which allow observations to be taken and medicines to be administered where necessary during night state.

The day after reception a GP review is undertaken and any prescribing needs addressed. Following confirmation with community drug services or pharmacies, supervised programmes are continued. A treatment pathway is in place for titration for those who have had breaks in supervised programmes or who have been using illicitly.

Treatment is recovery focused, however maintenance programmes are followed for those on remand or short term sentences. Service users are able to control the rate of methadone reduction regimes (within safely agreed parameters of not more than 2mL/ week or 5mL / fortnight), giving them a sense of control and ownership. Formal reviews take place at 5 days and at 13 weeks however, interim reviews can take place at any time in accordance with clinical need.

Men are offered a consultation with an ISMT practitioner and a recovery plan is initiated from the second day in prison. ISMS review dates are planned and agreed. The table below is extrapolated from monthly HJIP performance reporting spreadsheets and illustrates some key activities.

Figure 31 Integrated Substance Misuse Services

	Oct-14	Nov-14	Dec-14	Jan-15
Number of 5 day reviews in month	25	34	24	39
Number of 13 week reviews in month	15	10	14	22
Number of patients engaging with psychosocial services	282	266	282	290
Number of patients prescribed methadone maintenance regime	60	65	61	54
Number of patients with ISMS reduction plan	29	28	56	13

The service offers both 1:1 and group work.

A range of courses / services are available including:

- acupuncture
- stress solutions / stress management
- relaxation classes
- emotional freedom
- cannabis awareness
- legal high awareness
- stimulant awareness

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- alcohol awareness
- relapse prevention
- Road to Recovery (co facilitated with RIOT)

There are also crisis groups and peer support groups delivered by both clinical & psychosocial staff. Men are able to phone a substance misuse helpline from their in- cell telephones to access support.

The team reported a greater sense of integration since the start of the new service and acknowledge that systems of joint working are developing. It was noted that psychosocial practitioners do not yet have access to SystemOne, which would be beneficial from a joint care planning perspective.

Discharge clinics are held each Tuesday and where possible, the team refer on to community drugs teams. However, unplanned discharges do occasionally occur and can be problematic, requiring quick and effective communication with community services to arrange continuation of treatment. As HMP Dovegate receives more resettlement prisoners, discharge planning will assume greater emphasis and increased liaison with through the gate resettlement workers and community rehabilitation companies will be required.

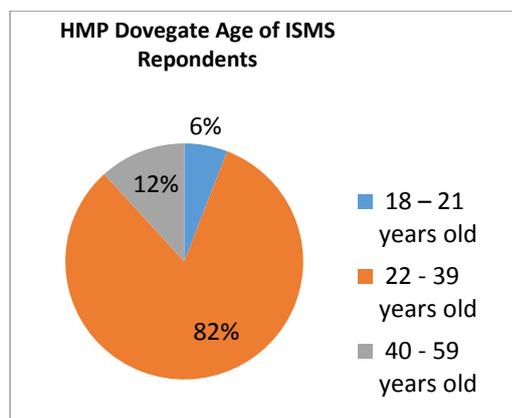
As with other prisons in the cluster, it was felt that New Psychoactive substances or ‘legal highs’ presented the most concerning illicit drug use, with HMP Dovegate experiencing some acute episodes of bizarre behaviour and unwell patients (as experienced in other areas).

Safer Prescribing meetings are held with representation from GPs, ISMS, Integrated Mental Health and Clinical Lead to discuss individual patient prescribing issues and issues with tradable medicines.

### 14.3 Stakeholder Feedback

To illicit the views of ISMS service users, 40 questionnaires were distributed. 35 questionnaires were returned giving 87.5% response rate. In addition a focus group was held with 7 service users. Feedback from service users is presented below. It is important to note that some of the feedback reported may not be factually correct, but has nevertheless been included as it represents service user perception.

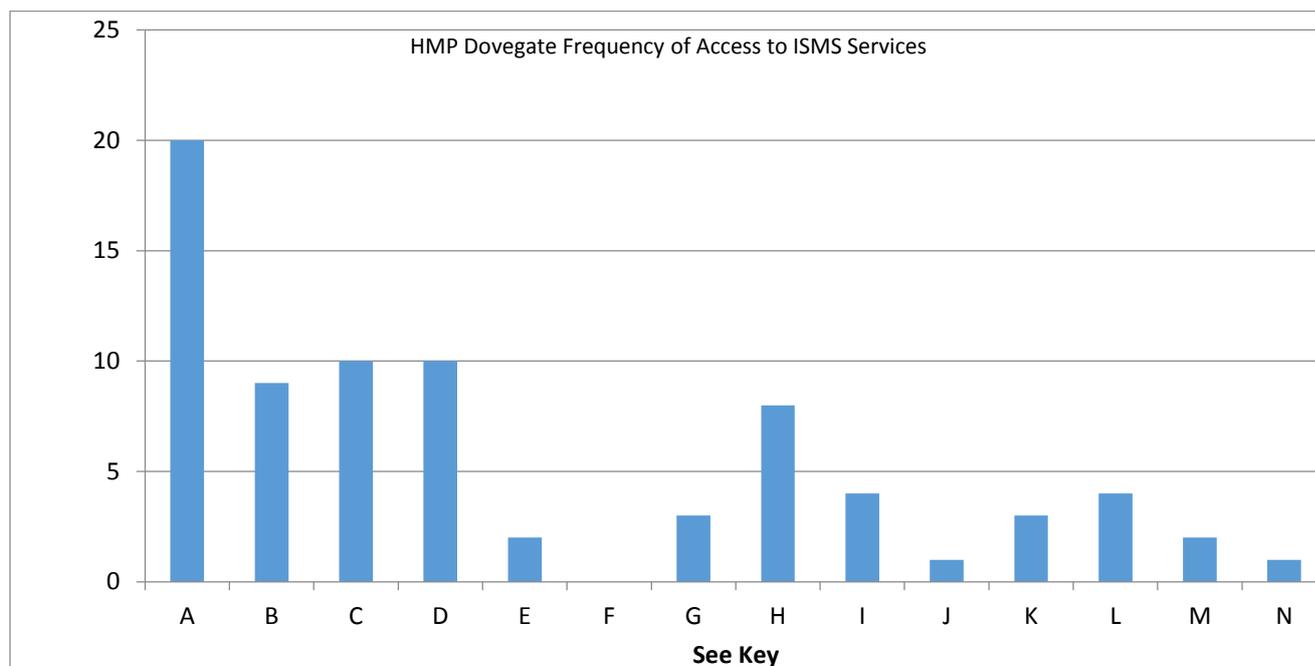
Figure 32 Age of Respondents ISMS Questionnaires



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The majority of respondents (82%, n=28) were between 22-39 years of age. 12% (n=4) were aged 40-59 years old and 6% (n=2) were 18-21 years old.

Figure 33 Frequency of Access ISMS Services



**Key**

- A - Prescribed medication for opiate withdrawal**
- B - Prescribed medication for benzodiazepine withdrawal
- C - Maintenance medication**
- D - 1:1 Support from drugs worker
- E - Group drugs work**
- F - Anti-coagulant services (INR measurement, Warfarin tablets,
- G - Harm reduction advice (overdose, needle sharing, blood borne**
- H - Prescribed medication for alcohol withdrawal
- I - 1 to 1 support from alcohol worker**
- J - Group alcohol work
- K - Reviews with non- clinical substance misuse workers**
- L - Reviews with clinical staff (nurses or doctors)
- M - Alternative therapies to assist with detox (e.g. Acupuncture, Art therapy)**
- N - Other (please state)

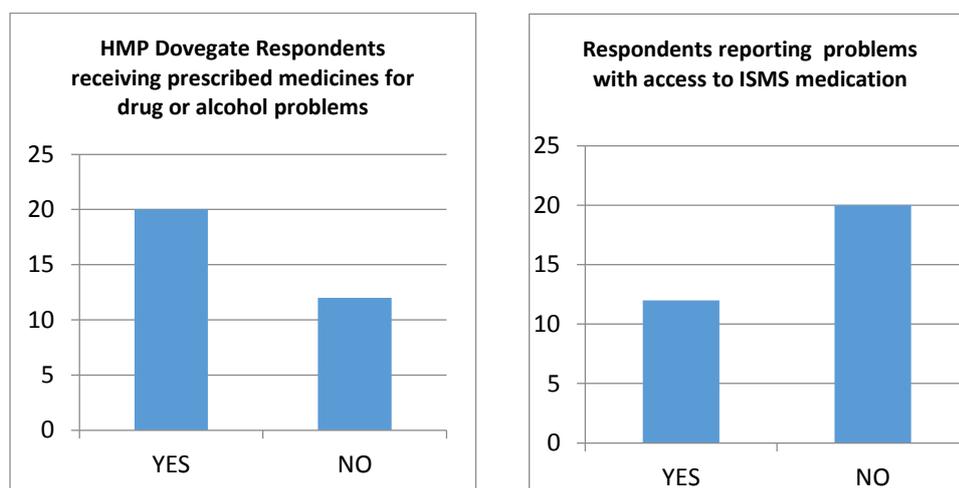
Most respondents had accessed prescribed medication for opiate withdrawal. Maintenance medication and 1:1 support from a drugs worker had also been accessed. Few respondents had

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accessed group alcohol work or alternative therapies and no respondents had accessed anti-coagulant services.

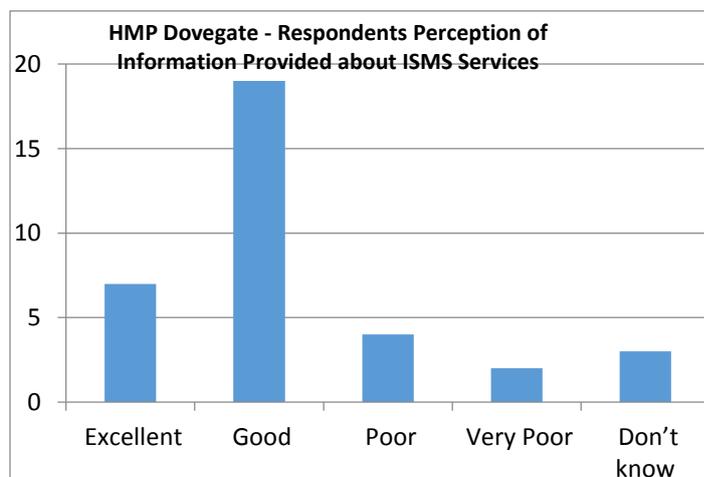
Figure 34 ISMS Respondents Receiving Prescribed Medication

Figure 35 ISMS Respondents Reporting Problems Receiving Medication



The majority of respondents (62.5%, n=20) were receiving prescribed medicines for drug or alcohol problems at the time of the HNA. Of these 20 men, 60% (n=12) reported problems accessing their medication. This was also reflected in the textual comments of the questionnaires and in the focus group discussions where frustration with lack of first night prescribing was a recurrent theme. In addition to first night prescribing, men felt that there was not enough choice in detoxification and that Subutex (Buprenorphine) should be offered as an alternative. It was also commented that prescriptions from community GPs should be continued – with particular reference to strong analgesics and medicines for neuropathic pain. The HNA acknowledges that safer prescribing practice can require review and discontinuation of such medications

Figure 36 Respondents Perception of Information Received about ISMS Services



55.8% of respondents rated the information provided to them about drug and alcohol recovery services 'good'. A further 20% deemed it 'excellent'. This is a very positive response.

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Figure 37 ISMS Service User Questionnaire Comments

HMP Dovegate ISMS Service User Questionnaire Comments	
<b>What are the best things about drug and alcohol services in this prison?</b>	Are there any things about drug and alcohol services that you think could be improved?
Helps you for when you get out	No (8 x comments)
The support (2 x comments)	How long it takes for staff to get your medication sorted
They help you	Giving prescribed medication from outside because doctors automatically don't give meds from GP. We should get treated as NHS quality outside
The speed in which you are seen and prescribed	
They help you to get clean plus get your life back on track	Less stress
They help present drug users	We could be listened to more and not looked upon as druggies
Help people stay clean	
They try and help you	The first night you are in prison you should get something
They help to get me off them	Give people the meds they need to recover Need to detox them to instead of maintaining them for long periods
Medication puts you at ease when withdrawing	Yes, loads
	The lofexadine detox is too short
	More help
	3 way conversation with drug worker
	Detoxing programme could be better
	Don't waste money on smack heads who end up selling/swapping them, spend money on food or medicine that will benefit people who need it.
	Drug use is their choice why help when the shouldn't take it anyway and they still use

Service users reported feeling involved in their care and it was commented by the men in the service user focus group that ISMS practitioners were very approachable and had a good

rapport with service users. Several men felt the service was better than services they had experienced at other establishments.

### 14.3 Recommendations Substance Misuse

- It is recommended that an evening GP is recruited as soon as possible. Pending recruitment, locum cover by an experienced substance misuse clinician should be secured so that first night prescribing for both alcohol and opiate dependant patients can be initiated.
- Prior to the introduction of first night prescribing, processes will need to be in place to confirm community prescriptions promptly. Reception staff will also need awareness training regarding medication administration in police custody for those being remanded directly to prison (via the courts) from police custody.
- An appropriate alternative antispasmodic to Buscopan should be provided for the relief of abdominal cramps associated with opiate withdrawal.
- ISMS practitioners should have access to SystmOne to facilitate joint care and recovery planning.
- The development of Recovery Champions 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 develop initiatives.
- 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 healthcare providers is formed to develop a prisons healthcare approach to management of New Psychoactive Substances.

## 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 bedwatches are considered in order to continue to meet healthcare needs.

Hospital escorts and bedwatches were identified as a concern in interviews with the Clinical Lead, Head of Healthcare and Prison Governor. The issue has been raised at partnership meetings and identified as a clinical risk to patient care.

The commissioner led Health & Justice Secondary Care Activity Report analysed escort and bedwatch activity for all prisons across the cluster from August 2013 to August 2014 and found that:

There were 267 attendances at A&E (unscheduled care) made by 248 patients from HMP Dovegate.

The highest costs for scheduled care appointments across the region was incurred by HMP Dovegate (£76,355), attributing to 16.37% of the total costs of outpatient activity.

Between July 2014 and December 2014, 620 outpatient appointments were booked and 315 (50.8%) were subsequently cancelled either on the day of the appointment or prior to the appointment date. This is an extremely high cancellation rate that limits patient access and impacts on care quality and patient experience.

Figure 38 Hospital Cancellations

HMP Dovegate Hospital Cancellations				
	Total booked	Cancelled on day	DNA rate	Cancelled prior
<b>July</b>	117	28	24%	15
<b>August</b>	109	24	22%	11
<b>September</b>	109	29	27%	12
<b>October</b>	110	24	22%	32
<b>November</b>	88	37	42%	35
<b>December</b>	87	37	43%	31

There were eight bed watches cumulatively totalling 955.33 hours/39.8 days in December 2014. 75% (n=8) of bed watches took place at Queens Hospital. Burton on Trent, 1 at Royal Stoke and 1 at Royal Derby.

This only provides a snapshot of activity and it is strongly recommended that a full and detailed analysis of escorts and bed watches is undertaken to understand all the issues for HMP Dovegate and develop a robust action plan.

It would be beneficial for the Healthcare Department to develop strong links with Directorate Leads at Queens Hospital and to develop ongoing dialogue to identify and address local actions to reduce cancellations of hospital escorts and improve patient experience.

### 15.1 Recommendations – Planned and Unplanned Secondary Care

Hospital escorts and bedwatches were identified as a concern in interviews with the Clinical Lead, Head of Healthcare and Prison Governor. This has been raised at partnership meetings and identified as a risk to patient care.

Improvement in the management of secondary care appointments would benefit commissioners, the healthcare provider organisation and the prison provider and most significantly, patient care. For these reasons, a raft of recommendations have been made to support this objective.

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- It is recommended that funding for a temporary resource is identified and a three month project allocated to maximise efficiency of all patient appointments, combining analysis and management of internal clinic DNAs and issues with management of planned and unplanned secondary care visits to hospital.
- The above project should have a clear outline and agreed measurable objectives and outcomes for demonstrable improvement in both HMP Dovegate clinic appointments and improved efficiency in secondary care arrangements.
- As a first step in creating a baseline and understanding all issues, a detailed analysis of secondary care appointment should be made, cross referencing information held on SystemOne, prison escort and bedwatch spreadsheets, Offender Management Unit (OMU) data and additional administration systems. The analysis should include
  - Number of appointments per month
  - Appointments by location
  - Planned appointments by department/speciality
  - Time from referral to appointment – routine referrals
  - Analysis or time from referral to appointment – urgent referrals
  - Unplanned escorts by day of week and time of day
  - Unplanned escorts by clinical reason
  - Unplanned escorts by clinical outcome
  - Unplanned escort by assessing clinician
  - Bed watches per month
  - Bed watch by location
  - Bed watch by length/ duration
  - An appropriate summary of the analysis should be shared with commissioners, providers, prison partners, CCGs and local senior hospital personnel to broaden support for an approach that increases efficiency and reduces cost whilst simultaneously improving patient experience and quality of care.
- Develop a system for recording all cancellations / postponements to appointments on SystemOne utilising the appointment reporting functionality, thus enabling more accurate analysis of cancellations.
- Develop a SystemOne template with background READ codes to record all unscheduled hospital visits (escorts and bedwatches) to enable accurate future analysis and ensure all nursing staff and GPs are trained in its use.
- Within the baseline work, all cases where waiting times have exceeded national targets should be individually reviewed so that mechanisms can be put in place to monitor this and prevent extended waits.
- All GPs should be encouraged to consider release dates when making initial hospital referrals.
- Where referrals are non-urgent, the expected date of release falls within NHS eighteen week target and the patient is likely to have a registered GP on release, consideration should be given to requesting hospital appointments for dates after release.

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- As a healthcare innovation, the opportunity to utilise NHS 'Choose and Book' in the above recommendation should be explored, as there are no security issues with patients to choose appointments AFTER their release dates. This affords patients choice in their care which is more equitable with wider community practice.
- Based on the evidence base from the secondary care analysis, the potential to arrange visiting consultant appointments for most frequently accessed specialities should be explored.
- In-house x-ray and ultrasound clinics commenced in December 2014. Global diagnostics provide x-ray and ultrasound clinic every 2 months. It is anticipated that this will result in a reduction in escorts to hospital and it is recommended that this is reviewed on an ongoing basis.
- 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.
- Opportunities for combining the use of mobile unit and liaison with orthopaedic consultants to replace face to face consultations with informed telemedicine consultations should be explored - e.g. x rays undertaken by mobile unit and forwarded to consultant / orthopaedic team for review in advance of telemedicine consultation.
- It is recommended that links are forged and liaison entered into with local Out-Patient Departments (OPD) to identify opportunities to make appointments as efficient as possible (for example routine check bloods, ECGs could be done at prison prior to appointment and results forwarded in advance or sent in hand held notes with the patient).
- Undertake a staff training needs analysis of GPs and nurses to identify training that could be provided to enable on-site management
- Develop local triage protocols / guidelines to support staff in decision making.
- A bedwatch protocol should be developed detailing the robust approach to be taken in contacting hospitals when patients are on bedwatches to establish opportunities for early discharge.
- Whenever there are ongoing bedwatches a Registered Nurse should be assigned to contacting hospitals on a daily basis and should record all discussions with the hospital on patient records on SystemOne.
- Commissioners and Head of Healthcare to visit Queens Hospital, Burton on Trent to meet with senior managers and agree an approach to early discharge planning to keep bedwatch hours to a minimum.
- Explore opportunity for pre-operative assessments to be completed at the prison, developing joint accountability and shared care protocols with local hospital day surgery units where required.
- Continue to review all EBW data on a regular and on-going basis to identify any areas for development.
- Successes from the approach should be shared with other prisons across the region.

## 16. Stakeholder Analysis

### 16.1 Methodology

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

Semi-structured face to face interviews were conducted with the prison director, Head of Healthcare, Clinical Lead, Integrated Mental Health Lead, and Integrated Substance Misuse Service (ISMS) Lead.

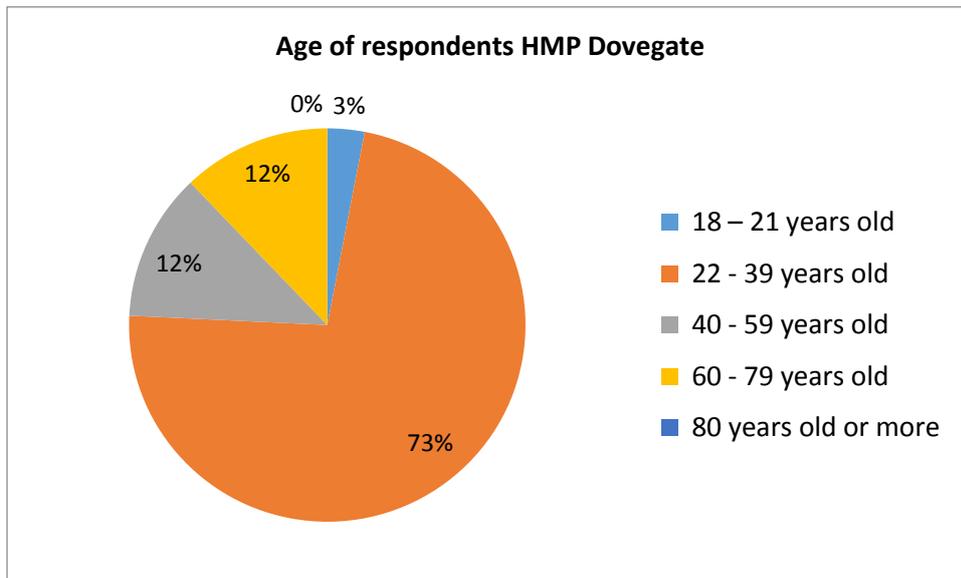
90 Service user questionnaires were distributed (50 x general healthcare questionnaires and 40 x ISMS questionnaires). The ISMS questionnaires are discussed in section 14 of the report. A focus group was held and themes from these incorporated into the HNA, along with themes and comments from general field notes made during on-site activities.

### 16.2 Questionnaires

50 general questionnaires were distributed and 33 returned, giving a response rate of 66%.

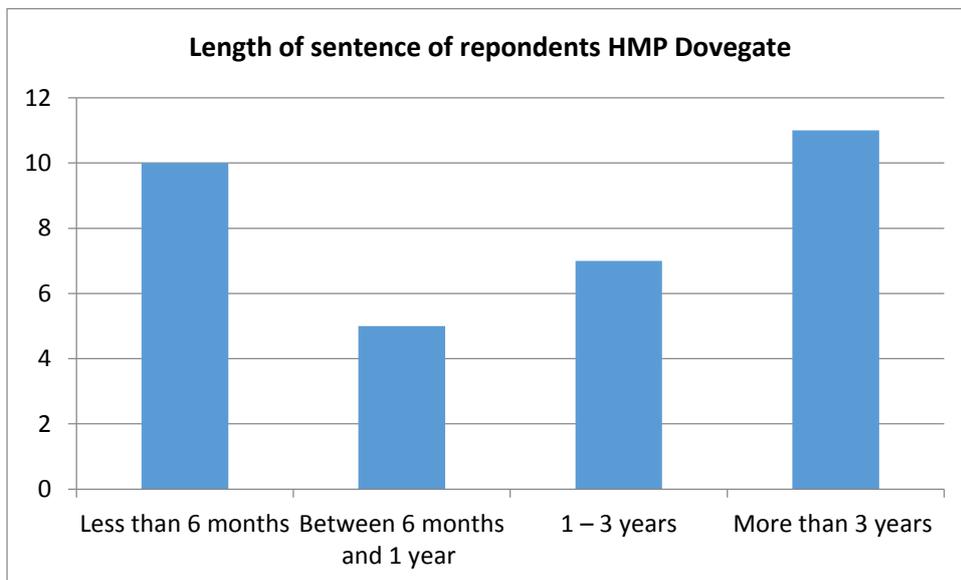
General questionnaire results are illustrated below.

*Figure 39 Age of Respondents HMP Dovegate*



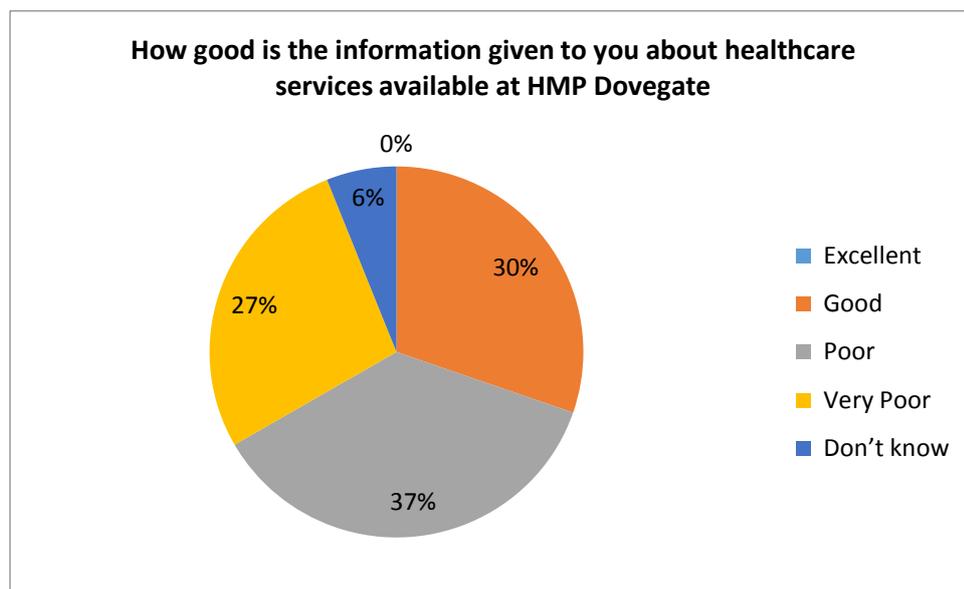
The majority of respondents (73%, n=24) were aged 22-39 years old. 3% (n=1) fell below this age bracket and 24% (n=8) were above 39 years of age. There were no prisoners aged 80 years or more.

Figure 40 Length of Sentence of Respondents HMP Dovegate



33.3% (n=11) of prisoners were serving sentences of more than three years. 30.3% (n=10) were serving sentences of less than 6 months, 15.2% (n=5) were serving sentences of between 6 months and 1 year and 21.2% (n=7) were serving sentences of 1 to three years.

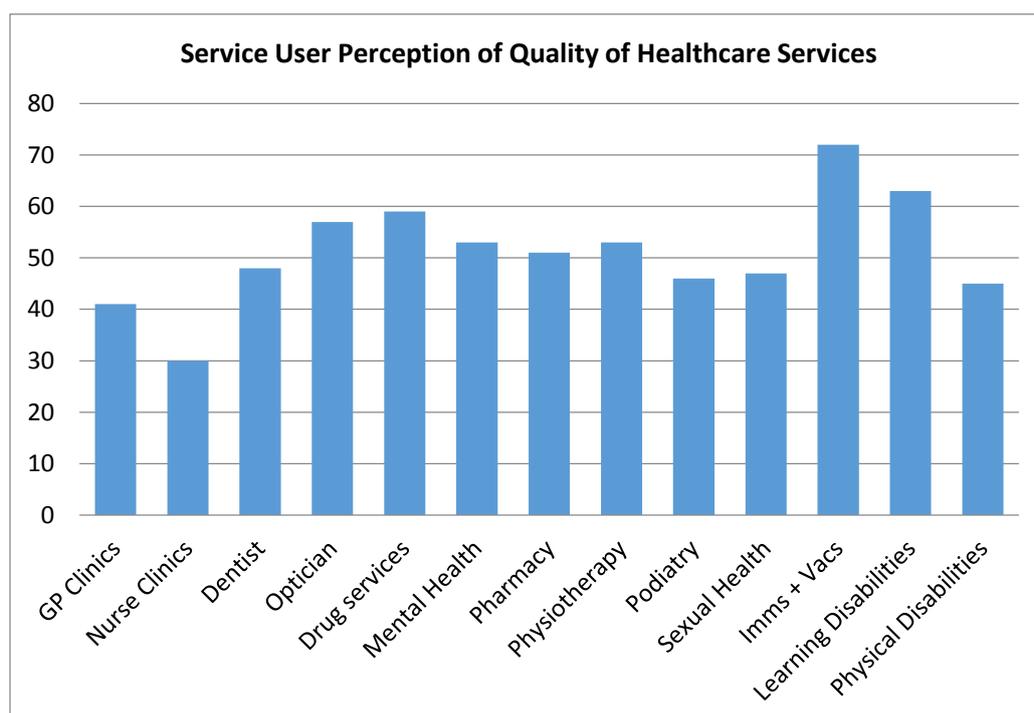
Figure 41 Service User Perception Information Provided



The majority of respondents (64%, n=21) rated information given to them about healthcare at HMP Dovegate to be poor or very poor. No respondents perceived information provided to be excellent, although 30% (n=10) rated it 'good'.

Figure 42 Service User Perception of Quality of Healthcare Services

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.



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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.

Immunisation and vaccination services were perceived favourably, as were learning disability services and drug services. Nurse clinics were less favourably perceived, followed by GP clinics.

Figure 43 Comments from General Questionnaire

HMP Dovegate Service User Questionnaire Comments	
<b>What are the best things about healthcare services in this prison?</b>	Are there any things about healthcare services that you think could be improved?
<b>It's easy to apply as it is done on the machine and your app cannot be lost</b>	People should be prescribed meds as an individual not judged as a whole, this prison has a problem with certain medication and therefore the people that actually genuinely need them don't get them!!
<b>You have to be seen</b>	Waiting times x 3
<b>The substance misuse team were really good and helpful when I first came in</b>	For nurses to stop acting like doctors
<b>The waiting time is not that bad</b>	To be able to get an appointment with who you need to see instead of seeing the nurse
<b>50/50 between mental health and substance misuse team</b>	To be able to provide proper healthcare staff after hours i.e. at night
<b>We need healthcare to stay healthy</b>	I never seen a doctor on reception even though I had issues about my medication. I was told they put me down to see him but never did. I applied myself but still only got to see a nurse who wouldn't let me see an actual doctor
<b>Some nurses are helpful</b>	There are a lot of things the list is too long
	The doctors
	The doctors need to stop taking people off their meds when they on them for proper reasons. Plus they mess you about with hospital appointments such as when I was in Ryshill I was waiting to go to hospital about my knees and a shoulder injury and was told I would still go when I come to this jail. But now I'm here nothings getting done for me and I've been here about 5 months

### 16.3 Recommendations: Stakeholder Feedback

- It is recommended that to improve service user perception a service user involvement / health champion initiative is launched and service users encouraged to help develop health information within their role.

## 17. Independent Scrutiny

Independent reports on the healthcare services delivered to the men at HMP Dovegate are positive.

HMP Dovegate was subject to an unannounced short follow-up inspection in October 2011. The purpose of this inspection was to review the progress the establishment had made in implementing

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the recommendations of the 2008 inspection<sup>29</sup>. The HMIP report states that ‘of the 59 recommendations made in 2008, 84% had been either achieved or partially achieved’<sup>30</sup>, commenting that ‘against all 4 healthy prison tests we concluded that the prison was making sufficient progress’<sup>31</sup>.

The 2012 Annual IMB report commented that ‘overall, HMP Dovegate appears to be a safe, calm and well-run establishment, where prisoners are treated with respect and decency. The small, proactive Senior Management Team and committed and enthusiastic staff cope well with the needs of the wide range of prisoners in their care’<sup>32</sup>.

The report commended the prison for the improved stability in Healthcare, the management of the Care and Separation Unit, the reduction in the length of stay in the CSU and the reduction in waiting time for TSP and CALM<sup>33</sup>. Furthermore, HMP Dovegate was congratulated for its achievement of Level 4 status and for achieving the 5\* Health & Safety Award<sup>34</sup>.

In November 2013, the Care Quality Commission undertook a joint inspection with HMIP. HMP Dovegate was inspected against the following CQC outcomes

- |            |  |
|------------|--|
| 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      |

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<sup>29</sup> HMP Dovegate Follow-Up Unannounced (Short) Inspection by HMIP, 18<sup>th</sup>-20<sup>th</sup> October 2011, p5

<sup>30</sup> HMP Dovegate Follow-Up Unannounced (Short) Inspection by HMIP, 18<sup>th</sup>-20<sup>th</sup> October 2011, p5

<sup>31</sup> HMP Dovegate Follow-Up Unannounced (Short) Inspection by HMIP, 18<sup>th</sup>-20<sup>th</sup> October 2011, p5

<sup>32</sup> HMP Dovegate The Annual Report of the Independent Monitoring Board, 1st October 2011-30<sup>th</sup> September 2012, p6

<sup>33</sup> HMP Dovegate The Annual Report of the Independent Monitoring Board, 1st October 2011-30<sup>th</sup> September 2012, p6

<sup>34</sup> HMP Dovegate The Annual Report of the Independent Monitoring Board, 1<sup>st</sup> October 2011-30<sup>th</sup> September 2012, p7

The service was assessed as meeting all standards. The CQC report comments that

- Peoples privacy, dignity and independence were respected
- Peoples views and experiences were taken into account in the way the service was provided and delivered in relation to their care
- Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare
- People's health, safety and welfare were protected when more than 1 provider was involved in their care and treatment, or when they moved between different services
- People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard
- The provider had an effective system in place to regularly check and monitor the quality of the service people received
- The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others<sup>35</sup>

## 18. Deaths In Custody

A summary of deaths in custody that have occurred at HMP Dovegate since 2010 is provided below. Details of deaths for which inquests have not yet been held and the Prison and Probation Ombudsman (PPO) reports not published are suppressed and therefore not included.

### January 2010

#### **58 year old man who died at hospital as a result of a neuro-endocrine tumour**

The man initially allowed doctors at the hospital to treat him, but in May 2009 he refused all further treatment. He continued to be looked after by healthcare staff at Dovegate, without the intervention of palliative care services from the community until his death in January 2010.

### 2010

#### **49 year old man who died at hospital of heart condition leading to cardiac arrest**

The man had a heart condition which he reported on reception and he suffered a heart attack a week later. Prison healthcare staff treated him and he was taken to hospital. His condition deteriorated and he suffered further cardiac arrests from which hospital staff could not revive him.

### October 2010

#### **37 year old man who died of broncho pneumonia (due to multiple sclerosis) at Burton upon Trent Hospital**

For the first few years of the man's imprisonment, he enjoyed good health. However, following the onset of symptoms over a period of several months, he was diagnosed with multiple sclerosis. Over the next four years, staff at Dovegate provided a great deal of dedicated care to manage his condition and also referred him to outside hospitals as appropriate.

### August 2012

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<sup>35</sup> HMP Dovegate CQC Inspection Report 7<sup>th</sup> November 2013, <http://www.cqc.org.uk/location/1-157765389>

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**32 years old man who died of a bleed on the brain at Glenfield Hospital, Leicester**

When the man arrived at Dovegate on 28 July, he had very high blood pressure, headaches and vomiting, but it was two days before he was examined by a doctor. The man's high blood pressure was not thoroughly investigated during his medical consultations. The man collapsed in his cell on the evening of 31 July and was taken to hospital where he died a week later.

**May 2012**

**74 year old man who died at hospital from lung and heart disease**

The man had a history of chronic obstructive pulmonary disease (COPD) for which he had been treated since 2005. In May 2012, he had a heart attack while being treated in his cell for shortness of breath. He was taken to hospital, where he died a few days later.

**February 2013**

**30 year old man found hanging in his cell at HMP Dovegate**

The man was transferred to HMP Dovegate after committing an alleged assault at HMP Sudbury. He had no history of self-harm and staff at Sudbury did not consider he was a risk. When the man arrived at Dovegate, he was assessed by healthcare and prison staff who all concluded that he was not at risk of suicide. One morning in February, an officer discovered him hanging in his cell. Officers and healthcare staff tried to resuscitate him, but paramedics pronounced him dead on arrival.

**May 2013**

**25 year old man found hanging in his cell at HMP Dovegate**

He had a history of self-harm and had previously attempted suicide. He was prescribed medication for depression and was monitored under suicide and self-harm prevention procedures for 14 days, when he said that he no longer had any thoughts of harming himself. Several days later, an officer carrying out a routine check found him hanging in his cell.

**June 2013**

**30 year old man found hanging in his cell at HMP Dovegate**

The man disclosed previous episodes of depression, psychiatric treatment and said that he had been prescribed antidepressants. However, his health needs were not followed up and no checks were made with his community GP. The man was involved in a lengthy trial and had to attend court daily, which presented an increased risk of suicide and self-harm.

One morning in June, an officer discovered him hanging from the bunk bed in his cell. After several minutes, the man was cut down and a nurse led attempts at cardiopulmonary resuscitation. Paramedics pronounced him dead 3 minutes after their arrival.

A theme throughout PPO recommendations is ensuring that there is a coordinated response to emergency situations. All Care UK staff undergo life support skills training. Emergency equipment has been reviewed following the new contract commencement in October 2014.

## 19. Local Summary and Gap Analysis

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

The 2 key areas impacting significantly on meeting the healthcare needs of the population are the high levels of non-attendance at primary care clinics held within the prison and the high volume (and subsequently high cancellations) of secondary care appointments. These are not new areas of concern as they have been identified in the previous HNA, by commissioners and by the incumbent healthcare provider. These areas need to be urgently and rigorously addressed. It is suggested that resolution to these 2 issues would have a significant impact on patient care and experience, cost and resource. A number of recommendations have been made to support this.

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

## 20. 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	National screening programmes	All men eligible for bowel cancer screening should be identified through the SystmOne clinical reporting function. Awareness sessions and a screening 'catch up' programme should be launched to ensure all those eligible have been offered screening.
2	National screening programmes	The screening template should be adapted to capture new receptions / transfers eligible for bowel cancer screening and screening should be offered as a rolling programme.
3	National screening programmes	SystmOne should be used to flag men who become eligible for bowel cancer screening and those due for repeat screens during the duration of their prison sentence.
4	National screening programmes	Some 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.

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No.	Area	Recommendation
5	National screening programmes	A rolling programme of screening should utilise healthcare assistants and health trainers to provide lifestyle advice and information.
6	National screening programmes	SystemOne should be utilised to auto-generate flags when men reach the age of 65 and become eligible for Abdominal Aortic Aneurysm screening.
7	National screening programmes	All patient records should detail NHS numbers to facilitate inclusion and continuation of national screening programmes.
8	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.
9	Reception screening	All screening templates should be reviewed to ensure that they identify resettlement prisoners and link them in to referral and appointment systems that efficiently address all health and wellbeing needs prior to release whilst providing 'through the gate' information for continued engagement with healthcare services post release.
10	Primary Care Clinics	A robust multi-faceted campaign to reduce DNAs should be planned and implemented and DNA management regularly reviewed until rates reduce and remain at an agreed acceptable level.
11	Primary Care Clinics	A clear definition of what is recorded as DNA needs to be agreed, as definitions across the cluster differ and may result in inaccurate cross cluster comparisons.
12	Primary Care Clinics	All prisoners should be given written information about the approach to non- attendance.
13	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.

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No.	Area	Recommendation
14	Primary Care Clinics	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 if in the wider community.
15	Primary Care Clinics	Nursing staff could 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.
16	Primary Care Clinics	At HMP Leeds, DNA's were reduced by 30% through 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 Dovegate, it is recommended that a similar initiative is launched to support communication of key messages around appointment attendance.
17	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.
18	Communicable diseases	The healthcare provider should liaise with Public Health England Health protection team to develop the training identified as being required in the action plan of the Public Health England 'West Midlands Prison Health Protection Report' (2014) A review of the data collected for HJIP indicators is required to ensure that data is consistent and accurate.
19	Communicable diseases	A systematic approach to Hepatitis B vaccinations and to the data capture of vaccinations offered and declined, and the numbers of men already vaccinated needs to be implemented in order to increase vaccination coverage to meet important PHE targets.
20	Communicable diseases	An urgent review of Hepatitis C pathways needs to be undertaken to ensure that: <ul style="list-style-type: none"> <li>○ Screening is coordinated and all screening data accurately collated and captured</li> <li>○ Patients identified as Hepatitis C have access to specialist consultant review</li> <li>○ A system is implemented and resources identified to ensure that hospital appointments for those requiring Hepatitis C treatment are not cancelled and treatment continuity can be assured.</li> </ul>

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No.	Area	Recommendation
21	Communicable diseases	A review of the data collected for HJIP indicators is required to ensure that data is consistent and accurate.
22	Communicable diseases	Specific resource needs to be allocated to the management of communicable diseases and it is recommended that this is considered within future recruitment plans.
23	Sexual Health	It has not been possible to obtain data regarding prevalence of sexually transmitted conditions for this Health Needs Assessment and therefore it is recommended that this is either the subject of a separate sexual health needs assessment, or has specific focus when the next HNA is undertaken.
24	Social Care	Communication pathways with the Local Authority (Adult Social Services) should be developed to identify opportunities for information sharing and joint commissioning to meet the health and social care needs of prisoners at HMP Dovegate.
25	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. 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.
26	Mental Health	The SystemOne and RiO templates being developed by the team should be designed to efficiently capture data for HJIP reporting and performance and clinical outcomes monitoring.
27	Mental Health	A local READ code formulary should be developed for the integrated mental health team so that accurate prevalence data for mental health conditions can be collated to accurately assess need and inform future service developments.
28	Mental Health	The team should liaise with the prison provider to review the ACCT planner process and ensure that accurate and timely information is provided to enable support of the ACCT process.
29	Mental Health	As this is a new service, it may be useful to undertake a focused mental health needs assessment a year after service commencement to support ongoing development.

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No.	Area	Recommendation
30	Learning Disabilities & Autistic Spectrum Disorders	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.
31	Learning Disabilities & Autistic Spectrum Disorders	It is recommended that the regional resource is commissioned to provide: <ul style="list-style-type: none"> <li>○ assessment, treatment and support and referral services for service users whilst in prison</li> <li>○ education and awareness raising for healthcare staff and HMPS and NOMS colleagues</li> <li>○ 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</li> </ul>
32	Learning Disabilities & Autistic Spectrum Disorders	The Steering group should link with any existing multi-agency autism strategy groups to review, develop, implement and evaluate local care pathways.
33	Learning Disabilities & Autistic Spectrum Disorders	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.
34	Learning Disabilities & Autistic Spectrum Disorders	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.

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No.	Area	Recommendation
35	Substance Misuse	It is recommended that an evening GP is recruited as soon as possible. Pending recruitment, locum cover by an experienced substance misuse clinician should be secured so that first night prescribing for both alcohol and opiate dependant patients can be initiated.
36	Substance Misuse	Prior to the introduction of first night prescribing, processes will need to be in place to confirm community prescriptions promptly. Reception staff will also need awareness training regarding medication administration in police custody for those being remanded directly to prison (via the courts) from police custody.
37	Substance Misuse	An appropriate alternative antispasmodic to Buscopan should be provided for the relief of abdominal cramps associated with opiate withdrawal.
38	Substance Misuse	ISMS practitioners should have access to SystmOne to facilitate joint care and recovery planning.
39	Substance Misuse	The development of Recovery Champions 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 develop initiatives.
40	Substance Misuse	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.
41	Substance Misuse	It is suggested that a multi-disciplinary <b>regional</b> 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.
42	Service user Involvement	It is recommended that to improve service user perception a service user involvement / health champion initiative is launched and service users encouraged to help develop health information within their role.

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No.	Area	Recommendation
43	Planned and unplanned secondary care	It is recommended that funding for a temporary resource is identified and a three month project allocated to maximise efficiency of all patient appointments, combining analysis and management of internal clinic DNAs and issues with management of planned and unplanned secondary care visits to hospital.
44	Planned and unplanned secondary care	The above project should have a clear outline and agreed measureable objectives and outcomes for demonstrable improvement in both HMP Dovegate clinic appointments and improved efficiency in secondary care arrangements
45	Planned and unplanned secondary care	<p>As a first step in creating a baseline and understanding all issues a detailed analysis of secondary care appointment should be made, cross referencing information held on SystmOne, prison escort and bedwatch spreadsheets, Offender Management Unit (OMU) data and additional administration systems, The analysis should include</p> <ul style="list-style-type: none"> <li>○ Number of appointments per month</li> <li>○ Appointments by location</li> <li>○ Planned appointments by department/speciality</li> <li>○ Time from referral to appointment – routine referrals</li> <li>○ Analysis or time from referral to appointment – urgent referrals</li> <li>○ Unplanned escorts by day of week and time of day</li> <li>○ Unplanned escorts by clinical reason</li> <li>○ Unplanned escorts by clinical outcome</li> <li>○ Unplanned escort by assessing clinician</li> <li>○ Bed watches per month</li> <li>○ Bed watch by location</li> <li>○ Bed watch by length/ duration</li> <li>○ An appropriate summary of the analysis should be shared with commissioners, providers, prison partners, CCGs and local senior hospital personnel to broaden support for an approach that increases efficiency and reduces cost whilst simultaneously improving patient experience and quality of care.</li> </ul>

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No.	Area	Recommendation
46	Planned and unplanned secondary care	Develop a system for recording for all cancellations / postponements to appointments on SystmOne utilising the appointment reporting functionality, thus enabling more accurate analysis of cancellations.
47	Planned and unplanned secondary care	Develop a SystmOne template with background READ codes to record all unscheduled hospital visits (escorts and bedwatches) to enable accurate future analysis, and ensure all nursing staff and GPs are trained in its use.
48	Planned and unplanned secondary care	Within the baseline work, all cases where waiting times have exceeded national targets should be individually reviewed so that mechanisms can be put in place to monitor this and prevent extended waits.
49	Planned and unplanned secondary care	All G.Ps should be encouraged to consider release dates when making initial hospital referrals.
	Planned and unplanned secondary care	Where referrals are none urgent, the expected date of release falls within NHS eighteen week target, and the patient is likely to have a registered GP on release, consideration should be given to requesting hospital appointment for a date after release.
50	Planned and unplanned secondary care	As a healthcare innovation, the opportunity to utilise NHS` Choose and Book` in the above recommendation should be explored, as there are no security issues with patients to choose appointments AFTER their release dates. This affords patients choice in their care which is more equitable with wider community practice.
51	Planned and unplanned secondary care	Based on the evidence base from the secondary care analysis, the potential to arrange visiting consultant appointments for most frequently accessed specialities should be explored.
52	Planned and unplanned secondary care	In-house x-ray and ultrasound clinics commenced in December 2014. Global diagnostics provide an x-ray and ultrasound clinic every 2 months. It is anticipated that this will result in a reduction in escorts to hospital and it is recommended that this is reviewed on an ongoing basis.

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No.	Area	Recommendation
53	Planned and unplanned 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.
54	Planned and unplanned secondary care	Opportunities for combining the use of mobile unit and liaison with orthopaedic consultants to replace face to face consultations with informed telemedicine consultations should be explored. – E.g. X rays undertaken by mobile unit and forwarded to consultant / orthopaedic team for review in advance of telemedicine consultation.
55	Planned and unplanned secondary care	It is recommended that links are forged and liaison entered into with local outpatient departments (OPD) to identify opportunities to make appointments as efficient as possible (for example routine check bloods, ECGs etc. could be done at prison prior to appointment and results forwarded in advance or sent in hand held notes with the patient)
56	Planned and unplanned secondary care	Undertake a staff training needs analysis of GPs and Nurses to identify training that could be provided to enable on-site management
57	Planned and unplanned secondary care	Develop local triage protocols / guidelines to support staff in decision making
58	Planned and unplanned secondary care	A bedwatch protocol should be developed detailing the robust approach to be taken in contacting hospitals when patients are on bedwatches to establish opportunities for early discharge.
59	Planned and unplanned secondary care	Whenever there are ongoing bedwatches a Registered Nurse should be assigned to contacting hospitals on a daily basis and should record all discussions with the hospital on patient records on SystemOne.

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No.	Area	Recommendation
60	Planned and unplanned secondary care	Commissioners and Head of Healthcare to visit Queens Hospital, Burton on Trent to meet with senior managers and agree an approach to early discharge planning to keep bedwatch hours to minimum.
61	Planned and unplanned secondary care	Explore opportunity for pre-operative assessments to be completed at the prison, developing joint accountability and shared care protocols with local hospital day surgery units where required.
62	Planned and unplanned secondary care	Continue to review all EBW data on a regular and on-going basis to identify any areas for development.
63	Planned and unplanned secondary care	Successes from the approach should be shared with other prisons across the region.