HMP NORWICH

HEALTH & SOCIAL CARE NEEDS ASSESSMENT

MARCH 2019

Version 3.1

UNSUPPRESSED VERSION

S Squared Analytics

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EXECUTIVE SUMMARY

EXECUTIVE SUMMARY OVERVIEW

PRISON OVERVIEW

HMP Peterborough is a local and resettlement prison for category B prisoners, with an extension for category C prisoners. HMP Norwich is also a local prison and it holds a mix of category B, C, and D prisoners. There have been some changes in the population of both prisons. The number of under 21-year olds in HMP Norwich has increased, while in HMP Peterborough, the number of 30-39 year olds has increased. There are more older prisoners in HMP Norwich than in HMP Peterborough.

There are plans to change the population make up of HMP Peterborough. The number of courts serving the prison are due to increase, resulting in an increase in the remand population by approximately 70 places to 330. The remaining population will be those sentenced to four years or less. Prisoners sentenced to more than four years will be transferred to a training prison. The change is due to occur in August 2019. There were some plans in place to change the population of HMP Norwich, with an increase in category C and category D prisoners.[1] There was no timeframe for the changes to the HMP Norwich population.

HEALTHCARE PROVISION

In HMP Norwich, healthcare and mental health services are provided by Virgin Care, IAPT services provided by Norfolk and Suffolk NHS Foundation Trust, and psychosocial services provided by Phoenix Futures. The healthcare provider is scheduled to change in April 2019. Virgin Care will provide healthcare, and Norfolk and Suffolk Foundation Trust will be the mental health service provider.

In HMP Peterborough, healthcare services are provided by Sodexo Justice Limited, with mental health services provided by Cambridgeshire and Peterborough Mental Health Trust. As part of the 2018 HMIP Inspection of HMP Peterborough, the CQC issued a warning notice to the provider after finding that the quality of the healthcare provision required significant improvement. In a follow up CQC assessment in December 2018, the CQC found that the provider was compliant with the warning notice.

MENTAL HEALTH

In both prisons, there are integrated primary and secondary mental health teams. In HMP Norwich, mental health services are currently provided by Virgin Care, however in April 2019, the provider is changing to Norfolk and Suffolk NHS Foundation Trust. In HMP Peterborough, mental health services are provided by Cambridge and Peterborough NHS Foundation Trust.

In HMP Norwich, there is a separate IAPT service in the prison. The IAPT service is provided by Norfolk and Suffolk NHS Foundation Trust. There is no separate IAPT provision in HMP Peterborough, however there is a good psychology provision. There were difficulties with running psychoeducational groups in both prisons. In HMP Peterborough, groups had not been run because of staff sickness. In HMP Norwich, the group work offering was in the process of being updated.

SUBSTANCE MISUSE

In HMP Norwich, Phoenix Futures has developed a programme of courses aimed at prisoners who stay for a short time in the prison. The courses are one-off sessions to allow the maximum number of prisoners to take part. In HMP Peterborough, the psychosocial team runs groups following templates produced in 2009 by the National Offender Management Service.

There is a high rate of illicit substance usage in HMP Peterborough. The 2018 HMIP Inspection highlighted the availability of drugs in the prison, and the negative effects this had on safety, with increases in debt, bullying, and violence. The positive MDT rate in HMP Peterborough was 37.2% in 2017-18. Rates of positive mandatory drug tests were not as high in HMP Norwich;

[1] HMPPS, (2018), Future Vision for the Adult Male Estate 2021

however, they had increased to 18.4% in 2017-18. In HMP Norwich, there is an up to date drug strategy, which the psychosocial team had been a part of devising. The HMP Peterborough strategy was from 2017-18 and required updating.

PRIMARY CARE

In HMP Norwich, care for patients with long-term conditions is managed between the GP, the nurse practitioner, and nursing staff. In HMP Peterborough, healthcare has introduced a lead band 7 nurse to oversee the management of care for patients with long-term conditions. Following the CQC notice, healthcare had introduced some systems that simplified the management of patients with long-term conditions. The nurse was assisted by nursing staff including a regular locum nurse who was a diabetes specialist. This improved the care for some patients. Regarding national screening programmes, there were no NHS Health Checks taking place in HMP Peterborough. The NHS Health Checks were managed by the nurse practitioner in HMP Norwich.

POPULATION CHANGES

There has been an increase in the proportion of under 21-year olds in HMP Norwich. If this trend continues, it is likely to affect the health needs of the population. Younger adults tend to be physically healthier, however, their substance misuse and mental health needs will require different treatments. Young adults are more likely to have neuro-psychological deficits such as cognitive difficulties, emotional literacy, ADHD, and autism. [2] Substance misuse needs are also likely to be affected, with possible changes including increases in cannabis and psychoactive substance use and reductions in those entering clinical treatment for opiates and alcohol.

Below shows for the current population the percentage that have the READ code "(XE2Q6) Attention deficit hyperactivity disorder" recorded. The table shows the rate for the READ code entered at the current establishment, and for the READ coded entered at any location. The table shows that the rate is higher in HMP Norwich than HMP Peterborough, which is likely be associated with the higher population of under-21-year-olds.

Figure 1.1.1: The current population with the READ code "(XE2Q6) Attention deficit hyperactivity disorder" recorded.

(XE2Q6) Attention deficit hyperactivity disorder	Current #	Current %	All #	All %
Norwich.	33	4.5%	70	9.5%
Peterborough	4	0.5%	42	5.1%

The remand population in HMP Peterborough is due to increase by approximately 70 places in August 2019. This will bring the remand population of the prison up to approximately 330 (42%) of the population. The average length of stay for a remand prisoner is nine weeks[3]. This means that over a year, there could be an extra 400 prisoners received.

The remand population will create additional demands on healthcare resources, particularly regarding identification and assessment of conditions. The extra remand population is likely to create:

- An increase in receptions and turnover meaning more prisoners passing through reception.
- An increase in suicidal thoughts and suicide attempts[4]
- An increase on the demands of IAPT and primary mental health services particularly relating to those prisoners who are in the prison for the first time.
- An increase on the demands of clinical substance misuse services for patients requiring stabilisation and detoxing interventions. A need for more observation cells.
- An increase in the demands on the pharmacy service regarding medication reconciliation and prescribing.
- Continuity of care procedures will be affected by the shorter length of stay of prisoners.

[2] House of Commons Justice Committee, (2017), *The treatment of young adults in the criminal justice system*
[3] HMIP (2012), Remand prisoners: a thematic review
[4] Using prevalence rates from the PHE Toolkit

1. Introduction

1.1. . HMP Norwich is also a local prison and it holds a mix of category B, C, and D prisoners.

2. Capacity

2.1. In HMP Norwich, although the population of 727 is lower than the operational capacity of 773, the population exceeds the In-Use CNA of 616.

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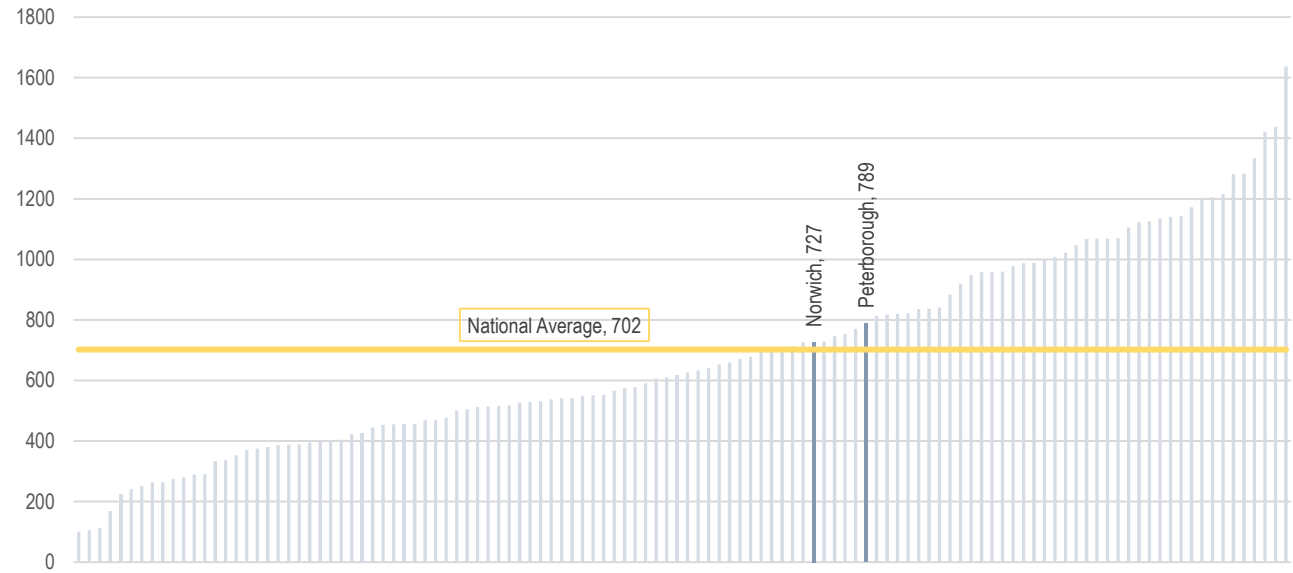
Figure 1.1.2: The population size of HMP Norwich ranked against all prisons in England and Wales.[5]



3. Long-Term Trend

3.1. In HMP Norwich, the operational capacity and In-Use CNA has remained stable during the analysed period of March 2011 to December 2018. The population has seen slight fluctuations although this has remained stable over the past few years.

4. Overcrowding

4.1. The overcrowding rates in HMP Norwich has remained stable at about 35% over the past 10 years (6). This equates to about 272 prisoners at any point during 2017-18. The rate of 35% ranks HMP Norwich as the 26th highest of the 33 local prisons in England and Wales.

5. Age

5.1. There are more older prisoners in HMP Norwich (14%) compared to HMP Peterborough (8%).

[5] HMP Norwich data from MoJ Statitistics. Peterborough data from local information.
[6] To March 2018.

5.2. A comparison against 2016 shows a shift in age structure in HMP Norwich. The number of under-21 year olds has increased while the number of 21-29 year olds has decreased.

5.3.

Figure 1.1.3: Age profile; HMP Norwich vs HMP Peterborough comparison.

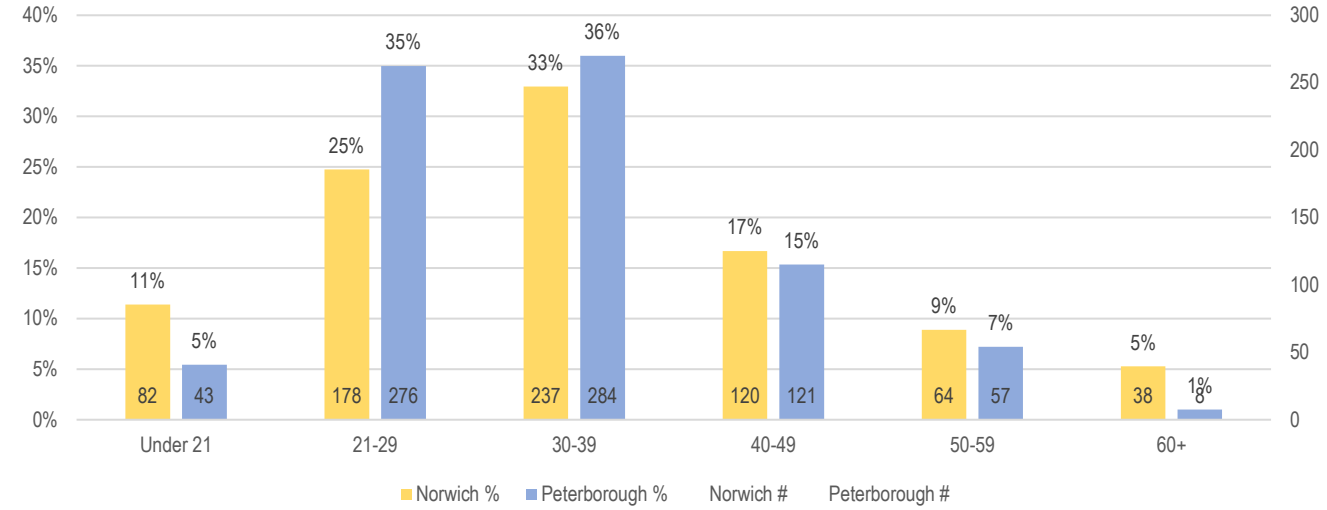


Figure 1.1.4: Age profile; HMP Norwich.

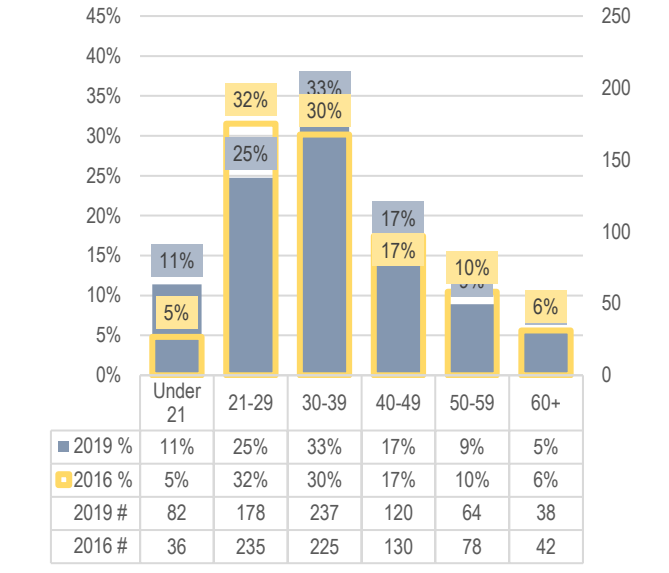
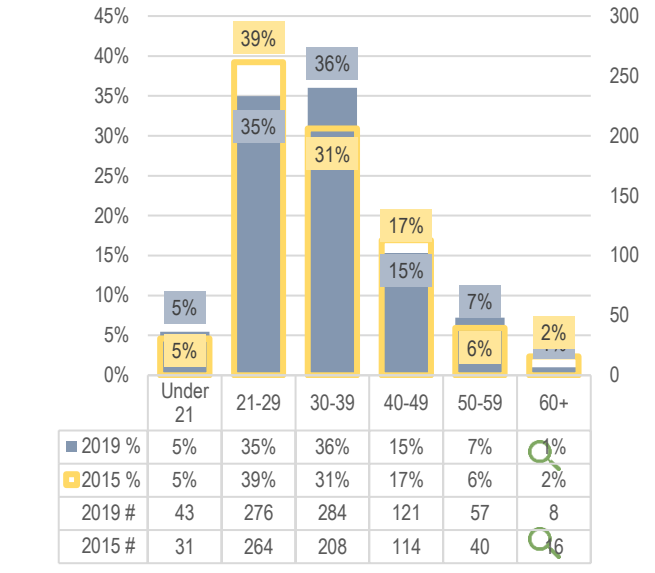


Figure 1.1.5: Age Profile; HMP Peterborough.



6. Ethnicity

6.1. The majority of the population is of white ethnicity, however the rate in HMP Norwich is 84% .

6.2. In HMP Norwich, a comparison against 2016 shows slight changes, with a decrease in the white ethnic group from 87% to 84% while proportion of black prisoners has increased from 7 to 10%.

Figure 1.1.6: Ethnicity profile; HMP Norwich vs HMP Peterborough comparison.

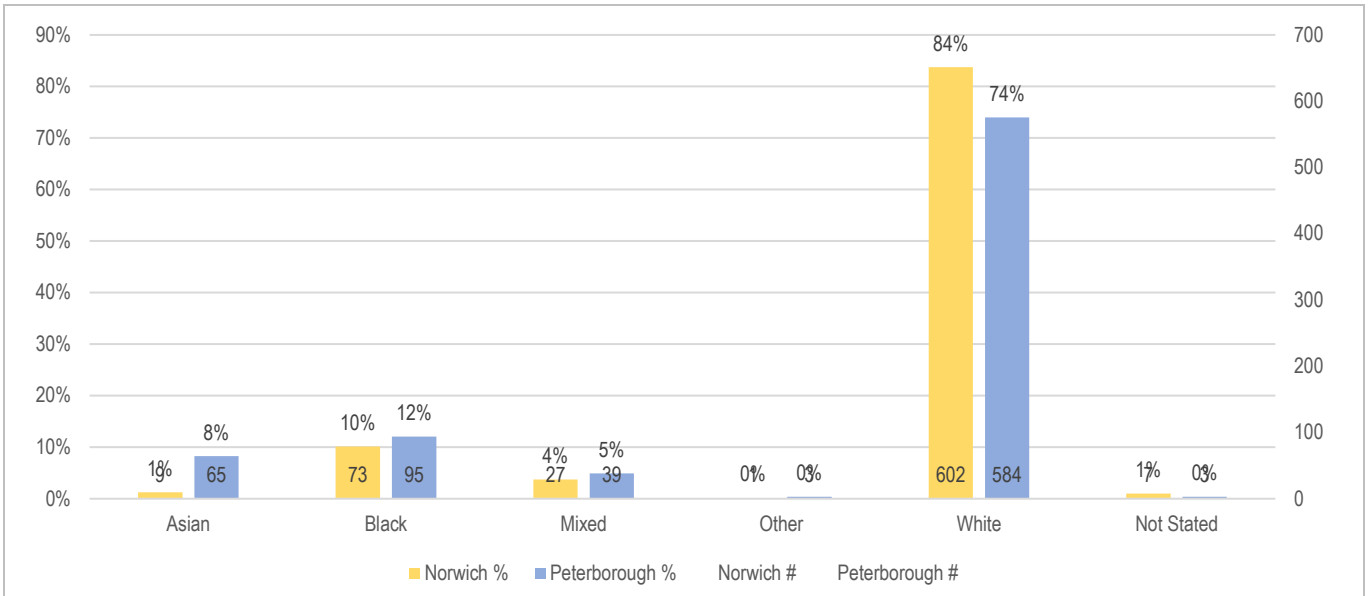
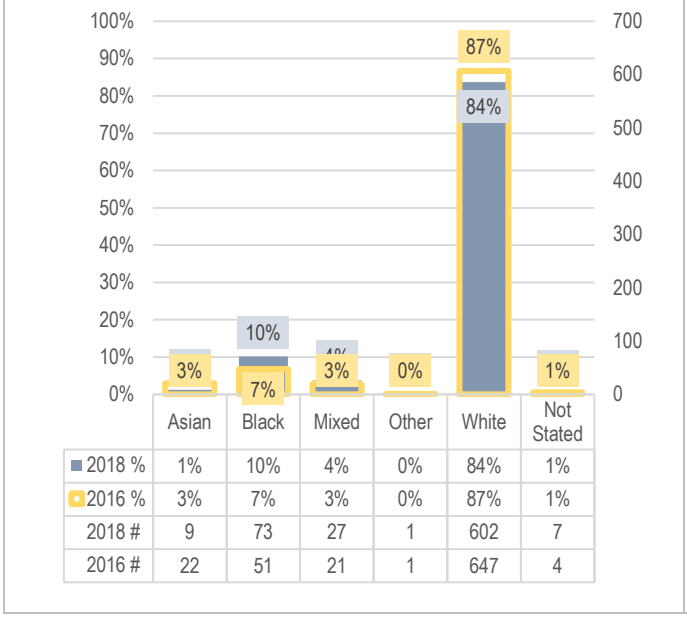
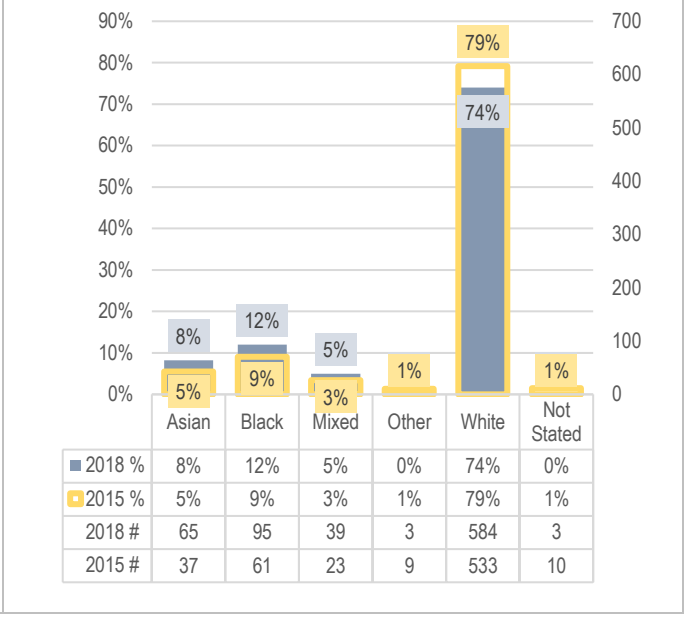


Figure 1.1.7: Ethnicity profile; HMP Norwich.



	Asian	Black	Mixed	Other	White	Not Stated
2018 %	1%	10%	4%	0%	84%	1%
2016 %	3%	7%	3%	0%	87%	1%
2018 #	9	73	27	1	602	7
2016 #	22	51	21	1	647	4

Figure 1.1.8: Ethnicity profile; HMP Peterborough.



	Asian	Black	Mixed	Other	White	Not Stated
2018 %	8%	12%	5%	0%	74%	0%
2015 %	5%	9%	3%	1%	79%	1%
2018 #	65	95	39	3	584	3
2015 #	37	61	23	9	533	10

7. Foreign National Prisoners (FNPs)

7.1. 8% of the population in HMP Norwich are recorded as FNPs which is similar to the national average of 9%. The rate of 8% in HMP Norwich has been stable since September 2015.

8. Religion

8.1. A high percentage across both prisons were recorded as “No Religion”. The rate was 37% (265 prisoners) in HMP Norwich and 33% (258 prisoners) in HMP Peterborough.

8.2. Muslims account for one of the largest religious groups in HMP Peterborough, accounting for 18% (143 prisoners). The rate is lower in HMP Norwich at 9% (66 prisoners).

9. Ex-Service Personnel

9.1. Available research indicates that around 3.5% to 7.0% of the current prison population is comprised of former service personnel.

9.2. The following table provides the prevalence in both prisons based on a number of sources including NOMIS and SystmOne.

Figure 1.1.9: Prevalence of ex-service personnel.		
	HMP Norwich	HMP Peterborough
NOMIS	Not Available	9 (1.1%)
HMIP	17 (2.3%)	12 (1.5%)[7]
SystmOne - (0912.) Member of armed forces	16 (2.2%	2 (0.2%)
SystmOne - (XaX3N) Military veteran	7 (0.9%)	2 (0.2%)

10. Offences

10.1. The analysis looking at the offence profiles of December 2018 population in comparison to 2015 shows that both prisons have seen an increase in the rate of offenders with an index offence of violence against the person.

[7] July 2018.

Figure 1.1.10: Index offence of the population; 2018 against 2015 comparison; HMP Norwich.

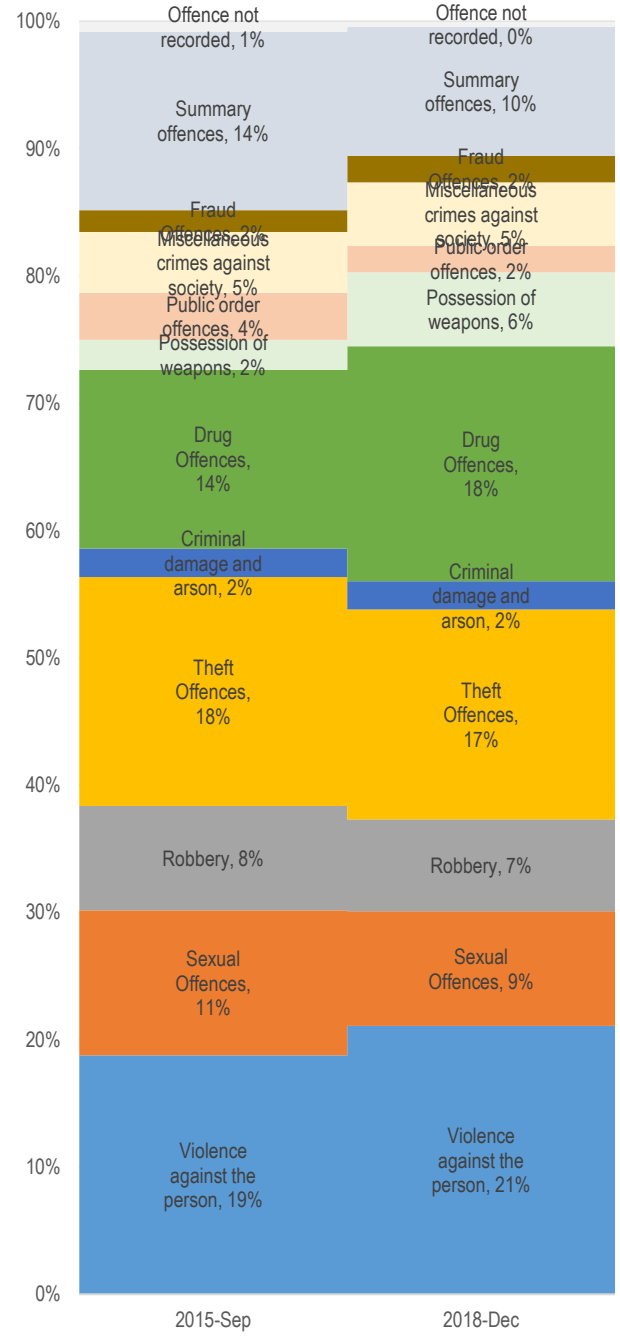
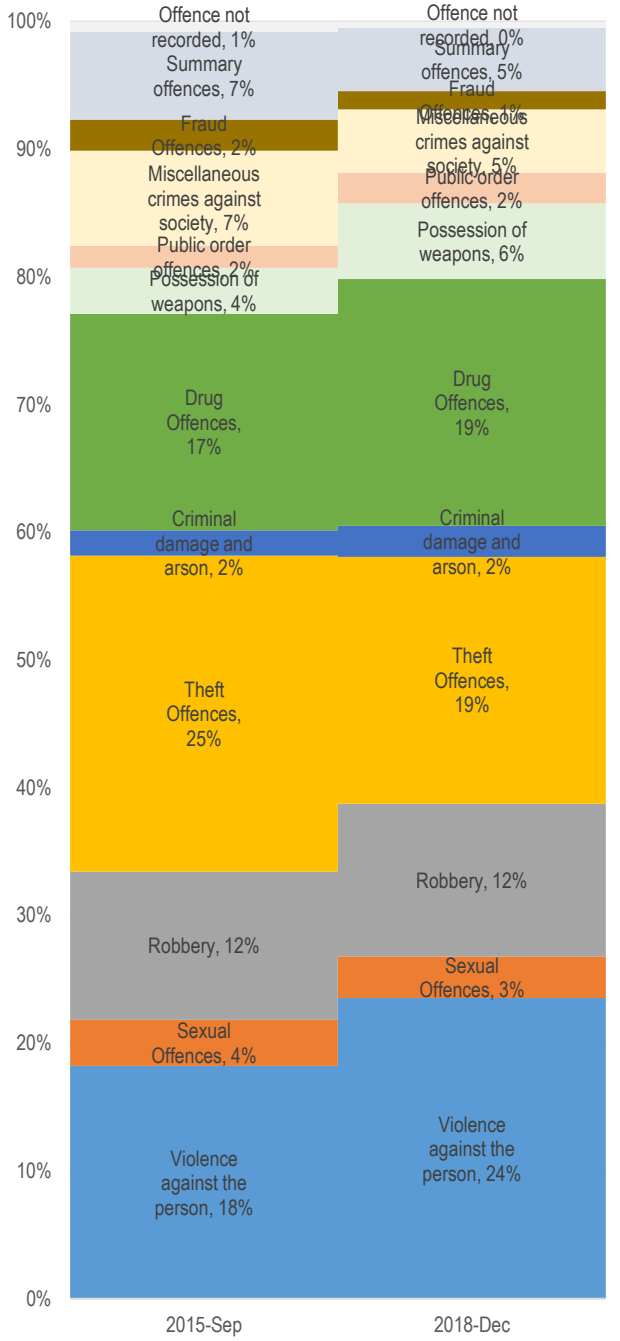


Figure 1.1.11: Index offence of the population; 2018 against 2015 comparison; HMP Peterborough (Male).



11. Introduction

11.1. In HMP Norwich, at the time of this assessment, healthcare and mental health services were provided by Virgin Care, IAPT services were provided by Norfolk and Suffolk NHS Foundation Trust, and psychosocial services were provided by Phoenix Futures.

11.2. The healthcare provider in HMP Norwich is scheduled to change in April 2019, with Virgin Care managing healthcare, and the Norfolk and Suffolk NHS Foundation Trust providing mental health care.

12. QOF Prevalence

12.1. As part of this HSCNA, an analysis of the QOF data was undertaken to provide an overview of the prevalence of health conditions across the population.

12.2. Exercise 1 looks at the number and rate of prisoners that appear or do not appear on a QOF register.

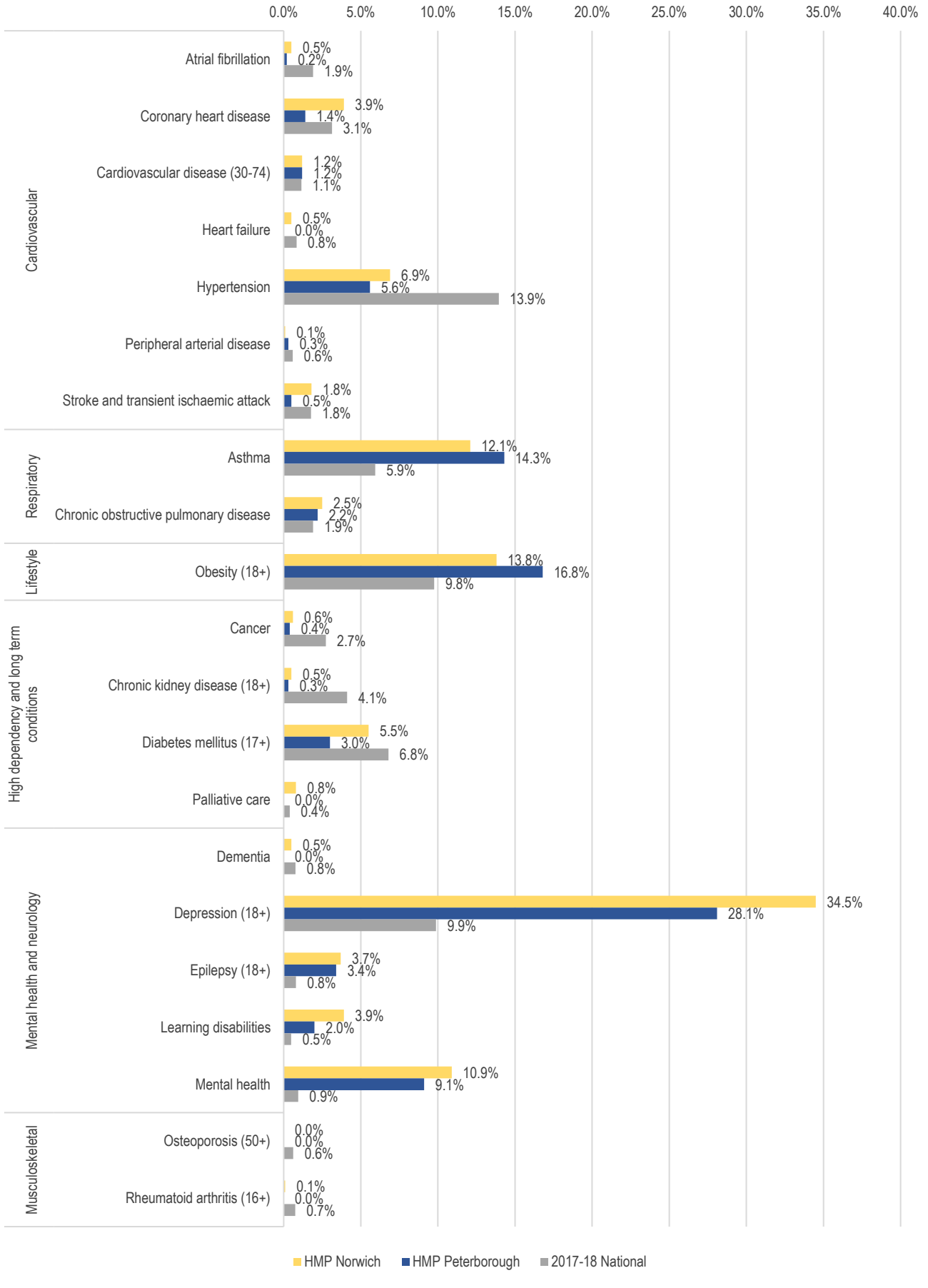
12.3. Of the 738 current prisoners in HMP Norwich, 304 (41%) do not appear on any of the 21 QOF registers. Not appearing on a register may indicate that this cohort does not have any health conditions that qualify them for QOF or that their health needs have not been identified.

12.4. Exercise 2 is an analysis comparing the prevalence of the QOF registers across the two prisons.

12.5. The demographic analysis showed that there was a higher rate of older prisoners in HMP Norwich than HMP Peterborough. Conditions that have a higher prevalence among the older population such as cardiovascular, dementia, and COPD, would expect a higher rate in HMP Norwich. This is generally reflected in the QOF data.

12.6. The mental health register and the depression register show a higher rate in HMP Norwich than HMP Peterborough. In addition, figure 3.1.1 illustrates that the rate in a number of selected mental health READ codes is higher in HMP Norwich than HMP Peterborough. National prison data is used as a comparison.

Figure 1.1.12: The prevalence of conditions based on the QOF register; percentage of the current population.



13. Screening

13.1. A retinopathy service visits both prisons regularly. There is 9% coverage in HMP Norwich and 7% in HMP Peterborough. Both prisons are below the national average of 19%.

13.2. Healthcare in both prisons distributes bowel cancer screening kits to eligible patients. Coverage in both prisons is similar with 5% coverage in HMP Norwich and 4% in HMP Peterborough.

13.3. HMP Norwich had coverage of 19% for eligible prisoners who were screened for AAA. This was higher than the national average. The coverage in HMP Peterborough was only 2%.

13.4. NHS Health Checks were carried out in HMP Norwich, but there were none in HMP Peterborough.

EXECUTIVE SUMMARY – ENGAGEMENT

14. Introduction

14.1. In HMP Norwich, a prisoner survey was run with assistance from the Patient and Liaison Officer. The response rate was low, with only 22 surveys returned.

14.2. In addition to the surveys, minutes from the regular healthcare representative forum meetings were used. he meetings are a chance for healthcare representatives to relay prisoners' needs.

14.3. The forum was a positive addition to healthcare provision since the previous needs assessment. The meetings are attended by the head of healthcare, who can give a direct response to patients' needs. Meetings are minuted, and issues are followed up at the next meeting.

15. HMP Norwich

15.1. Healthcare representatives stated that sometimes patients have to wait 2-3 hours for medication, so they would like to see more staff available for medication administration.

15.2. It was reported that there were no lockable lockers in cells on H-wing. Patients wanted these installed so that they would be able to have their medication in-possession.

15.3. There was feedback on issues relating to external hospital appointments. Issues with transport had led to patients arriving late for appointments and on one occasion an appointment had been cancelled. Patients found external appointments stressful due to being chained and handcuffed. This was beyond the control of healthcare.

15.4. Results from the survey found that:

- 17 respondents, (80%), said that they had a physical health concern, with 20 respondents engaging with healthcare.
- 9 respondents, (47%), said that they were currently experiencing a mental health concern.
- Respondents believed that their offending behaviour and diet had the biggest impact on their health (6 respondents each (29%)).
- Nurses, GPs, and the optician were seen as the easiest service to access. Dentist and the mental health service were the hardest to access. Nurses and the GP also got the best quality scores.

EXECUTIVE SUMMARY – MENTAL HEALTH

16. Introduction

16.1. There are a number of research studies that show that there is a higher prevalence of mental health problems among prisoners compared with the general population.[8]

16.2. The population of both HMP Norwich and HMP Peterborough includes both sentenced and remand prisoners. Research indicates that mental health needs are high among both the sentenced and remand population.

16.3. Prevalence figures from Public Health England indicate that remand prisoners have greater mental health needs than sentenced prisoners. This can be partially attributed to factors relating to recent imprisonment[9].

16.4. In a national survey of newly sentenced prisoners, 61% of the sample were identified as likely to have a personality disorder, 10% a psychotic disorder, and over a third reported significant symptoms of anxiety or depression.[10]

16.5. The early identification of mental health needs is important to ensure that prisoners receive appropriate support during their early days in prison.

17. Prevalence

17.1. In general, the prevalence of mental health conditions based on data from SystmOne shows a higher prevalence in HMP Norwich than in HMP Peterborough.

17.2. Across the five QOF registers that form mental health and neurology, the rates are higher in HMP Norwich than in HMP Peterborough.

17.3. Looking specifically at the mental health register, the rate in HMP Norwich was 11% compared to 8.7% in HMP Peterborough. The analysis by age shows that the prevalence in the 30-39 and the 40-49 age groups for HMP Peterborough is notably lower than HMP Norwich.

17.4. Using the mental health conditions listed in the PHE Toolkit, there are a number of mental health conditions where there is a higher actual prevalence in HMP Norwich compared to HMP Peterborough.

17.5. The READ codes associated with the reception screen also show a higher prevalence in HMP Norwich than in HMP Peterborough. This could be related to better use of READ codes in HMP Norwich.

18. Provision

18.1. In both prisons, there are integrated primary and secondary mental health teams. In HMP Norwich, mental health services are currently provided by Virgin Care, however in April 2019, the provider is changing to Norfolk and Suffolk NHS Foundation Trust. In HMP Peterborough, mental health services are provided by Cambridge and Peterborough NHS Foundation Trust.

18.2. In HMP Norwich, there is a separate IAPT service in the prison. The IAPT service is provided by Norfolk and Suffolk NHS Foundation Trust.

18.3. In HMP Peterborough, the mental health team found that they were receiving a high number of inappropriate referrals to the service. The team were receiving referrals that they felt should be managed within primary care. There was feedback that the irregular nature of the locum GPs did not help with consistency in mental health referrals.

[8] Public Health England (2014), Health and Justice Health Needs Assessment Template: Adult Prisons (part 2).

[9] The PPO Report states that "The sudden separation from family can be difficult to cope with, and many new arrivals are also suffering from drug or alcohol withdrawal symptoms. Those who are in prison custody for the first time can find the experience especially intimidating, as few will know what to expect. In addition to their immediate needs, going to prison can cause problems relating to the life they have left behind. These factors can have a substantial impact on the short- and long-term mental health of the prisoner."

[10] Stewart, D (2008), The problems and needs of newly sentenced prisoners: results from a national survey, Ministry of Justice. Available online: http://webarchive.nationalarchives.gov.uk/20100505212400/http:/www.justice.gov.uk/publications/docs/research-problems-needsprisoners.pdf

RECOMMENDATION

HMP NORWICH – There is a need for more high intensity interventions for patients with trauma related needs. The psychologist post should be filled as soon as possible.

19. Trauma and Post-Traumatic Stress Disorders

19.1. Many people in contact with the criminal justice system have experience of interpersonal trauma. This has been linked to the onset of a range of mental health problems including post-traumatic stress disorder, depression, anxiety disorders and substance misuse. 29% of prisoners report having experienced emotional, physical or sexual abuse as a child. Limited availability of trauma informed mental health services can lead to poor responses to this client group.[11]

19.2. In HMP Peterborough, patients with trauma and PTSD related issues can be treated by the psychologist. In HMP Norwich, the IAPT service offer one-to-one interventions for patients with trauma-related mental health issues.

19.3. In HMP Norwich, there is a vacant psychologist position. This affected the treatment of patients with more complex trauma and PTSD needs.

19.4. In HMP Norwich, it was emphasised by the IAPT Team Manager that there was a potential unmet need in patients who had suffered from childhood sexual abuse. The IAPT service works with patients for a maximum of 20 sessions, and this is not likely to be long enough for a patient who may have experienced multiple traumatic episodes.

19.5. In HMP Norwich, data on patients who have suffered childhood sexual abuse is not collected, however the psychological therapist said that 9 out the 10 clients on their caseload had suffered some form of child sexual abuse.

20. ADHD

20.1. In HMP Peterborough, an ADHD pathway has been developed, with assessments carried out by the psychologist. There had been 15 patients who had been diagnosed with ADHD by the psychologist in the previous six months.

20.2. It would be expected that HMP Norwich would have similar instances of ADHD due to its sizeable proportion of under-21 year olds.

20.3. Below shows for the current population the percentage that have the READ code "(XE2Q6) Attention deficit hyperactivity disorder" recorded. The table shows the rate for the READ code entered at the current establishment, and for the READ coded entered at any location. The table highlights that the rate is higher in HMP Norwich than HMP Peterborough, which is likely be associated with the higher under-21 population.

Figure 1.1.13: The percentage that have the READ code "(XE2Q6) Attention deficit hyperactivity disorder" recorded

(XE2Q6) Attention deficit hyperactivity disorder	Current #	Current %	All #	All %
Norwich.	33	4.5%	70	9.5%
Peterborough	4	0.5%	42	5.1%

RECOMMENDATION

HMP NORWICH – There should be a clear ADHD pathway in HMP Norwich.

[11] PHE Toolkit

21. Personality Disorders

21.1. The PHE Toolkit estimates the prevalence among the sentenced prisoner population as being 64%, and the remand population as being 78%. Applying this rate to HMP Norwich and HMP Peterborough provides a similar expected prevalence rate across the two prisons at around 66.9% to 67.7% of the population. In terms of the actual prevalence as recorded on SystmOne based on the READ code the rates are significantly lower than the expected rates.

21.2. Both mental health teams manage patients with personality disorders. Both teams attend their respective prison-run complex case meetings where they provide input into the management plans of patients with complex needs, including personality disorders.

21.3. There is good mental health team input into the ACCT review process in both prisons.

21.4. In HMP Norwich, there has been a gap in the personality disorder pathway since the psychologist post became vacant. The psychologist was able to help with the diagnosing of personality disorders and had a role in working with the prison to get a prisoner onto the prison personality disorder pathway.

RECOMMENDATION

HMP NORWICH – The lack of a psychologist has meant that there are gaps in the diagnosing of those with a personality disorder. Communication with the prison regarding the personality disorder pathway has also been impacted. The psychologist post should be filled as soon as possible.

22. Constant Supervisions

22.1. Below are the number of constant supervisions in 2018 as reported in the HJIPs.

22.2. The number of constant supervisions during this period was significantly higher in HMP Norwich compared to HMP Peterborough.

Figure 1.1.14: 2018 (HJIPs); Jan 2018 to Dec 2018.	HMP Norwich	HMP Peterborough
Patients on an episode of constant supervision who received a mental health assessment	19	1
Number of MH assessments carried out within 24hrs, with a care plan recorded	19	1

23. Dementia

23.1. The PHE Toolkit estimates that the prevalence of dementia for those aged 50 and over is 1-5%. Information from the QOF register showed that there were 4 patients with dementia in HMP Norwich and 0 patients in HMP Peterborough.

RECOMMENDATION

HMP PETERBOROUGH –

23.2. In HMP Norwich, there were experienced nurses and health care assistants based on L-wing who work with patients with dementia. At the time of this assessment, patients with dementia were based on L-wing, where a dementia charity visited regularly.

24. Mental Health Transfers

24.1. In HMP Norwich, the number of patients transferred to a mental health secure unit has increased. There is a shortage of local beds, which meant that patients could be sent to units further away from Norwich.

24.2. Between April 2018 and December 2018, there were 14 mental health secure assessments in HMP Norwich, up from 9 over the same period the previous year. None of the 8 patients transferred to a secure unit between April to December 2018 were transferred within the recommended target of 14 days. In comparison, the previous year saw 3 of the 7 transfers within 14 days.

24.3. In HMP Peterborough, the number of mental health secure assessments has fallen from 21 to 15 when comparing April 2018 to December 2018 against the same period of the previous year.

24.4. The number of patients transferred to a secure unit in HMP Peterborough within the 14-day target is concerning. Of the 9 transfers between April 2018 and December 2018, 0 were transferred within 14 days. In comparison, 14 of the 16 transfers between April 2017 and December 2017 were carried out within 14 days.

EXECUTIVE SUMMARY – SELF-HARM

25. Suicide and Self-Harm Policy

25.1. HMP Norwich had an up to date self-harm and suicide prevention policy. The policy was due to be reviewed in August 2019.

25.2. The suicide and self-harm policy in HMP Norwich lists a number of areas where healthcare is expected to play a role in the care of prisoners who self-harm and those at risk of self-harm. These include:

- Reception health screening, including the role of mental health staff
- Duties when an ACCT is opened
- Ongoing management of an ACCT
- ACCTs for segregated prisoners
- The wider role of the mental health team in offering support to prisoners

25.3. In HMP Peterborough, the pathway for suicide and self-harm is detailed in the self-harm and suicide prevention policy. The policy was ratified in July 2018. The head of healthcare and the mental health lead are listed as key participants in the suicide and self-harm prevention meeting.

25.4. The HMP Peterborough policy includes limited details on the role of healthcare services into suicide and self-harm prevention in the prison. These include:

- At the reception screen
- The management of a prisoner on an open ACCT document in the Separation and Care Unit

25.5. There is no mention of how healthcare is expected to participate in the ACCT review process, or its wider role in preventing suicide and self-harm in the prison.

RECOMMENDATION

HMP PETERBOROUGH –

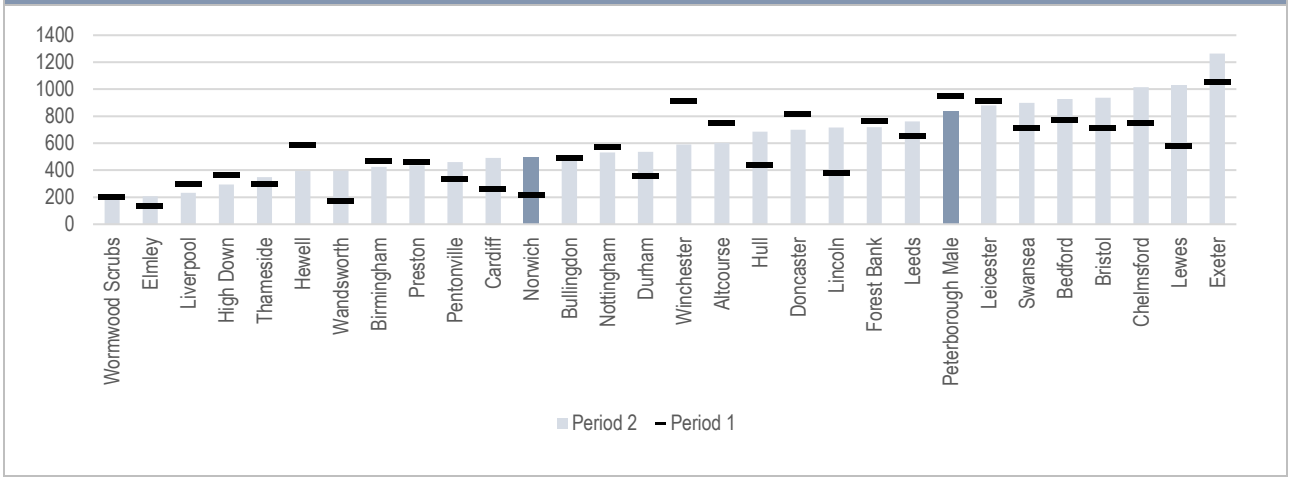
26. Self-harm

26.1. In HMP Norwich, self-harm issues and trends are analysed at the monthly suicide and self-harm meetings. Cutting and ligatures are the main methods of self-harm.

26.2. From local data, between 1 January 2018 until 11 December 2018, there were 433 incidents of self-harm in HMP Norwich. MoJ Statistics show that there were 319 incidents for the 12 months to June 2018, which is an increase on previous years. This is also highlighted in the performance digest.

26.3. The following chart uses data from the Annual Prison Performance Ratings 2017/18 Statistical Bulletin. The data looks at the rate of self-harm incidents for the year to March 2018 and is weighted according to the technical guide and only includes prisons of the same category. The chart shows the change between period 1 (Apr 17 to Sep 17) and period 2 (Oct 17 to Mar 18) (negative change shows improvement).

Figure 1.1.15: Rate of self-harm incidents for the year to March 2018; weighted according to the technical guide.



26.4. .

27. ACCT

27.1. The number of current open ACCTs are similar between the two prisons.

27.2. In HMP Norwich, there were 28 open ACCTs at the time of this assessment. There are approximately 50 new ACCT documents per month. ACCT documents are most commonly opened on A-wing, which includes the induction unit and the IDTS wing.

27.3. There are good links between mental health staff and safer custody staff regarding the prevention of self-harm in the prison. Mental health staff attend all ACCT reviews for clients on their caseload. The head of safer custody said that the mental health staff provided valuable input into how to work with patients with self-harm needs.

28. Listeners

28.1. In HMP Norwich, there were 15 listeners equating to 1 listener for every 50 prisoners, which meets the recommended number. Listeners were mainly based on M and C-wing. There are no listeners based on A or B-wing, where the majority of ACCT documents are opened. There are 2 reception orderlies who oversee reception. There are Samaritans phones on each unit. There are some issues with phone reception on some of the wings, however the Samaritans phones work in the listener suites.

EXECUTIVE SUMMARY – LEARNING DISABILITIES

29. Introduction

29.1. Among the prison population, the prevalence of those with learning disabilities is approximately 7%. The number with learning difficulties is higher, with the *No One Knows* report suggesting that those with either a learning difficulty or a learning disability is between 20-30%[12].

29.2. This estimate gives an indication as to the proportion of prisoners who need additional support in their everyday living due to problems with thinking and understanding.

29.3. Based on the QOF register, the rate in HMP Norwich is 3.9% (29 prisoners). In HMP Peterborough the rate is 2.2% (18 prisoners). Both of these rates are lower than the expected 7% rate.

29.4. Prisoners with learning disabilities are particularly vulnerable to bullying and predation so may require safeguarding and orientation work.

29.5. The recent joint inspection report by prison and probation inspectorates found that there were gaps in the identification of those with learning disabilities throughout the criminal justice pathway[13]. In light of these gaps, it is important for prisons to have robust identification procedures in place to ensure that those with learning disabilities are not missed when they enter prison.

30. Local Provision

30.1. There are basic learning disability screening questions on the reception healthcare screens of both prisons. There are no learning disability screening questions on the secondary health screens of either prison.

RECOMMENDATION

BOTH – Identifying learning disabilities in both prisons require that staff administering the health screen have up-to-date training regarding learning disability awareness. Healthcare should ensure training is up to date. The possibility of including a longer screening tool on the secondary screen should be considered.

30.2. In HMP Norwich, there was previously a cluster-wide head of learning disabilities role, which no longer exists. This role had helped to raise the awareness of learning disabilities with prison and healthcare staff.

RECOMMENDATION

HMP NORWICH – A distinct learning disability lead role should be created, with responsibility for promoting the management of those with learning disabilities across the prison.

30.3. In HMP Norwich, patients with learning disabilities are managed by the mental health team. The team can liaise with the regime regarding the management of the patient within the prison. Those with learning disabilities often need help with safety, orientation, adjustment, and work.

RECOMMENDATION

HMP PETERBOROUGH –

[12] Offender Health Research Network, (2007), No One Knows
[13] Criminal Justice Joint Inspection, (2015), A joint inspection of the treatment of offenders with learning disabilities within the criminal justice system

RECOMMENDATION

HMP PETERBOROUGH

30.4. Learning disability specific health checks are available in both prisons.

EXECUTIVE SUMMARY – SOCIAL CARE

31. General

31.1. Social care provision in HMP Norwich is the responsibility of Norfolk County Council. In HMP Peterborough, it is the responsibility of Peterborough City Council.

31.2. There are good social care pathways in both prisons with good evidence of joint working between healthcare, the prison and social work assessors.

32. Local Provision

32.1. In HMP Norwich, a new integrated health and social care service has been commissioned and will start from April 2019. The service will provide a service across the three Norfolk prisons. A memorandum of understanding regarding social care processes in the prison was still being ratified.

RECOMMENDATION

HMP NORWICH – To ensure that the memorandum of understanding regarding social care processes in the prison is finalised before April 2019.

33. L-wing (HMP Norwich)

33.1. L-wing in HMP & YOI Norwich has a 15-bedded unit, which is set up to house older and infirm prisoners. The social care need on this wing is much higher and full-time staff are present to provide care and support to those on the unit.

33.2. There are four HCAs employed full-time on L-wing to carry out personal care tasks for patients.

33.3. Seven patients on the wing are in wheelchairs, with another four needing a mobility aid.

33.4. For patients being released from the prison, the lead nurse on L-wing liaises with the multi-disciplinary team including social service regarding the needs of patients in the community.

33.5. At the time of this assessment, there were eight patients on other wings waiting to be transferred on to L-wing.

EXECUTIVE SUMMARY – SUBSTANCE MISUSE

34. Introduction

34.1. This HSCNA includes an expanded chapter on substance misuse. Substance misuse is usually only covered from a health perspective and is focused mainly on the treatment services. This HSCNA will cover wider factors, including drug supply and demand.

35. Drug Trends

35.1. Published prevalence rates of drug and alcohol use in prison indicate the extent of the substance misuse problem in prisons. Drug users report engaging in much higher levels of criminal activity than non-drug users, and several studies have found that drug use appears to intensify, motivate, and perpetuate offending behaviour.

35.2. The 2015 HMIP Thematic Report into substance misuse in prisons highlighted the changing trends in drug use among prisoners. Drug use in prisons is mirroring changes in drug use in the community; for example, reductions in the use of illicit drugs, particularly opiates. In prisons, the misuse of synthetic cannabis and diverted medication is a major issue.

35.3. In the community, the percentage of adults reporting illicit drug use has remained stable over the past eight years, and is lower than in the years prior to 2008-0914.

35.4. Cannabis is the most widely used drug in the community; however, the 6.6% in 2016-17 who said they had used the drug in past year is lower than the rates seen 10 years ago.

35.5. The use of amphetamines and amyl nitrate in the community has also decreased.

35.6. Despite the overall fall in treatment numbers in the community, the number of adults coming to treatment for crack cocaine addiction, and particularly crack and opiates addiction, has increased substantially since last year. Overall, there were 3,271 more people accessing treatment for crack addiction than in 2015-16, an increase of 17%. Almost two-thirds (63%) of the opiate users also had crack problems, up from just over half (54%) in 2015-16.15

35.7. Drugs that have seen relatively little change in use in the community include powder cocaine and ecstasy.

35.8. The use of psychoactive substances (PS) was first included in the Crime Survey for England and Wales report from 2014-15 and has declined in use since then.

35.9. The following table provides an overview of drug trends in the community, the wider prison estate, HMP Norwich and HMP Peterborough. Data for the community is taken from the Crime Survey for England and Wales, and NDTMS data is used for the prison information. Notes:

- NDTMS data only covers those that have accessed treatment, so may not reflect unmet need. For example, the rate of PS in HMP Norwich is lower than the national estate. This may indicate that levels of use are lower in the prison, or that those using PS are not accessing the treatment system as widely as the national prison estate.
- The percentages shown for NDTMS are for those that were in treatment during the reporting period. The percentages in the table are for the recorded first drug, second drug, and third drug as a proportion of the total in-treatment population.

Figure 1.1.16: Drug trends.

	Community[16]	Wider Prison Estate	HMP Norwich	HMP Peterborough
Alcohol		2017-18 (Full year) – 41% 2018-19 (Q1 & Q2) – 39%	2017-18 (Full year) – 43% 2018-19 (Q1 & Q2) – 40%	2017-18 (Full year) – 24% 2018-19 (Q1 & Q2) – 25%
Cannabis	2015-16 = 6.5% 2016-17 = 6.6%	2017-18 (Full year) – 26% 2018-19 (Q1 & Q2) – 26%	2017-18 (Full year) – 27% 2018-19 (Q1 & Q2) – 31%	2017-18 (Full year) – 24% 2018-19 (Q1 & Q2) – 17%

14 Crime Survey for England and Wales.
15 Public Health England (2018), What we learned about alcohol and drug treatment in prisons from the 2016-17 statistics, https://publichealthmatters.blog.gov.uk/2018/01/31/what-we-learned-about-alcohol-and-drug-treatment-in-prisons-from-the-2016-17-statistics/
16 Taken from the Crime Survey for England and Wales, table "last year drug use among adults aged 16 to 59".

	2017-18 = 7.2%			
Heroin	2016-17 = 0.1% 2016-17 = 0.0% 2017-18 = 0.01%	2017-18 (Full year) – 49% 2018-19 (Q1 & Q2) – 49%	2017-18 (Full year) – 60% 2018-19 (Q1 & Q2) – 50%	2017-18 (Full year) – 71% 2018-19 (Q1 & Q2) – 62%
Crack	2015-16 = 0.1% 2016-17 = 0.1% 2017-18 = 0.1%	2017-18 (Full year) – 42% 2018-19 (Q1 & Q2) – 44%	2017-18 (Full year) – 54% 2018-19 (Q1 & Q2) – 51%	2017-18 (Full year) – 67% 2018-19 (Q1 & Q2) – 59%
PS	2015-16 = 0.7% 2016-17 = 0.4% 2017-18 = 0.4%	2017-18 (Full year) – 7% 2018-19 (Q1 & Q2) – 9%	2017-18 (Full year) – 2% 2018-19 (Q1 & Q2) – 2%	2017-18 (Full year) – 3% 2018-19 (Q1 & Q2) – 3%

36. Drug Supply Reduction

36.1. In HMP Norwich, there was an up to date drug strategy. The psychosocial team had input into the drafting of the document.

36.2. In HMP Norwich, the amount of drugs found reduced between 2016-17 and 2017-18. Cannabis and psychoactive substances were the most common drugs found. Minutes from the drug strategy meeting show that psychoactive substances are mainly brought into the prison via letters.

36.3. In HMP Peterborough, the drug strategy was from 2017-18 and needed to be updated. The psychosocial team had input into the drafting of the document.

RECOMMENDATION
HMP PETERBOROUGH –
HMP PETERBOROUGH –

36.4.

37. Reduce Drug Demand

37.1. The HMIP Thematic Report states that "when prisoners feel safe in custody, they experience lower levels of stress, and the desire to self-medicate will be reduced".[17]

37.2. The HMIP Thematic Report highlights that provision of purposeful activity to reduce boredom and promote better sleep patterns will help reduce drug demand.

37.3. The HMIP Thematic Report states that providing "…timely access to health services, including effective pain management, dental care and external hospital appointments, [reduces] the demand for self-medication".

37.4. The Centre for Social Justice (CSJ) recommends that the frequency of rMDT be significantly increased so that a quarter of prisoners are tested every month.[18] Below shows the trend in positive rMDTs.

37.5. In HMP Norwich, the positive testing rate for traditional drugs (excluding psychoactive substances) for 2017-18 was 11.1%. Including psychoactive substances, the positive testing rate increases to 18.4%.

[17] HMIP, (2015), Changing Patterns
18 https://www.gov.uk/government/collections/prison-and-probation-trusts-performance-statistics - 2017 to 2018 data will be published in October 2018.

38. Identification

38.1. In both prisons, new prisoners are screened for substance misuse needs on arrival.

38.2. In both prisons, there is a pathway whereby those who fail a prison MDT are seen by substance misuse services.

38.3. In HMP Norwich, patients requiring a substance misuse intervention are held on A-wing. Phoenix Futures sees all those beginning a clinical substance misuse intervention the day following their arrival in prison.

38.4. 3.

39. Psychosocial Interventions

RECOMMENDATION

HMP PETERBOROUGH –.

39.1. The two staffing models of the prison psychosocial teams were very different. In HMP Norwich, there was 1 service manager post, 2 team leader posts, 8.6 practitioners, and 1 family worker. In HMP Peterborough, there were 4 prison officer posts (with 1 vacancy), and 2 civilian posts.

39.2. The table below shows the caseload figures of the psychosocial teams in the prison:

Figure 1.1.17: Caseload figures of the psychosocial teams.	HMP Peterborough
Prison population	789
Total caseload	264 (33% of the population)
Clinical clients	154
Non-clinical clients	110
Clinical and non-clinical (Local Discharge Unit)	

39.3. In HMP Norwich, Phoenix Futures has developed a programme of courses aimed at prisoners who stay for a short time in the prison. The courses are run as one-off sessions to allow the maximum number of prisoners to take part.

39.4. In HMP Norwich, a dedicated family worker started in October 2018. The role was still being developed and by December 2018, the worker had six clients.

39.5.

40. Transfers to Community

RECOMMENDATION

HMP PETERBOROUGH –

RECOMMENDATION

HMP NORWICH – To investigate the low treatment commencement rate of those transferred to Norfolk.

40.1. At 20%, the treatment commencement rate for transfers from HMP Norwich to the community was low. Around half of the referrals were to Norfolk, with this partnership reporting a low commencement rate of 10%.

41. Transfers to Prison

41.1. The treatment commencement rate in HMP Norwich at 52% is higher than HMP Peterborough, and similar to prisons of a similar role. Over half of the referrals from HMP Norwich were to HMP Wayland and HMP Highpoint; both of which reporting good commencement rates. For HMP Peterborough, prisons that report a poor treatment commencement rate include HMP The Mount, HMP Stocken, and HMP Hollesley Bay.

EXECUTIVE SUMMARY – PRIMARY CARE

42. Overview

42.1. In HMP Norwich, healthcare applications are processed by the night nursing staff. Nurses check applications and refer to the GP, nurse practitioner, and nursing staff as appropriate. Additional information can be collected by the day nurses on the following day if required.

43. Asthma

43.1. For the current population, the expected prevalence of asthma is the same across both prisons at about 12.5%. The actual prevalence in both prisons is similar to the expected rate.

43.2. In HMP Norwich, patients with asthma are seen by nursing staff in regular clinics. Patients with more complex needs can be seen by the nurse practitioner or the GP.

43.3. There were no nursing staff trained in spirometry in HMP Norwich.

RECOMMENDATION

HMP NORWICH – There should be an offering of spirometry in the prison.

44. Cancer

44.1. At the time of this assessment, there were 4 patients with cancer in HMP Norwich; this is reflected on the QOF register. One of the patients was based on L-wing and was sent out for regular chemotherapy.

44.2. In HMP Norwich, there is an end of life care pathway in place. For patients who reach the end stages of life, healthcare has close links with the Priscilla Bacon Lodge Hospice in Norwich. L-wing has been accredited as meeting the Gold Standard Framework in end of life care.

44.3. The number of patients on the HMP Peterborough cancer QOF register was 3.

44.4. Healthcare were managing one patient with palliative needs at the time of this assessment. Healthcare had contacted the MacMillan Trust and a nurse from the organisation had visited the patient.

44.5. There was a written End of Life pathway, however nursing staff had not been trained in end of life care, including the administering of syringe drivers. Syringe drivers were administered by a community nurse when required.

RECOMMENDATION

HMP PETERBOROUGH –

45. Cardiovascular Disease

45.1. In HMP Norwich, patients with heart problems are generally managed between the GP and the nurse practitioner.

45.2. In HMP Norwich, patients can be identified with heart problems via the NHS Health Check. The NHS Health Check is not performed in HMP Peterborough.

RECOMMENDATION

HMP PETERBOROUGH –

45.3. There are higher rates of most types of CVD related conditions in HMP Norwich.

45.4. There is no cardio-rehabilitation available in either prison.

46. Diabetes

46.1. The prevalence rates in the PHE Toolkit is understood to be too low. For this HSNCA, estimates from APHO (now part of PHE) Diabetes Prevalence Model Estimates were used.

46.2. Applied to HMP Norwich gives a prevalence of 6.1% for the current population. For HMP Peterborough, the rate is lower at 5.1%. The actual rate in HMP Norwich at the time of this HSCNA was 5.4% (40 prisoners) which is slightly lower than the expected rate of 6.1% (45 prisoners). In HMP Peterborough there is a significant gap between the actual rate of 2.6% (21 prisoners) and the expected rate of 5.1% (42 prisoners).

46.3. The analysis by age shows a general increase in prevalence in correlation with an increase in age group. In most age groups, the rates are higher in HMP Norwich in comparison to HMP Peterborough.

46.4. The analysis by ethnicity shows potential unidentified prisoners with diabetes. For example, in HMP Peterborough, no prisoners of Asian ethnicity are on the register. Similarly, in HMP Norwich, no prisoners from either a black, mixed, or other ethnic group are on the register.

46.5. In HMP Norwich, patients with diabetes are managed between nursing staff, the nurse practitioner and the GP.

46.6. There is no diabetic specialist visiting nurse in either prison.

47. Epilepsy

47.1. In HMP Norwich, patients with epilepsy are seen by the GP or nurse practitioner. Patients with epilepsy are given a single cell. The reason given for this was that some patients with alcohol induced fits could become violent. Healthcare can provide the prison with recommendations regarding accommodation requirements.

47.2. In both prisons, the rate of patients on the epilepsy QOF register is higher than the expected rate of 2%. The prevalence in HMP Norwich is 3.8% compared to 2.7% in HMP Peterborough.

47.3. The analysis by demographics suggest that there may be unmet need. For example, in both prisons, none of the under-21 population are on the register. In addition, no prisoners of Asian, Mixed, or Other ethnicity are on the epilepsy register.

48. Obesity

48.1. In HMP Norwich, healthcare runs weight loss clinics where health promotion and healthy lifestyle advice are given.

48.2. In both prisons, the prevalence of obesity was approximately 13-14%.

EXECUTIVE SUMMARY – PHARMACY

49. Pharmacy

49.1. In HMP Norwich, the pharmacy supplies medicines to HMP Norwich, as well as HMP Bure and HMP Wayland.

49.2. There are no pharmacy-led clinics in either prison, although in HMP Norwich there is a plan for medication use review clinics to begin. At the moment these are run by the GP.

RECOMMENDATION

GENERAL – Pharmacy-led clinics should be explored, particularly medicine use review clinics.

49.3. In HMP Norwich, patients being prescribed pain medication are reviewed by the lead GP within seven days. There was robust management of pain medication, with 11 current prisoners having had their pregabalin discontinued following a GP review.

49.4. The pharmacist in HMP Norwich also monitored the use of pain medications, and following an audit in August 2018, no patients were prescribed morphine above 120 mgs.

49.5. In both prisons, the in-possession risk assessment is completed at the reception screen.

49.6. There was an up to date in-possession policy in HMP Norwich, while the HMP Peterborough policy was in the process of being reviewed.

EXECUTIVE SUMMARY – CLINICS

50. General

50.1. There are a range of external clinicians who provide services in the prison.

Figure 1.1.18: The frequency of clinic sessions in HMP Norwich and HMP Peterborough	HMP NORWICH	
	Frequency (weekly)	Waiting Time
Dentist	2.5	4-6 weeks (routine)
GP	10	1 – 4 days
Physiotherapist	1	4 weeks
Podiatry	1	<4weeks
Optician	1.5[19]	2 weeks

51. GP

51.1. The number of patients with booked appointments in HMP Norwich has seen a large increase, from 320 a month in 2017-18 to 451 a month in 2018-19..

51.2. Although the number of booked appointments has increased in HMP Norwich, the percentage of booked appointments attended has decreased from 77% to 69% between 2017-18 and 2018-19 and is now similar to HMP Peterborough.

51.3. The waiting times in HMP Norwich varied between one to four days in 2018-19.

52. Dentist

[19] Approximately 7 per month

52.1. Dental services in HMP Norwich are provided by John G. Plummer and Associates. The provider will be changing from April 2019 and the current dental staff will be returning to the practices.

52.2. In HMP Norwich, the provider detailed a few issues relating to the equipment. The provider said that there were delays in the replacing of hand instruments and other equipment. The delays were over disputes about payment. The provider chose to replace items itself to ensure care was not delayed. The provider stated that light cures needed replacing in both dental suites.

52.3. Both prisons have not seen any changes with the monthly average number of patients booked with an appointment when comparing 2018-19 against 2017-18. Despite having a larger population, the number of booked appointments in HMP Peterborough at 94 a month is lower than HMP Norwich at 186 a month.

52.4. HMP Norwich has seen an increase from 43% in 2017-18 to 50% in 2018-19 for the percentage of booked appointments attended. The 50% rate is still lower than the 69% in HMP Peterborough, the comparator prison, regional average, and national average.

52.5. The waiting times in HMP Norwich varied from 2 to 28 days in 2018-19.

RECOMMENDATION

HMP NORWICH – The new provider should ensure that there are appropriate processes in place for the servicing and replacing of dental equipment.

53. Optician

53.1. Optician services in HMP Norwich are provided by Norfolk Ophthalmic Limited. There are approximately 7 sessions per month. Most sessions occur in the main site of the prison, with 1 session every 4 weeks taking place in the LDU.

54. Physiotherapist

54.1. In HMP Norwich, physiotherapy is provided by Back in Motion.

RECOMMENDATION

HMP PETERBOROUGH –.

55. Podiatry

55.1. Randall's Footcare provides podiatry services to HMP Norwich. There are 2 half day sessions every 2 weeks, with approximately 9 patients seen per session.

RECOMMENDATION

HMP PETERBOROUGH –

EXECUTIVE SUMMARY - COMMUNICABLE DISEASES

56. Overview

56.1. HMP Norwich runs blood-borne virus screening using the dried blood spot testing method. This is not offered in HMP Peterborough. Nursing staff in HMP Peterborough reported that it was sometimes difficult to access the veins of injecting drug users.

RECOMMENDATION

HMP PETERBOROUGH –

56.2. Regarding hepatitis C treatment, there are visiting specialists in both prisons who oversee the care of those who are undergoing hepatitis C treatment.

PRISON OVERVIEW

BRIEF OVERVIEW OF THE PRISON

	HMP NORWICH
YEAR BUILT	1887
PRISON TYPE INCLUDING ROLE	HMP (& YOI) Norwich is a local resettlement prison holding prisoners who are category B or lower. HMP & YOI Norwich is a local prison holding male prisoners aged 18 and over. The population is mainly comprised of remand prisoners and newly sentenced prisoners.
WHERE THE PRISONERS ARE RECEIVED FROM	This establishment mostly holds prisoners remanded or sentenced by courts in the east of England and the London regions and receives most of its prisoners from courts in the area, particularly Norwich and Ipswich.
HISTORICAL CHANGES	HMP & YOI Norwich has occupied its current site overlooking the city of Norwich since 1887. Following closure of the last remaining large Victorian prisoner wing in August 2009, a new residential unit was opened catering for prisoners new to custody and substance misusers requiring support.
RESIDENTIAL UNITS AND DESCRIPTION	HMP & YOI Norwich holds a mix of remand and sentenced category B, C and D adult prisoners and remanded and sentenced young adults. The prison is split across three distinct sites with different functions: most prisoners are held on the reception site, which acts as a local prison for mainly remanded and category B prisoners. The Local Discharge Unit (LDU), outside the main perimeter, holds category C prisoners and some specialist functions. Britannia House, also outside the main perimeter, is a resettlement unit for category D prisoners.
HEALTH PROVIDERS	Healthcare services are provided by Virgin Care. Psychosocial services are provided by Phoenix Futures. IAPT services are provided by Norfolk and

	Suffolk NHS Foundation Trust.

FUTURE CHANGES

The table below shows a number of factors that may impact on the future population for each establishment, which may lead to subsequent impacts on health and social care need.

HMP NORWICH	HMP PETERBOROUGH
CAPACITY OF THE PRISON - CAN THE PRISON PHYSICALLY HOLD ANY MORE PRISONERS?	
There are a number of factors that could increase the capacity of a prison. Firstly, is there capacity within the existing units for more prisoners to be housed? Secondly, is there any opportunity for the prison to expand?	
HMP Norwich is on a large site, and there is potentially space to expand the prison. However there are no plans to increase to population at the time of this assessment.	
PRISON RECONFIGURATION	
A reconfiguration of the prison could lead to changes in the demographics of the population. Prison reconfiguration can be driven by wider prison reorganisation plans. Reconfiguration can change the function of prisons, which in turn will impact on the demographics of the population.	
As part of the prison reconfiguration process, there were some plans in place to change the population of HMP Norwich, with an increase in category C and category D prisoners. There was no timeframe for the changes to the HMP Norwich population.	

CAPACITY

POPULATION NUMBERS

Figure 1.2.1 provides a summary of the Certified Normal Accommodation (CNA), the operational capacity, and the population as at December 2018 for HMP Norwich. Although the population number is lower than the operational capacity, it is higher than the in-use CNA. The data was taken from official published figures[20] which does not provide a breakdown for the male and female populations in HMP Peterborough. The information for HMP Peterborough in figures 1.2.2 and 1.2.3 was taken from local data.

In terms of population size, HMP Norwich is lower than HMP Peterborough.

Figure 1.2.1: Population numbers of HMP Norwich: December 2018.

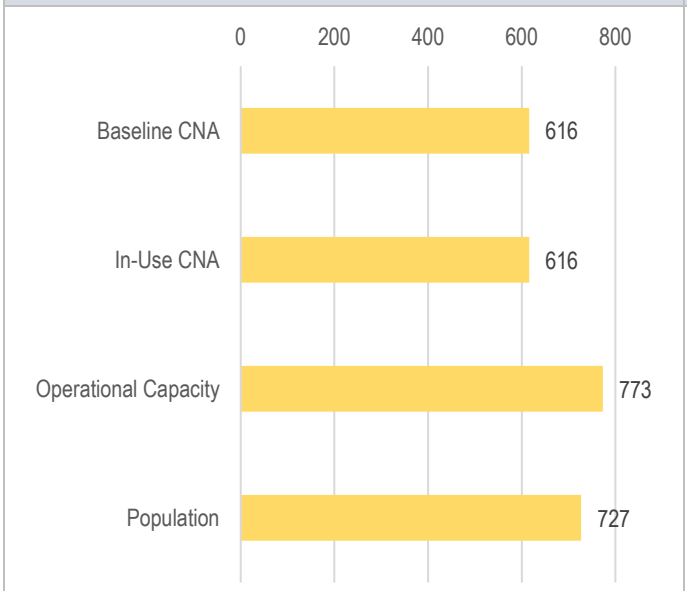


Figure 1.2.2: Population numbers of HMP Peterborough: December 2018.

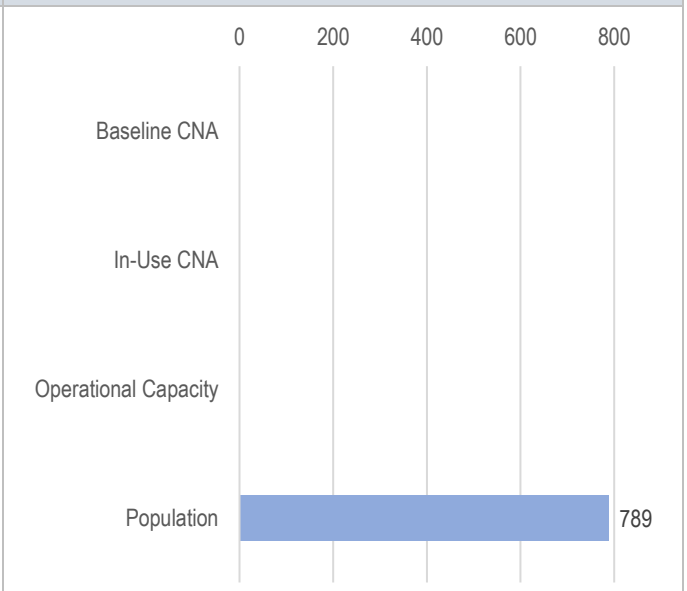
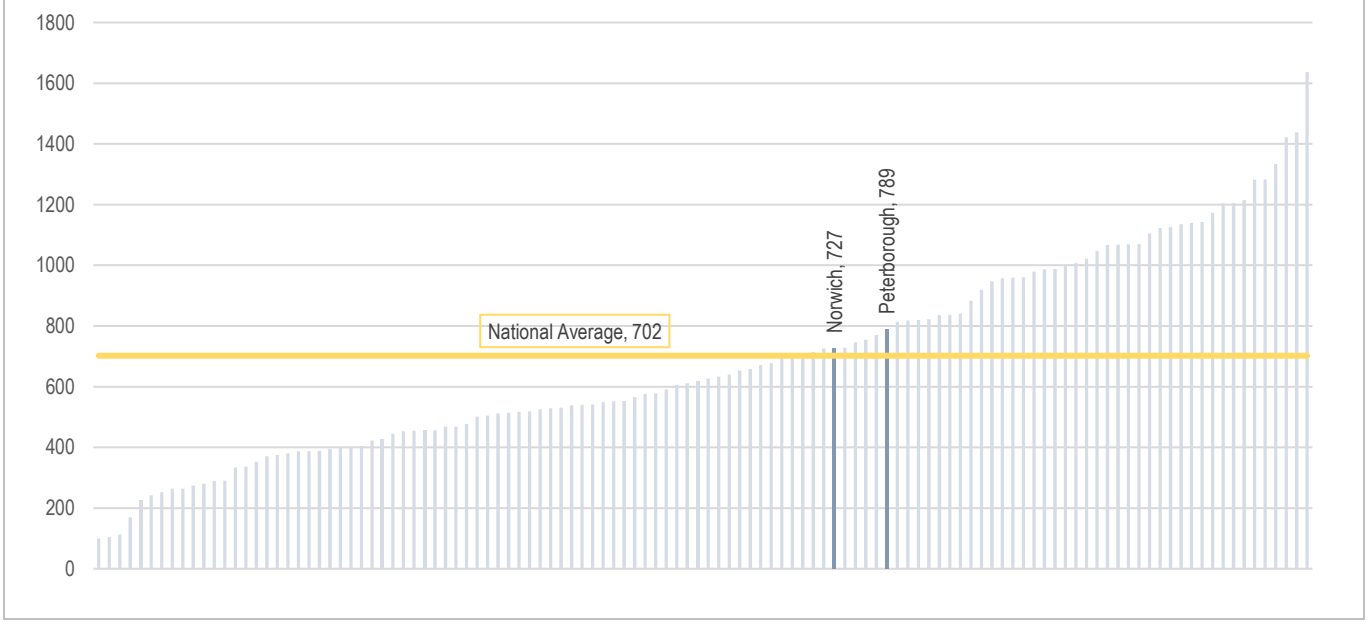


Figure 1.2.3: The population size of HMP Norwich and HMP Peterborough ranked against all prisons in England and Wales.[21]



[20] https://www.gov.uk/government/statistics/prison-population-figures-2019
[21] HMP Norwich data from MoJ Statistics. Peterborough data from local information.

LONG-TERM TRENDS[22]

The long-term trend for HMP Norwich shows that the in-use CNA, operational capacity, and population has remained relatively stable. After March 2012, the data for HMP Peterborough is not available by the male and female populations.

Figure 1.2.4: The long-term population trend in HMP Norwich.

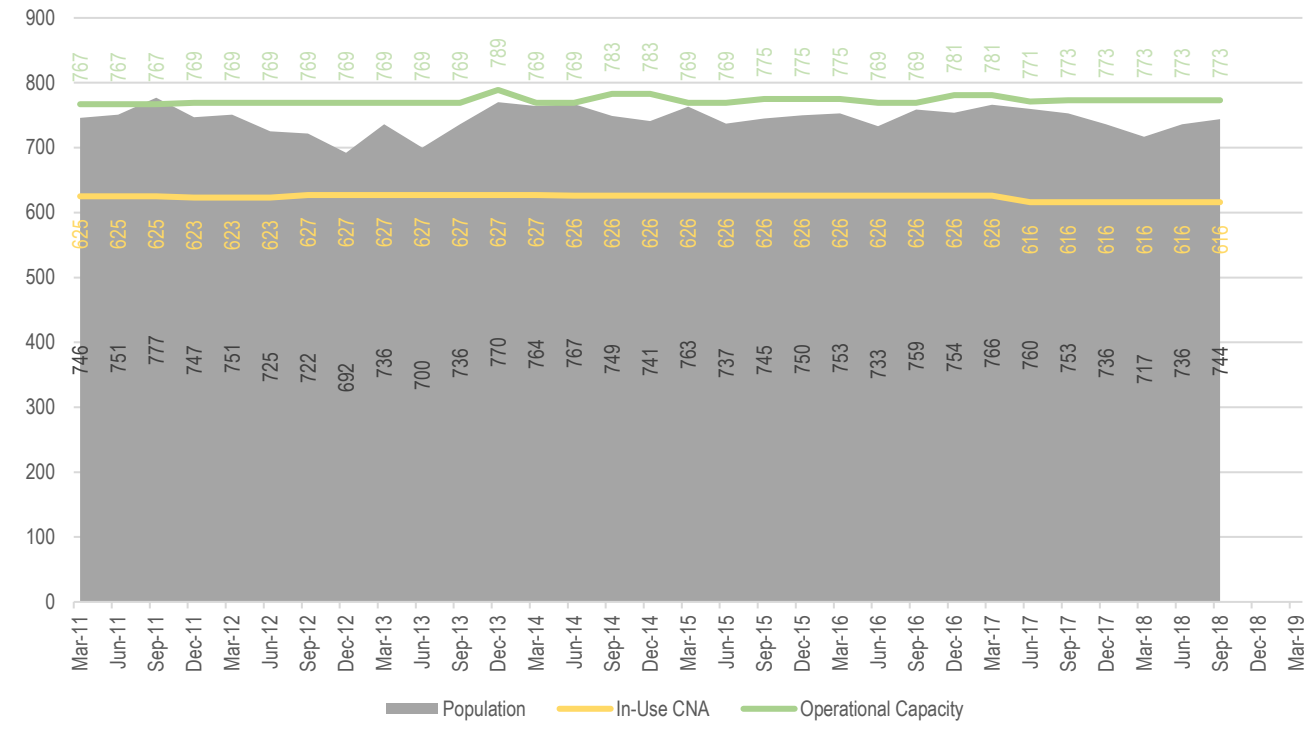
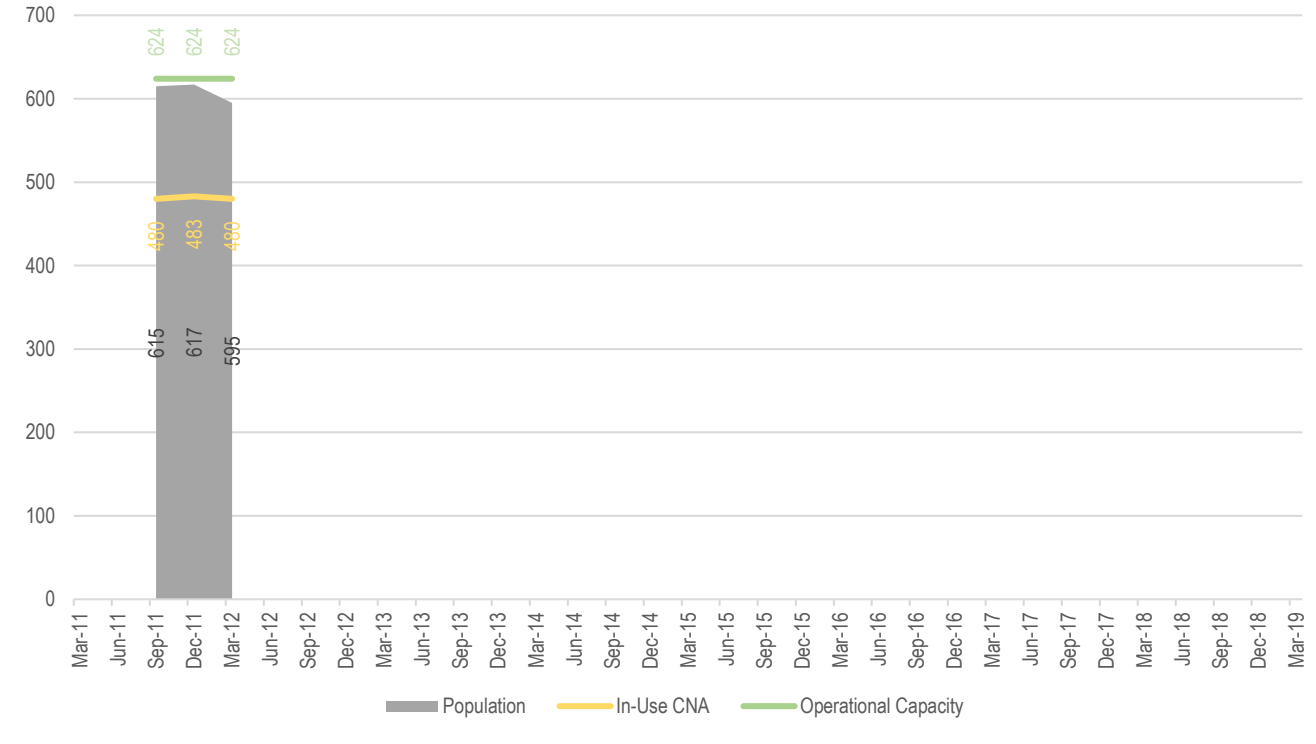


Figure 1.2.5: The long-term population trend in HMP Peterborough.



[22] https://www.gov.uk/government/statistics/prison-population-figures-2018

OVERCROWDING

Below shows the percentage of prisoners[23] held in crowded accommodation[24] in establishments in England and Wales, the 12 months ending March 1999 to the 12 months ending March 2018. The data for HMP Peterborough male population was not available. For HMP Norwich, the rate has remained stable at around 35%, which is relatively low compared to other local prisons.

Figure 1.2.6: Long-term trend; HMP Norwich.

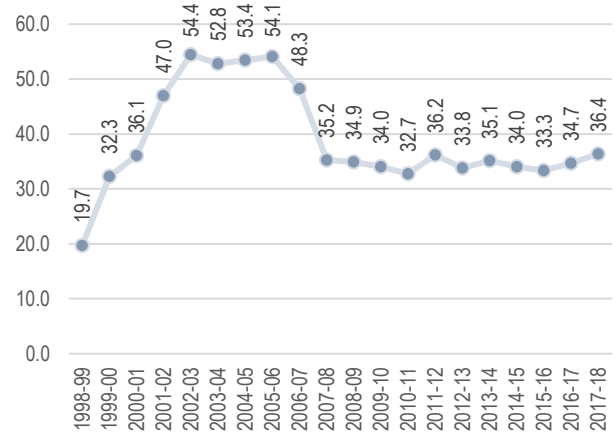


Figure 1.2.7: Long-term trend; HMP Peterborough.

Figure 1.2.8: Comparison against other local prisons; 2017-18[25].

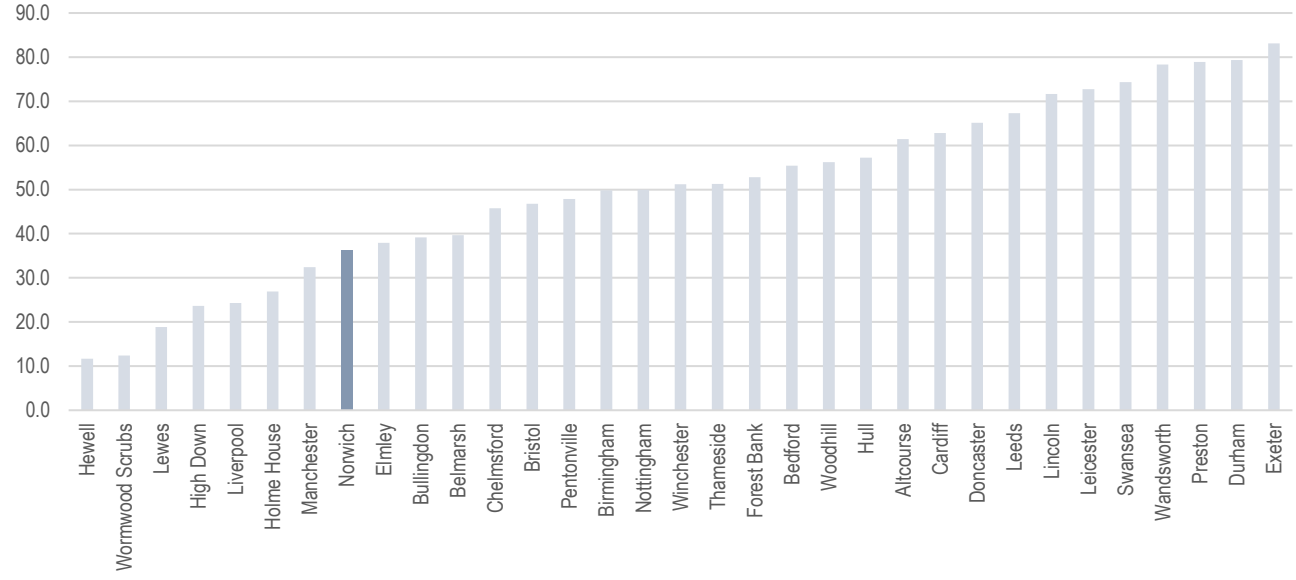


Figure 1.2.9: Number of prisoners held in crowded accommodation[26] in establishments in England and Wales, the 12 months ending March 2012 to the 12 months ending March 2018.

	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Norwich	276	247	259	255	247	257	272
Peterborough	Data not available for HMP Peterborough by male and female populations.						

[23] Percentages are calculated by dividing the number of prisoners held as doubled, trebled and crowded by the average population for the period.
[24] Crowding is measured as the number of prisoners who, at unlock on the last day of the month, are held in a cell, cubicle or room where the number of occupants exceeds the uncrowded capacity of the cell, cubicle or room.
[25] Data not available for HMP Peterborough by male and female populations.
[26] Figures include the number of prisoners held two to a single cell, three prisoners in a cell designed for one or two and any prisoners held crowded in larger cells or dormitories.

AGE

Comparing the population of the two prisons by age shows a number of differences. There is a higher rate of under-21 year olds and over 50 year olds in HMP Norwich in comparison to HMP Peterborough. In HMP Norwich, a comparison against 2016 shows that the under-21 age group has increased from 5% of the population to 11% of the population, which has been offset by a decrease in the 21-29 age group.

In HMP Peterborough, the 30-39 age group has seen an increase whilst the 21-29 age group has seen a decrease.

Figure 1.2.10: Age profile; HMP Norwich vs HMP Peterborough comparison.

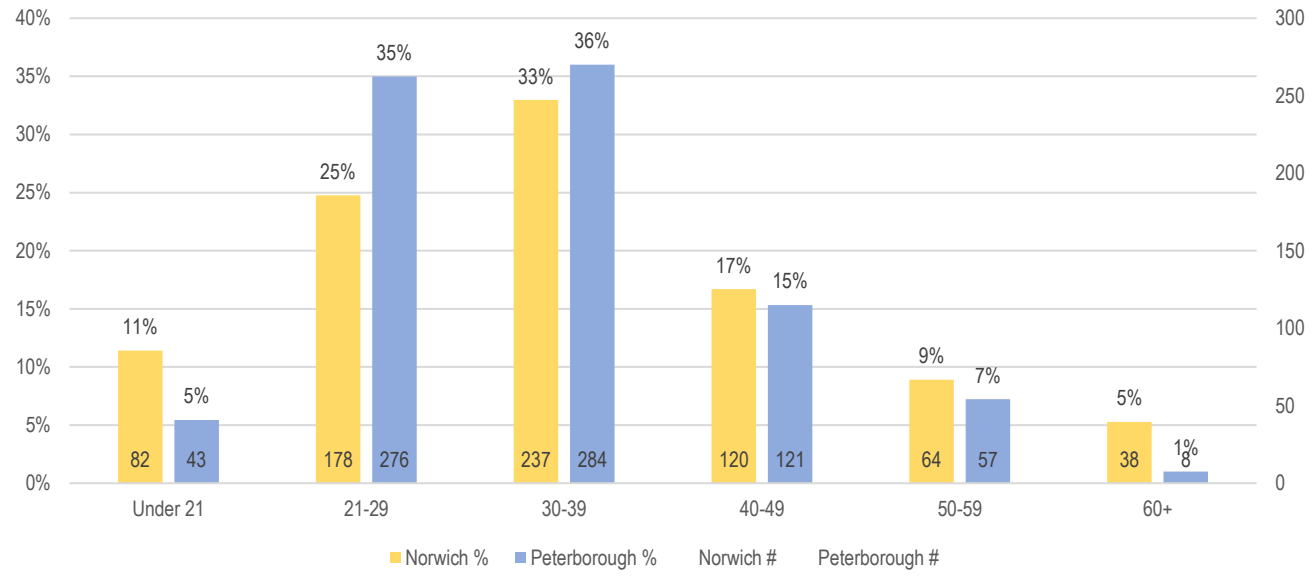


Figure 1.2.11: Age profile; HMP Norwich.

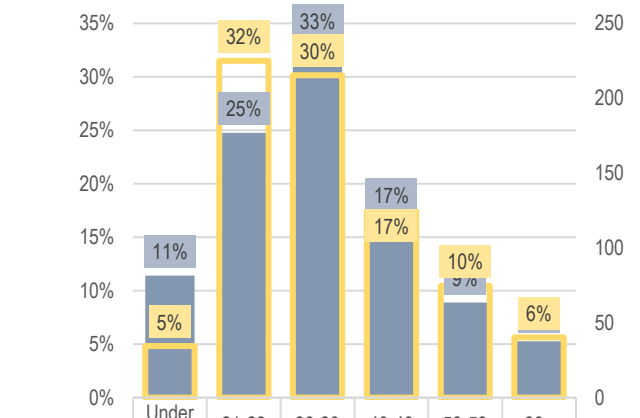
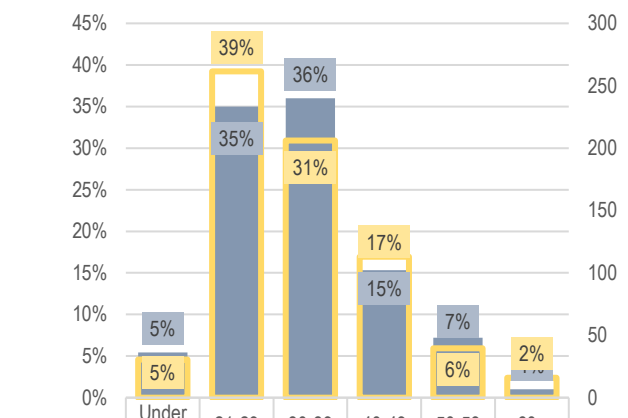


Figure 1.2.12: Age Profile; HMP Peterborough.



ETHNICITY

In both prisons, those of White ethnicity account for the majority of the population, however the rate in HMP Norwich is higher at 84% compared to 74% in HMP Peterborough. There is also a higher rate of Asian prisoners in HMP Peterborough compared to HMP Norwich.

In HMP Norwich, a comparison against 2016 shows slight changes, with a decrease in the White ethnic group from 87% to 84% while proportion of Black prisoners has increased from 7 to 10%.

Prisoners of White ethnicity in HMP Peterborough have decreased from 79% to 74%, while the proportion of prisoners of Asian, Black, and Mixed ethnicity has increased.

Figure 1.2.13: Ethnicity profile; HMP Norwich vs HMP Peterborough comparison.

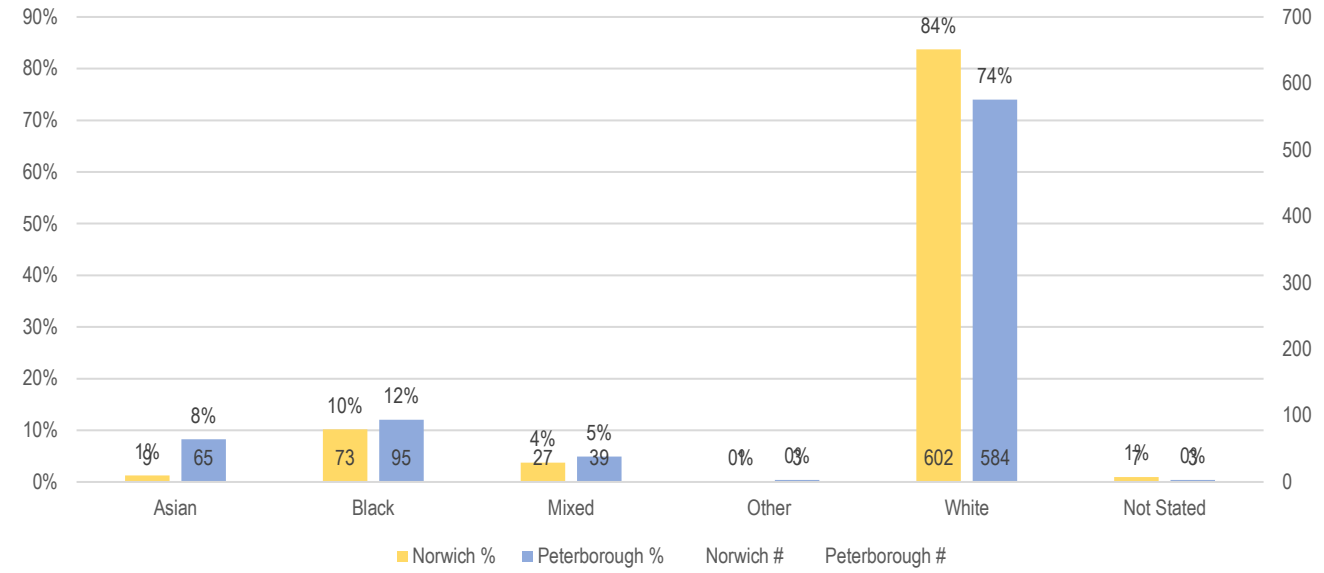
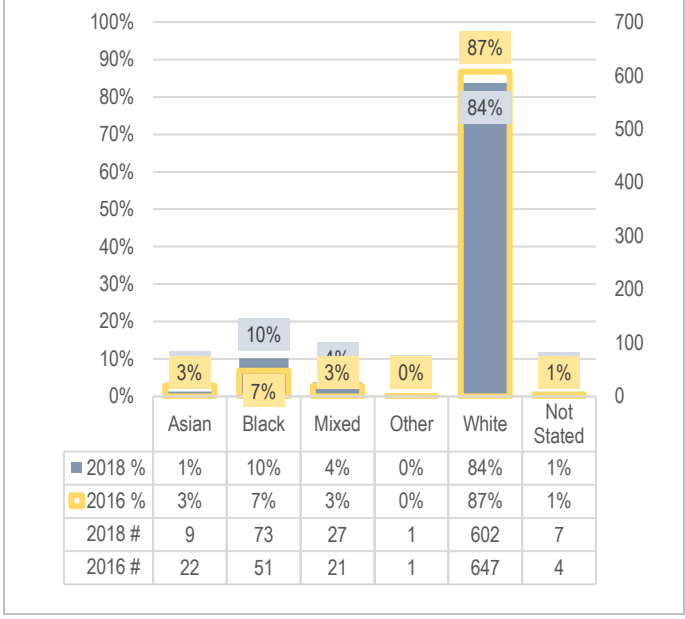
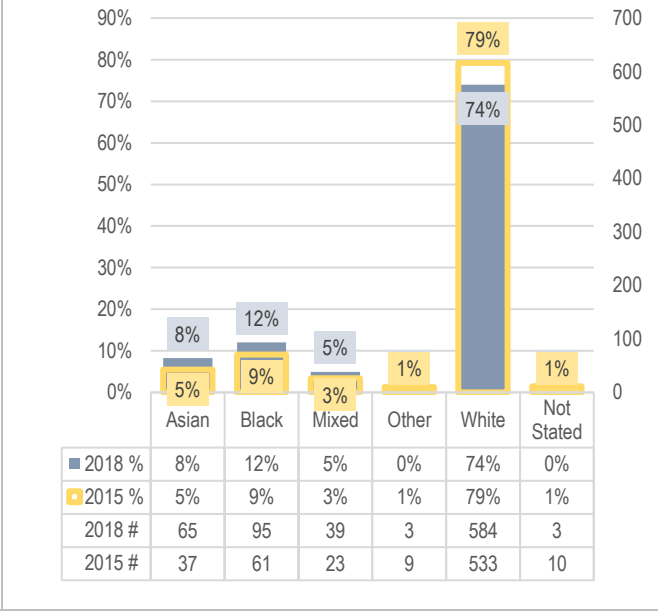


Figure 1.2.14: Ethnicity profile; HMP Norwich.



	Asian	Black	Mixed	Other	White	Not Stated
2018 %	1%	10%	4%	0%	84%	1%
2016 %	3%	7%	3%	0%	87%	1%
2018 #	9	73	27	1	602	7
2016 #	22	51	21	1	647	4

Figure 1.2.15: Age Profile; HMP Peterborough.



	Asian	Black	Mixed	Other	White	Not Stated
2018 %	8%	12%	5%	0%	74%	0%
2015 %	5%	9%	3%	1%	79%	1%
2018 #	65	95	39	3	584	3
2015 #	37	61	23	9	533	10

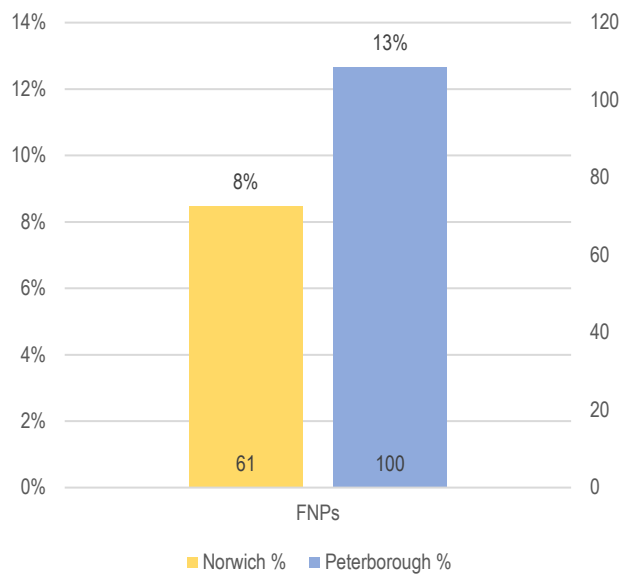
FOREIGN NATIONAL PRISONERS (FNP)

The following chart shows the percentage of the population who are FNPs. The rate has remained stable in HMP Norwich since September 2015[27].

The 13% in HMP Peterborough is slightly lower than the 15% reported in the 2015 HMIP Inspection Report.

The national average is 9%.

Figure 1.2.16: Foreign National Prisoners[28].



NATIONALITIES

In both prisons, those of British nationality account for the majority of the population. In HMP Peterborough, the remaining population are composed of a range of nationalities, although no single nationality accounted for more than 2% of the total.

Figure 1.2.17: Nationalities; HMP Norwich.

HMP Norwich	Count	%
British	651	93%
Irish	7	1%
Polish	7	1%
Romanian	7	1%
Albanian	6	1%
Nigerian	4	1%
Portuguese	4	1%
Czech	2	0%
Pakistani	2	0%
Unknown	2	0%
Bulgarian	1	0%
Chinese	1	0%
Greek	1	0%
Indian	1	0%
Iranian	1	0%
Iraqi	1	0%
Italian	1	0%
Sudanese	1	0%
Zimbabwean	1	0%
Total	**701**[29]	

Figure 1.2.18: Age Profile; HMP Peterborough.

HMP Peterborough	Count	%
British	688	87%
Albanian	18	2%
Lithuanian	17	2%
Irish	9	1%
Polish	7	1%
Romanian	7	1%
Portuguese	6	1%
Pakistani	4	1%
Trinidadian, Tobagonian	3	0%
Afghan	2	0%
Bulgarian	2	0%
Iranian	2	0%
Iraqi	2	0%
Nigerian	2	0%
South African	2	0%
Slovakian	2	0%
Bangladeshi	1	0%
Chinese	1	0%
Dutch	1	0%
Eritrean	1	0%
French	1	0%
Gambian	1	0%
German	1	0%
Ghanaian	1	0%
Guyanese	1	0%
Italian	1	0%
Jamaican	1	0%
New Zealand	1	0%
Sudanese	1	0%
Somalian	1	0%
Turk	1	0%
Zimbabwean	1	0%
Total	**789**	

[27] Available data from MoJ data.
[28] January 2019.
[29] Missing values.

RELIGION

The Prison Service provides opportunities and facilities necessary to enable prisoners to practise their religion. These include:

- Access to a chaplain or minister of their own religion
- A place to go to practice their faith
- Authorised religious reading materials
- Provision of diets to meet special religious needs[30].

The following table shows the national prison population by religious group as of December 2016. The table also includes a column for the population in England and Wales as taken from the 2011 census.

Figure 1.2.19: National prison population by religious group, and population in England and Wales[31].

	Number	% of prison population	% pt. change on 2002	Census 2011
Christian	40,919	48.5%	-9.5%	59.3%
Muslim	12,825	15.2%	+7.5%	4.8%
Hindu	400	0.5%	+0.1%	1.5%
Sikh	759	0.9%	+0.3%	0.8%
Buddhist	1,529	1.8%	+1.2%	0.4%
Jewish	449	0.5%	+0.3%	0.5%
No religion	25,749	30.5%	-0.9%	25.1%
Other	1,547	1.8%	+1.3%	
Not recorded	130	0.2%	+0.1%	7.2%[32]
Total	84,307			

At the end of 2016, the largest group of prisoners were Christians, who formed 48.5% of the prison population, a decrease of 9.5% compared to June 2002. Next in size was the 'no religion' group, who formed 31.5% of the prison population, down 0.1% from 2002. The third largest group were Muslims, who formed 15% of the prison population, an increase of 7.5% as compared to 2002. Buddhists, Sikhs, Jewish and Hindus also represented a growing section of the prison population.

Prisoners who identified themselves as 'other' included Pagans, Spiritualists and Taoists. Although some prisoners identified themselves as Rastafarians, Nation of Islam followers and Scientologists, these movements were not recognised as religions in prison.

From the 2011 Census, Christianity was the largest religion in the general population in England and Wales (59.3%). The second largest religious group were Muslims (4.8%). Around a quarter of the population reported that they have no religion.

Practising a religion in prison helped some prisoners cope with the pains of imprisonment, facilitating personal transformation and growth. It provided meaning-making activities, including personal study, reading widely, sharing birthdays and other events through communal meals and belonging to a group. Religion filled a gap where there was a lack of meaningful and purposeful activity.[33] For these reasons, some prisoners find themselves converting to a religion after their conviction.

[30] http://www.prisonreformtrust.org.uk/Portals/0/Documents/PIB%20extract%20-%20Your%20faith.pdf
[31] MoJ (2016), *Offender Management Statistics Quarterly*, July to September 2016, 26 January 2017; NOMIS, Census 2011
[32] Religion not stated
[33] https://www.prc.crim.cam.ac.uk/publications/trust-report

A high percentage across both prisons were recorded as “No Religion”. The rate was 37% (265 prisoners) in HMP Norwich and 33% (258 prisoners) in HMP Peterborough.

Muslims account for one of the largest religious groups in HMP Peterborough, accounting for 18% (143 prisoners). The rate is lower in HMP Norwich at 9% (66 prisoners).

Figure 1.2.20: Religion; HMP Norwich.

HMP Norwich	Count	%
No Religion	265	37%
Roman Catholic	122	17%
Church of England	109	15%
Christian	96	14%
Muslim	66	9%
Buddhist	15	2%
Mormon	10	1%
Pagan	6	1%
Atheist	3	0%
Eastern Orthodox	3	0%
Unknown	3	0%
Greek Orthodox	2	0%
Jewish	2	0%
Pentecostal	2	0%
Agnostic	1	0%
Evangelical	1	0%
Hindu	1	0%
Jehovah's Witness	1	0%
Other	1	0%
Rastafarian	1	0%
Sikh	1	0%
Total	**711**[34]	

Figure 1.2.21: Religion; HMP Peterborough.

[34] Missing values.

EX-SERVICE PERSONNEL

As highlighted in the HMIP Report *People in prison: Ex-service personnel*[35], "The number of ex-service personnel in prison is a contentious issue; accurate figures have proven notoriously difficult to ascertain and the exact number of ex-service personnel in custody is currently unknown."

The survey data from the HMIP Report found that out of 4,731 adult male prisoners in 2012–13 the average proportion of prisoners identifying themselves as ex-service personnel was 7% (n=318). The review by Stephen Phillips QC MP, 'Former Members of the Armed Forces and the Criminal Justice System', says that" The data that presently exist are based upon this definition. As I have noted, those data indicate that somewhere between 3.5% and 7% of the current prison population is comprised of former service personnel."

Other key findings from these reports that are relevant to this HSCNA are:

- Analysis of the Defence Analytical Services Agency (DASA) data showed that older ex-service personnel were also overrepresented in the prisoner population: 29% of ex-service personnel in prison were over 55 compared to 9% of the general prisoner population.
- Service in the armed forces may, in some cases, also lead to an increased risk of alcohol misuse and mental health difficulties, including anxiety, depression and post-traumatic stress disorder (PTSD). Therefore, it is likely that those ex-service personnel who do come into contact with the criminal justice system may be affected by one or more of these vulnerabilities.
- Ex-service personnel were more likely to be serving longer sentences: 63% reported that their sentence was over four years (compared with 53% of the general prisoner population); 39% reported that their sentence was over 10 years (compared with 26% of the general prisoner population).
- On arrival into prison, ex-service personnel were as likely as the general prisoner population to report problems with issues such as alcohol abuse (17%) and mental health (15%).
- Ex-service personnel were more likely to report feeling depressed or suicidal on arrival into prison (18% compared with 14%).
- The incidence of physical health problems on arrival into prison was higher among ex-service personnel than the general prisoner population (24% compared with 13%).
- A higher proportion of prisoners identifying as ex-service personnel stated that they had a disability (34% compared with 19% of the general prisoner population).
- Identification is not, presently, routine, and even in those places where it is common practice, many who have served in the armed forces have reservations about self-identifying, both because of a feeling of shame at behaviour contrary to the ethos of the armed forces and because of fears for personal safety given high-profile attacks on former service personnel.

The following table provides the prevalence in both prisons based on a number of sources including NOMIS and SystmOne.

Figure 1.2.21: Prevalence of prisoners that have served in the armed forces.	HMP Norwich
NOMIS	Not Available
HMIP	17 (2.3%)
SystmOne - (0912.) Member of armed forces	16 (2.2%
SystmOne - (XaX3N) Military veteran	7 (0.9%)

[35] HM Inspectorate of Prisons (2014), *People in prison: Ex-service personnel*.

OFFENCES

The following charts looks at the offence profiles of December 2018 population in comparison to 2015. Both prisons have seen an increase in the rate of offenders with an index offence of violence against the person, with trend being more pronounced in HMP Peterborough.

Figure 1.2.22: Index offence of the population; 2018 against 2015 comparison; HMP Norwich.

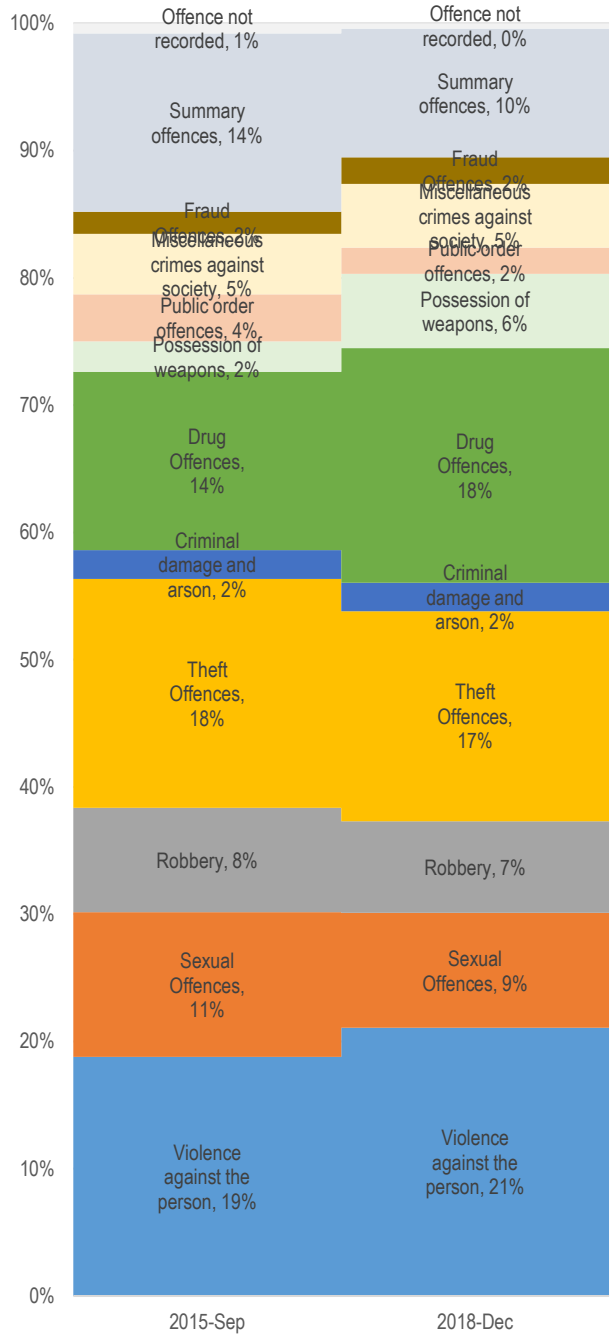


Figure 1.2.23: Index offence of the population; 2018 against 2015 comparison; HMP Peterborough (Male).

ADDITIONAL INFORMATION

The following table provides additional information including sentence status, sentence length, remaining sentence length, and originating area.

Figure 1.2.22: Sentence status[36].

	HMP Norwich	
Sentence Status	#	%
Sentenced	437	63%
Recall	71	10%
Convicted Unsentenced	57	8%
Remand	87	13%
Civil Prisoners	0	0%
Detainees	2	0%
Other	35	5%
Total	689	-

Figure 1.2.23: Sentence length.

	HMP Norwich	
Sentence Length	#	%
Unsentenced	153	21%
Less than 6 months	67	9%
6 months to less than 12 months	48	7%
12 months to less than 2 years	71	10%
2 years to less than 4 years	178	25%
4 years to less than 10 years	115	16%
10 years and over (not life)	36	5%
ISPP	0	0%
Life	51	7%
Total	719	-

Figure 1.2.24: Remaining sentence length[37].

	HMP Norwich	
Remaining Sentence Length	#	%
Detainees		0%
Less than 6 months		0%
6 months to less than 12 months	395	70%
12 months to less than 2 years	74	13%
2 years to less than 4 years	22	4%
4 years to less than 10 years	17	3%
10 years and over (not life)	7	1%
ISPP		0%
Life	51	9%
Total	566	-

Figure 1.2.25: Originating area.

	HMP Norwich	
Originating Area	#	%
East Midlands	12	2%
East of England	452	63%
London	38	5%
North East	1	0%
North West	8	1%
South East	16	2%
South West	2	0%
Unknown	185	26%
Wales	1	0%
West Midlands	2	0%
Yorks & Humberside	2	0%
Total	719	-

[36] Appears to be missing values.
[37] Appears to be missing values.

HEALTHCARE OVERVIEW

This chapter provides an overview of healthcare services in the two prisons.

HMP NORWICH
Health services are provided 24 hours a day, with nursing staff available during the night. There is a 10-bed, 24-hour health care unit.
Healthcare applications are processed by the night nursing staff. Nurses check applications and refer to the GP, nurse practitioner, and nursing staff as appropriate. Additional information can be collected by the day nurses on the following day if required.
Completed healthcare application forms are posted in a box on the wings. A triage nurse checks all healthcare applications and directs prisoners to the appropriate service.
There is no telemedicine in the prison.
New prisoners arrive in the prison Monday to Saturday, with license recalls arriving any time. There is a doctor with psychiatric and substance misuse experience on reception for substance misuse prescribing for patients who require it. Most new receptions are moved to A-wing, the prison induction wing. Vulnerable prisoners are usually diverted to C-wing. Base on HJIP data, an average of 238 prisoners are received each month.
Patients with a planned release date are seen by nursing staff seven days before they are released. Nurses review their medication and provide information on registering with a GP. Patients with a substance misuse need are given information on naltrexone (if they have had the naltrexone training). Patients are seen on the day of their release, where healthcare provides them with their take away medication and information leaflets.

HMP NORWICH
4
1
1
-
-
10 beds

4
1
Virgin Care
Virgin Care
Virgin Care
Phoenix Futures

The following information looks at the prevalence of conditions as reported on the QOF Register. For the majority of conditions, the rates across the two prisons are similar. Exceptions to this include the higher rates of the depression and mental health register in HMP Norwich. Page 62 shows that the rate across a number selected mental health READ codes are higher in HMP Norwich than HMP Peterborough.

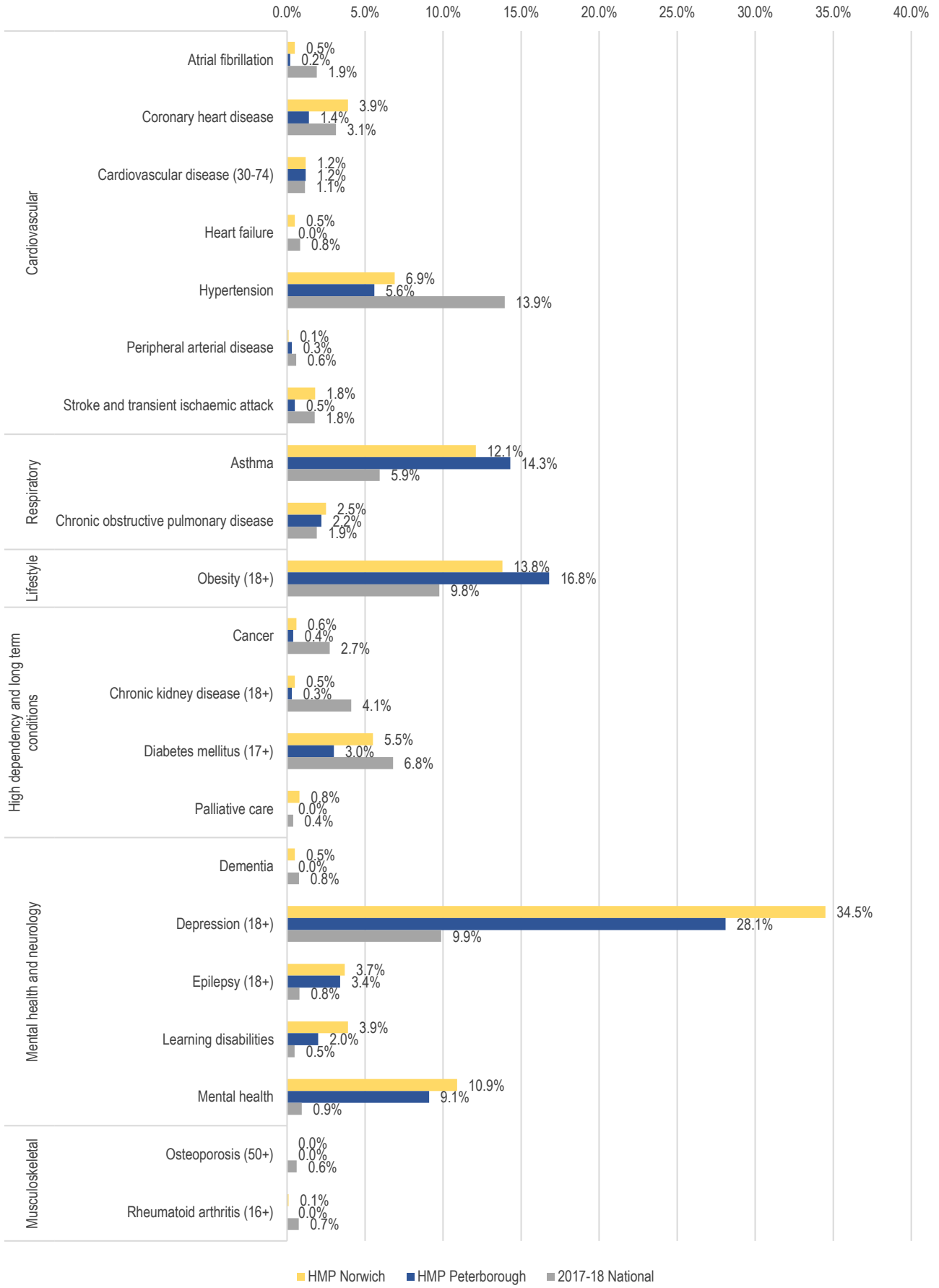
There are only two registers where the rate is higher in HMP Peterborough than HMP Norwich. These two registers are obesity and asthma.

Figure 1.3.1: The prevalence of conditions based on the QOF register; current population.

QOF Group	Indicator Group (Age Group)	HMP Norwich	HMP Peterborough
Cardiovascular	Atrial fibrillation	4	3
	Coronary heart disease	29	17
	Cardiovascular disease (30-74)	9	15
	Heart failure	4	1
	Hypertension	51	66
	Peripheral arterial disease	1	4
	Stroke and transient ischaemic attack	14	6
Respiratory	Asthma	90	169
	Chronic obstructive pulmonary disease	19	27
Lifestyle	Obesity (18+)	102	198
High dependency and long-term conditions	Cancer	5	5
	Chronic kidney disease (18+)	4	4
	Diabetes mellitus (17+)	41	36
	Palliative care	6	0
Mental health and neurology	Dementia	4	0
	Depression (18+)	255	331
	Epilepsy (18+)	28	40
	Learning disabilities	29	24
	Mental health	81	108
Musculoskeletal	Osteoporosis (50+)	0	0
	Rheumatoid arthritis (16+)	1	1

See following page for a chart illustrating the percentage prevalence rates.

Figure 1.3.2: The prevalence of conditions based on the QOF register; percentage of the current population.



PRISONERS ON MULTIPLE QOF REGISTER SCREENS

The following analysis provides a summary of the rate of prisoners on multiple registers.

For example, there are a total of 21 QOF registers. Of the 738 current prisoners in HMP Norwich, 304 (41%) do not appear on any of the QOF registers, 237 (32%) appear on only 1 register, with the remaining appearing on 2 or more registers. The tables provide additional details by area. In HMP Peterborough, 407 (50%) do not appear on any register.

Figure 1.3.3: Prisoners on multiple QOF registers; HMP Norwich.

Number of Prisoners: 738

Area	Number of Conditions	0	1	2	3	4	5	6	>=7
Cardiovascular	7	673	31	24	7	3	0	0	0
Respiratory	2	637	93	8					
Lifestyle	1	636	102						
High dependency and long-term conditions	4	688	46	3	1	0			
Mental health and neurology	5	427	235	67	8	1	0		
Musculoskeletal	2	737	1	0					
Total	21	304	237	118	45	17	6	8	2
Area	Number of Conditions	0	1	2	3	4	5	6	>=7
Cardiovascular	7	91%	4%	3%	1%	0%	0%	0%	0%
Respiratory	2	86%	13%	1%					
Lifestyle	1	86%	14%						
High dependency and long-term conditions	4	93%	6%	0%	0%	0%			
Mental health and neurology	5	58%	32%	9%	1%	0%	0%		
Musculoskeletal	2	100%	0%	0%					
Total	21	41%	32%	16%	6%	2%	1%	1%	0%

The following table provides an overview of the screens listed in the PHE Toolkit. The charts include the performance in HMP Norwich, with additional information covering the performance of the comparator prisons, regional average, and national average[38]. 2018-19 data covers April 2018 to December 2018.

RETINAL SCREENING

Definition [Guidance Enhanced]

Denominator: All patients with diabetes who have not been screened in the past 11 months. (12 months for 2017-18).

Numerator: All diabetics with a code of XaIPm (seen by retinal screener), XaIPi (Digital retinal screening) or XaJO7(under care of retinal screener) added during the reporting period.

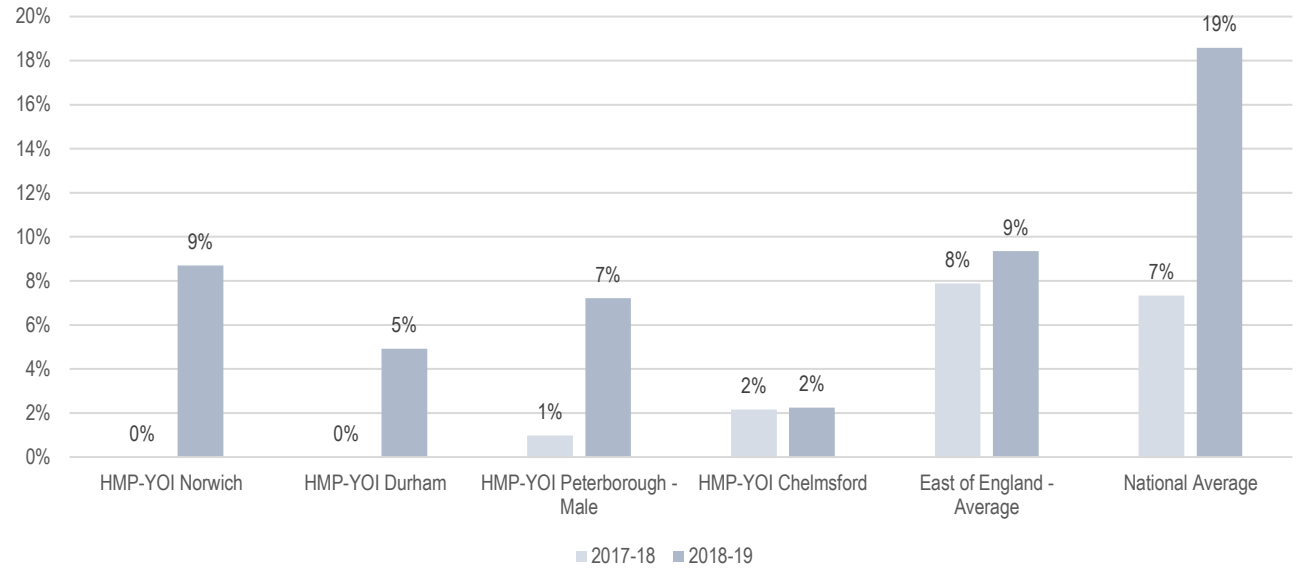
Provision

HMP Norwich – Retinopathy services are organised by the prison. The service visits the prison annually.

[38] HMP Durham data is not available until October 2017.

HMP Peterborough – A retinopathy service visits the prison twice a year.

Figure 1.3.5: Comparison against national and comparator prisons.



		2017-18		2018-19	
		Denominator	Numerator	Denominator	Numerator
HMP-YOI Norwich	Total	342	0	207	18
	Monthly Average	29	0	23	2
HMP-YOI Peterborough - Male	Total	513	5	319	23
	Monthly Average	43	0	35	3

BOWEL CANCER SCREENING

Definition [Guidance Enhanced]

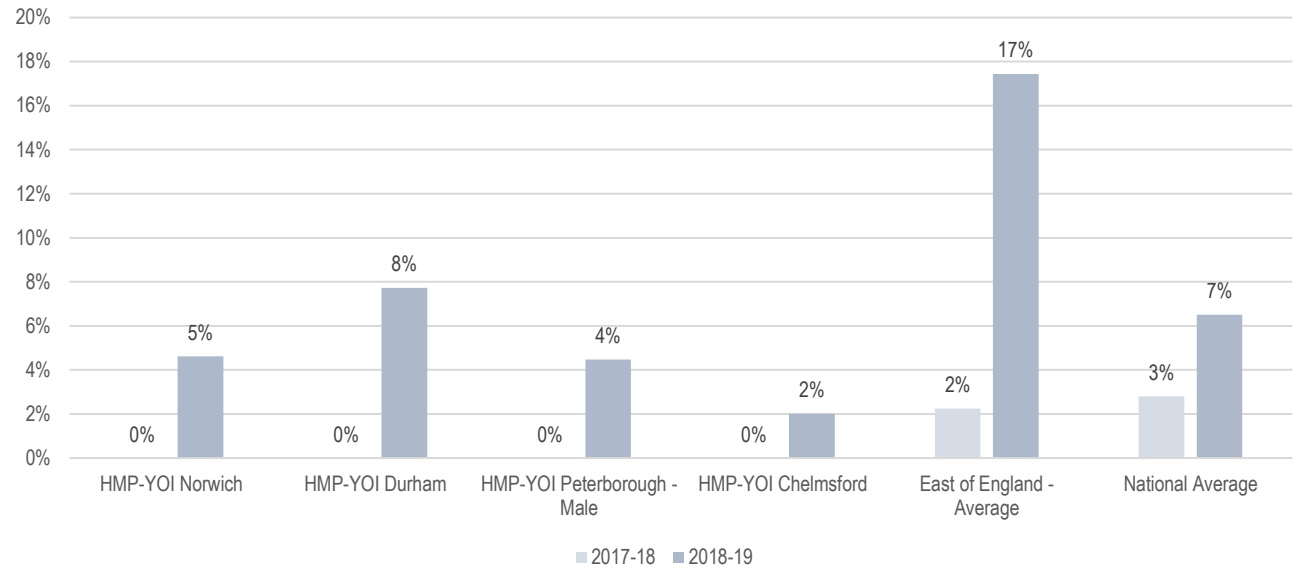
Denominator: Number of patients aged 60 – 74, who have not been screened in the last 2 years, during the reporting month.

Numerator: Number of patients with a result code of XaPkd (Normal) or XaPke (Abnormal) or XaPkc (unclear) or XaPkb (technical failure) or XaPka (kit spoilt), during the reporting month.

Provision

HMP Norwich – The lead nurse based on L-wing manages the bowel cancer screening for the whole prison.

Figure 1.3.6: Comparison against national and comparator prisons.



		2017-18		2018-19	
		Denominator	Numerator	Denominator	Numerator
HMP-YOI Norwich	Total	244	0	130	6
	Monthly Average	20	0	14	1
HMP-YOI Peterborough - Male	Total	87	0	67	3
	Monthly Average	7	0	7	0

Abdominal Aortic Aneurysm (AAA) Screening

Definition [Guidance Enhanced]

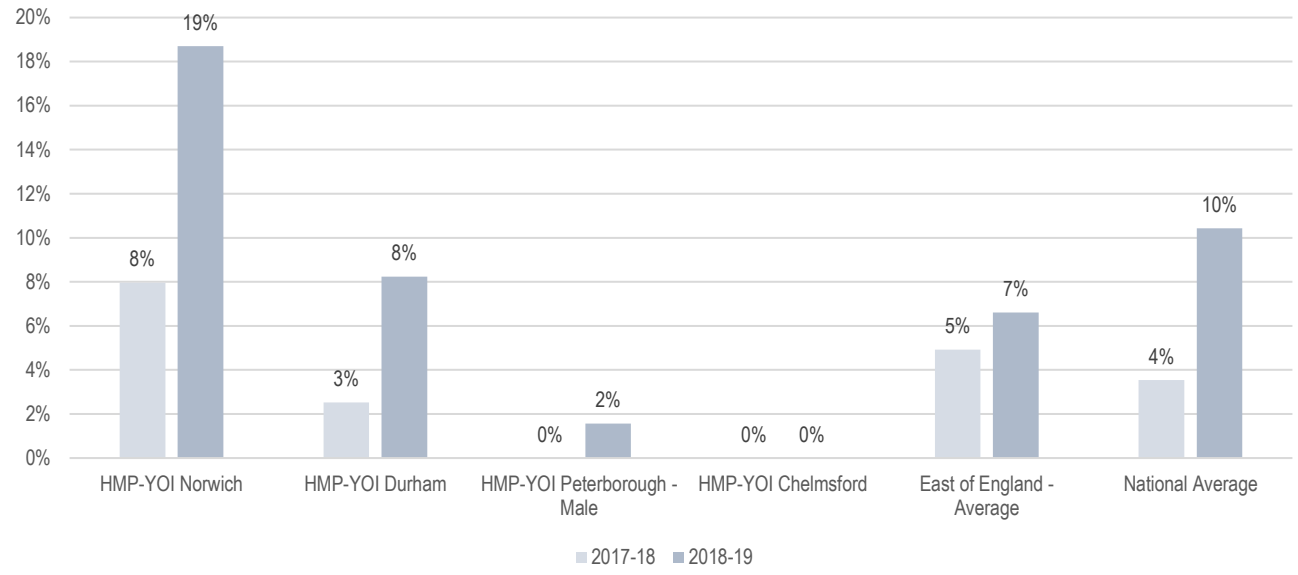
Denominator: All males >= 65 years old, except those with a read code of Normal (XaYVq), Declined (XaVxm), Abnormal (XaYVr), AAA occurred before screening age (X204N) or those already placed on a surveillance programme (Xad2n)

Numerator: Those patients receiving AAA ultrasound screening during the reporting period (XaYZb)

Provision

HMP Norwich – The AAA service visits, but their frequency depends on the numbers eligible for treatment.

Figure 1.3.7: Comparison against national and comparator prisons.



		2017-18		2018-19	
		Denominator	Numerator	Denominator	Numerator
HMP-YOI Norwich	Total	201	16	123	23
	Monthly Average	17	1	14	3
HMP-YOI Peterborough - Male	Total	109	0	64	1
	Monthly Average	9	0	7	0

NHS Health Checks

Definition [Guidance Enhanced]

Guidance Note: NHS Health Checks to NHS Physical Health Checks. The eligibility criteria and name of the NHS Physical Health Check in prison has changed. Prisons across England will be expected to collect data on Prison Physical Health Checks (A01K04).

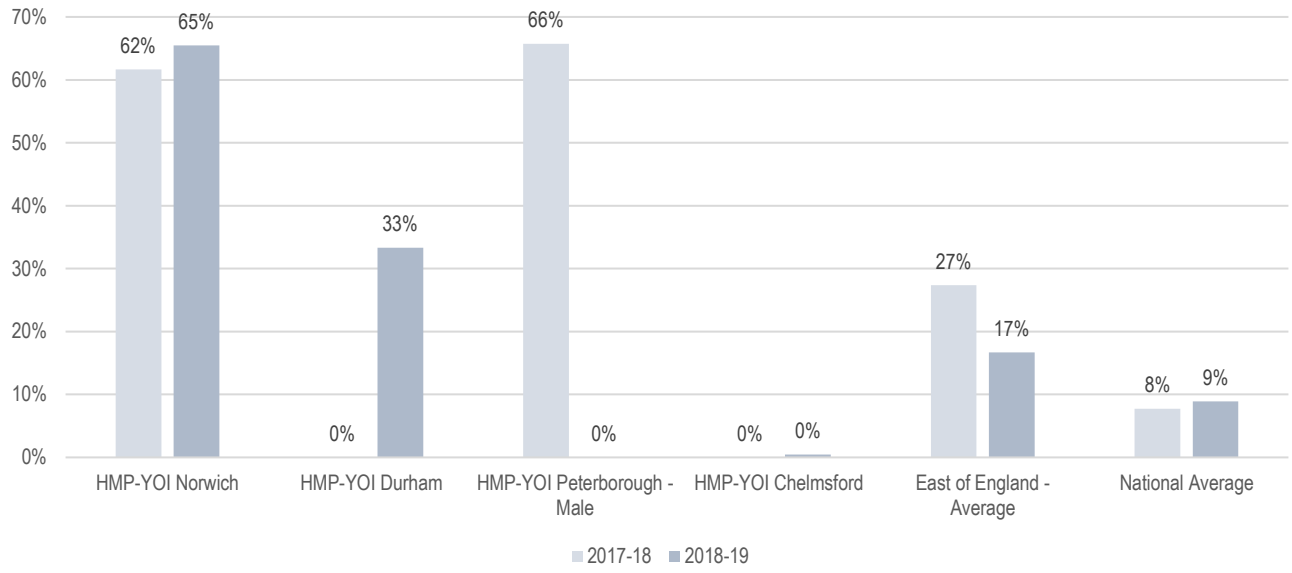
Denominator: All patients between the ages of 35 and 74 with a period of incarceration of two years or more (i.e sentenced to 4 or more years in custody), who have not received a health check in the preceding 5 years and do not have a diagnosis of coronary heart disease (XE2uV), chronic kidney disease (X30In), diabetes (C10..), hypertension (XE0Ub), atrial fibrillation (G5730), transient ischaemic attack (XE0VK), familial hypercholesterolemia (C3200), Heart failure (G58..), peripheral arterial disease (Xa0lV) or stroke (X00D1). Individuals: must not be being prescribed statins for the purpose of lowering cholesterol; must not have been assessed through a NHS Health Check, or any other check undertaken through the health service in England, and found to have a 20% or higher risk of developing cardiovascular disease over the next ten years.

Numerator: All patients receiving a physical health check in the reporting period. Read code XaR6f or XaRBQ (depending upon local practice)

Provision

HMP Norwich – NHS Health Checks are carried out in the prison.

Figure 1.3.8: Comparison against national and comparator prisons.



		2017-18		2018-19	
		Denominator	Numerator	Denominator	Numerator
HMP-YOI Norwich	Total	352	217	194	127
	Monthly Average	29	18	22	14
HMP-YOI Peterborough - Male	Total	2459	1616	834	0
	Monthly Average	205	135	93	0

CHLAMYDIA SCREENING UPTAKE

Definition [Guidance Enhanced]

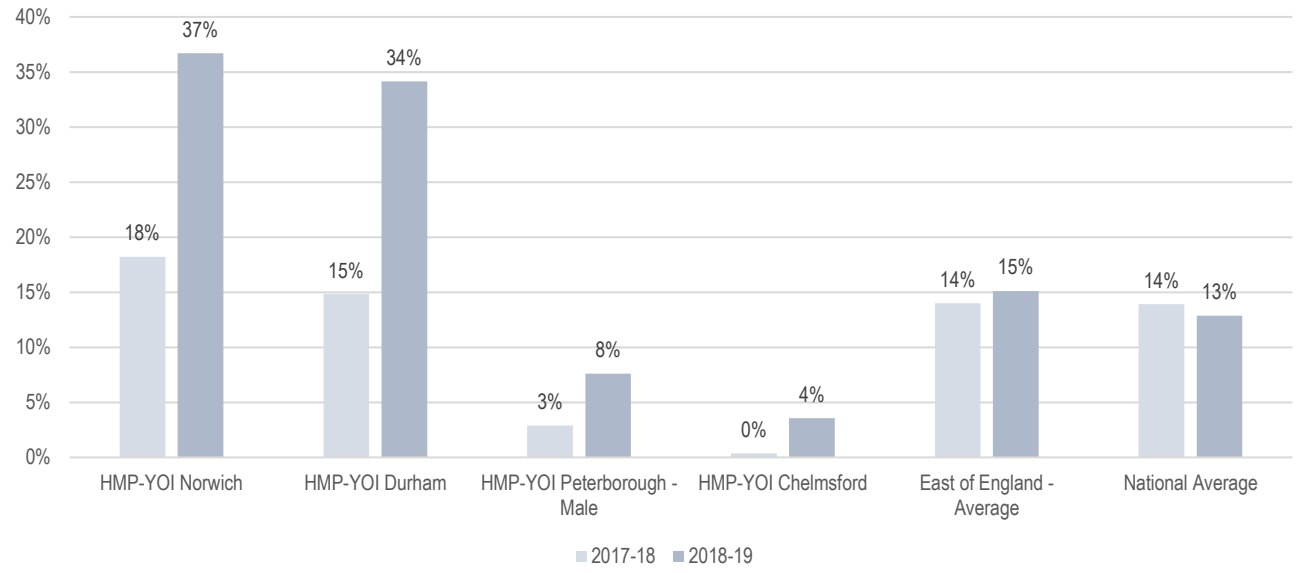
Denominator: All patients <=25 years, who have not been screened within their current sentence (do not have a code XaPwu when searched within the current sentence)

Numerator: All patients <=25 years with a code of XaPwu (Chlamydia screening)

Provision

Both prisons – Chlamydia and gonorrhoea tests are offered and given at the secondary health screen.

Figure 1.3.9: Comparison against national and comparator prisons.



		2017-18		2018-19	
		Denominator	Numerator	Denominator	Numerator
HMP-YOI Norwich	Total	774	141	414	152
	Monthly Average	65	12	46	17

DATA OVERVIEW

Figure 1.4.1: Overview of the data sources used for this HSCNA.			
Area	Data Source	Time Period	Comments
Reception Screen and Secondary Screen.	SystmOne	2016, 2017 and 2018 calendar years.	In both prisons, the screens used are based on the National Templates.
QOF	SystmOne	HMP Norwich: Snapshot as at 17th of January 2019. HMP Peterborough: Snapshot as at 1st of February 2019.	In HMP Norwich, the QOF data was used for the registers of different conditions. In addition, the information in the QOF was used to provide details of the management of these conditions. The QOF is generally reflective of actual activity in the prison.
HJIPs	HJIPs	April 2017 to December 2018.	The HJIPs is used to provide performance background to the different health areas. Comparisons against regional and national averages have been included. The comparisons also include the HJIP comparator prison.
Population and Demographic Data	C-NOMIS SystmOne MoJ Statistics	Various	A number of data sources were used. In general, SystmOne was used when analysis of health conditions was involved. Analysis of general demographic information used data from C-NOMIS and MoJ Statistics. This is due to limitations in SystmOne around some areas such as religion, ethnicity, sentence type.
Substance Misuse	NDTMS	2016-17, 2017-18 and 2018-19. 2018-19 data covers April 2018 to September 2018.	Used to provide substance misuse treatment information.
Other	Various	Various including the PHE toolkit and NICE.	A number of additional datasets and sources were used. These are referenced in the appropriate sections.
Surveys	S Squared	February 2019	
Interviews	Healthcare and prison staff	December 2018 to March 2019	

ENGAGEMENT

FOCUS GROUPS AND SURVEYS PAGE 58

INTRODUCTION

To support the health and social care needs assessment, prisoner surveys were run in both prisons. The surveys included questions on patients experience of healthcare, patient's general physical and mental health, and a section on substance misuse needs.

In HMP Norwich a paper survey was distributed to prisoners, with 22 surveys returned. In HMP Norwich, to supplement the surveys, minutes from the Healthcare Representative Forum meetings were used to highlight issues relating to healthcare. In HMP Peterborough, the surveys were included on the electronic kiosk machines used by prisoners to book appointments and communicate with the prison. There were 357 respondents. Unfortunately, due to a technical issue with the system, some answers were unusable.

HMP Norwich

SURVEY

In summary:

- 17 respondents, (80%), said that they had a physical health concern, with 20 respondents engaging with healthcare.
- 9 respondents, (47%), said that they were currently experiencing a mental health concern.
- Respondents believed that their offending behaviour and diet had the biggest impact on their health (6 respondents each (29%)).
- The table below shows the responses for how easy it was to access various services.

Figure 2.1.1: How easy is it to access the following services?

	Doctor	Nurse	Dentist	Optician	Mental Health service	Drug/ Alcohol services	Overall
Easy	71%	90%	63%	70%	36%	55%	78%
Neither	14%	5%	11%	20%	36%	45%	11%
Difficult	14%	5%	26%	10%	27%	0%	11%
Responses	21	21	19	20	11	11	18

- The table below shows the responses for the quality of various services:

Figure 2.1.2: What do you think of the quality of the following services?

	Doctor	Nurse	Dentist	Optician	Mental Health service	Drug/ Alcohol services	Overall
Easy	81%	94%	67%	67%	45%	67%	80%
Neither	13%	0%	13%	20%	27%	33%	13%
Difficult	6%	6%	20%	13%	27%	0%	7%

Responses	16	16	15	15	11	9	15

- The table below shows the responses for 'How do you rate the performance of healthcare in the following areas?'

Figure 2.1.3: How do you rate the performance of healthcare in the following areas?

	Information on healthcare services for prison staff	Information on healthcare services for patients	Waiting times	Access to nurses	Reduction in level of patients not attending appointments	Escorting of patients to healthcare appointments	Escorting of patients to secondary care appointments	Escorting of patients to emergency appointments	Reviews of care plans for patients with long-term conditions	Mental health training for prison and healthcare staff	Information on healthy lifestyles	Healthcare facilities
Unacceptable	0%	0%	5%	0%	8%	6%	6%	0%	6%	8%	0%	0%
Needs improvement	27%	17%	37%	10%	38%	11%	0%	13%	25%	33%	28%	24%
Meets expectations	27%	39%	21%	15%	31%	39%	53%	31%	31%	25%	22%	29%
Exceeds expectations	27%	28%	21%	30%	15%	28%	24%	31%	13%	25%	28%	24%
Outstanding	18%	17%	16%	45%	8%	17%	18%	25%	25%	8%	22%	24%
Responses	11	18	19	20	13	18	17	16	16	12	18	17

- 5 (24%) respondents considered their drug use to be a problem. The same number considered their alcohol use to be a problem.

FOCUS GROUPS

The patient and liaison officer runs regular Healthcare Representative Forum meetings in the prison. The officer made the minutes from previous forums available to the researchers and key points are highlighted below. The meetings are a chance for healthcare representatives to relay prisoners' experiences of healthcare.

H-wing

Healthcare representatives stated that sometimes patients have to wait 2-3 hours for medication, so they would like to see more staff available for medication administration.

Representatives said that some patients have had their dental appointments cancelled. Healthcare reported that occasionally there were issues with prison staffing which meant that patients could not make their appointments.

It was reported that there were no lockable lockers in cells on H-wing. Patients wanted these installed so that they will be able to have their medication in-possession.

L-Wing

Representatives said that the care on L-wing was very good. The nurses go the extra mile to make sure that needs are met.

There were some issues with medication. Firstly, there was confusion about repeat prescriptions not being processed, which caused delays in the receipt of medication. Secondly a patient receiving chemotherapy did not receive their medication twice in one week.

There was feedback on issues relating to external hospital appointments. Issues with transport had led to patients arriving late for appointments and on one occasion an appointment had been cancelled. Patients found external appointments stressful due to being chained and handcuffed.

SPECIALIST PATHWAYS

MENTAL HEALTH PAGE 62

SELF-HARM PAGE 83

LEARNING DISABILITIES PAGE 88

SOCIAL CARE PAGE 92

SUBSTANCE MISUSE PAGE 96

MENTAL HEALTH

OVERVIEW

INTRODUCTION

Mental health is covered in the PHE Toolkit. The Toolkit provides an overview, prevalence rates, and suggested data sources. [39]

The key points are:

- "...a recent Audit Office report shows that just 7% of short sentence prisoners accessed help from mental health services while nearly 60% of remand prisoners have a common mental disorder and 10% a psychotic disorder."
- "In a study of prisoners, 72% of male, and 71% of female prisoners were found to suffer from two or more mental disorders (including personality disorder, psychosis, neurosis, alcohol misuse and drug dependence), 20% suffered from four."
- "Presence of concurrent mental health and substance misuse problems can lead to difficulties in accessing support from either service."
- "The 2007 adult psychiatric morbidity survey shows that male remand prisoners are 20 times more likely to suffer psychosis and 20 times more likely to entertain suicidal thoughts than the general population."
- "Many people in contact with the criminal justice system have experience of interpersonal trauma, particularly women offenders. This has been linked to the onset of a range of mental health problems including post-traumatic stress disorder, depression, anxiety disorders and substance misuse."
- "29% of prisoners report having experienced emotional, physical or sexual abuse as a child, with the percentage much higher among women prisoners."
- "Limited availability of trauma informed mental health services can lead to poor responses to this client group."

ADDITIONAL LITERATURE

Published in 2009, the Bradley Review[40] looked specifically at diverting people with learning disabilities and mental health problems away from the criminal justice system.

The Bradley Review used a number of existing research papers for evidence, including *Too Little Too Late: An Independent Review of Unmet Mental Health Need in Prison*[41], *Bromley Briefings Factfile*[42], *No One Knows*[43], and the *Survey for the Office for National Statistics on Psychiatric Morbidity among Prisoners*.[44]

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

- At any one time, 10% of the prison population has serious mental health problems.
- 96% of prisoners with mental disorders returned to the community without supported housing, including 80% of those who had committed the most serious offences; more than three quarters had been given no appointment with outside carers.
- There are now more people with mental health problems in prison than ever before.
- Self-harm and suicide rates are significantly higher in the prison population compared to the general population.

[39] Public Health England (2014), *Health and Justice Health Needs Assessment Template: Adult Prisons (part 2)*.
40 Department of Health (2009), *The Bradley Report*.
41 Prison Reform Trust (2009), *Too Little Too Late: An Independent Review of Unmet Mental Health Need in Prison*.
42 Prison Reform Trust (2009), *Bromley Briefings Factfile*.
43 Prison Reform Trust (2008), *No One Knows*.
44 ONS (1998), *Survey for Psychiatric Morbidity among Prisoners*.

- People from black and minority ethnic (BME) communities with mental health problems represent about 10% of the UK population, but in prison, this rises to approximately 20%.
- There is conflicting research on the effect of prison on the mental health of prisoners. A paper released by Advances in Psychiatric Treatment[45] argued that imprisonment is detrimental to mental health. However, in 2010, the results of a study by the Offender Health Research Network (OHRN[46]) indicate that prison does not have a universally detrimental effect on mental health.

Coid et al. (2002)[47] found less mental ill health among Afro-Caribbean prisoners than among white prisoners, although these findings may partially be explained by a failure to recognise mental illness in Afro-Caribbean prisoners by healthcare staff[48] and a reluctance to seek help for mental health problems among these prisoners. This reflects the difficult relationship between Afro-Caribbean communities and mental health services (SCMH, 2002). [49]

The *Sainsbury Centre for Mental Health Report* suggests that treatment of people from BME communities is hampered by mutual mistrust between professionals in mental health and people from BME groups. The study concludes that too often, black people come to the attention of mental health services at a late stage and are often severely ill before they begin to receive treatment.

POLICY AND GUIDANCE

In February 2016 an independent mental health taskforce published *The Five Year Forward View for Mental Health*[50]. This made a series of recommendations for the NHS and government to improve outcomes in mental health by 2020-21, including ending the practise of sending people out of their local area for inpatient care and increasing access to talking therapies.

In October 2017, the government commissioned a review of the Mental Health Act 1983, in response to concerns about rising rates of detention and the disproportionate use of the Act among people from black and minority ethnic (BAME) groups. An interim report was published in May 2018 and flags several areas for change, such as 'advance planning' decisions so patients' preferences about their care receive suitable consideration. The review is also gathering evidence on the use of the Act among people from BAME groups.[51]

The full set of NICE guidelines for mental health conditions can be found on the following links:

https://www.nice.org.uk/guidancemenu/conditions-and-diseases/mental-health-and-behavioural-conditions

https://www.nice.org.uk/guidance/qs163

[45] Birmingham, L., 'The Mental Health of Prisoners', *Advances in Psychiatric Treatment*, (2003, 9 (3) pp191-199).
[46] OHRN (2010), *The pathway of prisoners with mental health problems through prison health services and the effect of the prison environment on the mental health of prisoners*.
[47] Coid, J., 'Ethnic differences in prisoners', *The British Journal of Psychiatry*, Dec 2002.
[48] Knight, L. and Stephens, M., 'Mentally Disordered Offenders in Prison: A Tale of Neglect', *International Journal of Criminology*, 2009.
[49] The Sainsbury Centre for Mental Health (2002), *Breaking the Circles of Fear*.
[50] Mental Health Taskforce to the NHS in England (2016), *The Five Year Forward View for Mental Health*.
[51] House of Commons Library (2018), *Mental Health Policy in England*

PREVALENCE

The following pages provide a summary of the prevalence rates outlined in the PHE Toolkit against local prevalence.

The chart (figure 3.1.1) shows:

- Expected Prevalence: This is the expected prevalence for each mental health condition. The calculation is based on the prevalence rates taken from the PHE Toolkit.
- 2019 Norwich READ %: This is the prevalence for the population as at the time of this HSNCA. The prevalence are for where the codes were entered in HMP Norwich.
- 2019 Peterborough READ %: This is the prevalence for the population as at the time of this HSNCA. The prevalence are for where the codes were entered in HMP Peterborough.
- Note that the READ codes used for this chart can be found in the table (figure 3.1.2).

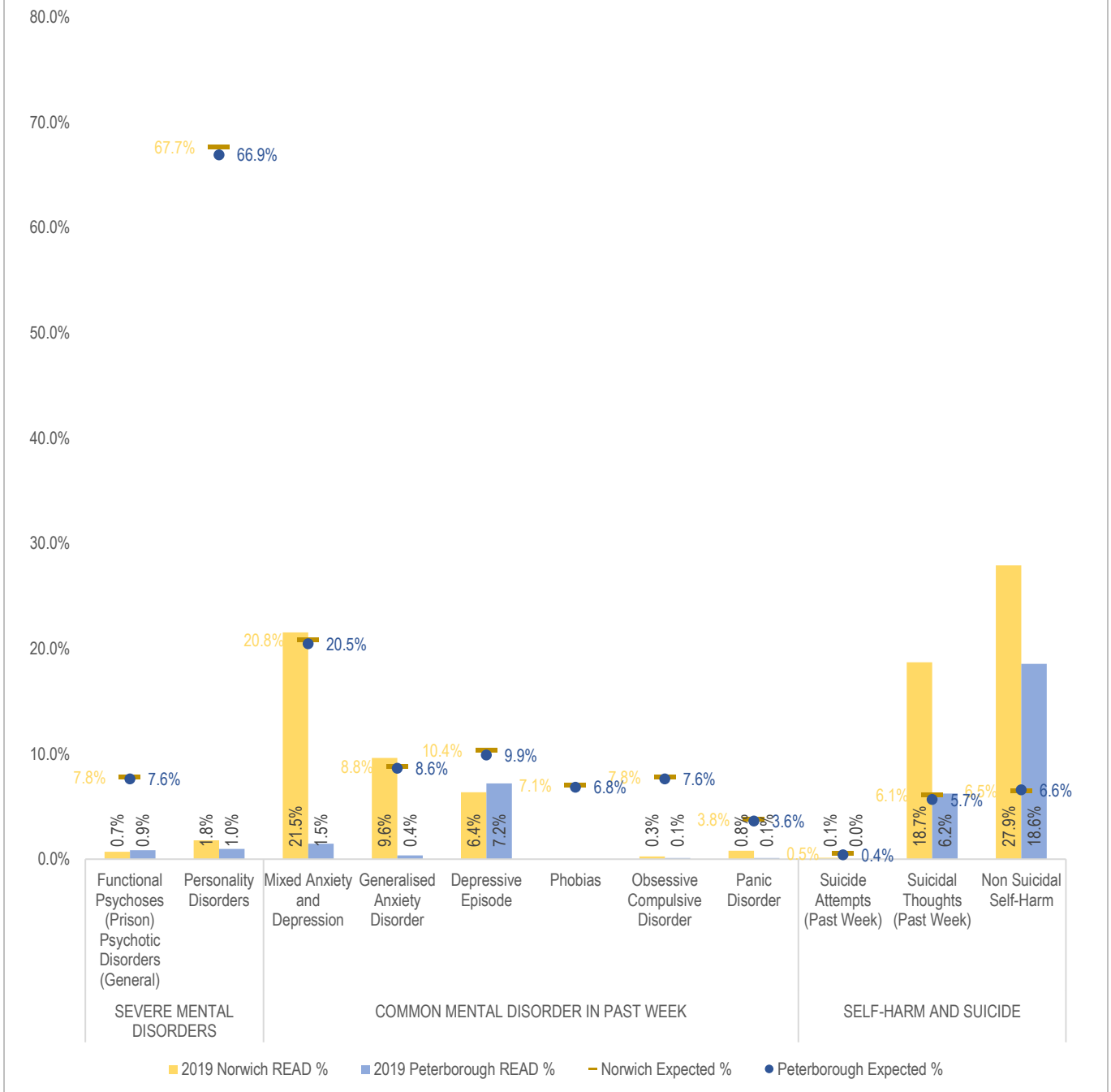
The table (figure 3.1.2) is similar to the chart (figure 3.1.1), however background data information is included such at the actual number of prisoners with the READ code, and the READ code used. The prevalence in the table contains two figures; the rate of the population coded at the present establishment and the rate inclusive of the code being entered at a previous location.

It should be noted that the READ codes recorded for a prisoner may not still be relevant. For example, those coded with "(Y0904) Prisoner feels like Self Harming or Suicide" may have been recorded at the reception screen and are no longer applicable to the prisoner.

For severe mental health disorders, the prevalence across both prisons is similar and lower than the expected rate. The expected prevalence for personality disorders is around 67%, however based on the READ code "(XE2b6) Personality disorder", the rate was 1.8% in HMP Norwich and 1.0% in HMP Peterborough.

There are 6 conditions associated as common mental health disorders. For mixed anxiety and depression, and generalised anxiety disorder, the rate in HMP Norwich is significantly higher than HMP Peterborough, and is similar to the expected rate.

Figure 3.1.1: Prevalence taken from PHE Toolkit; local prevalence based on SystmOne READ codes[52].

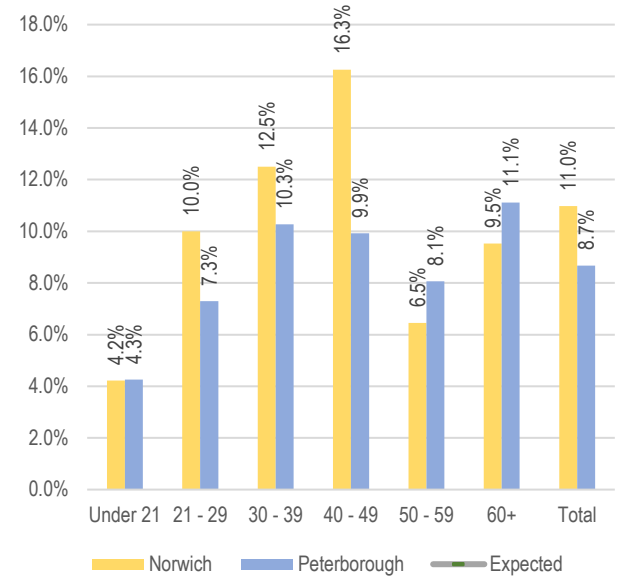


[52] PHE Toolkit; SystmOne

		HMP Norwich Expected	HMP Norwich	HMP Norwich (Any Establishment)
SEVERE MENTAL DISORDERS	Functional Psychoses (Prison) [(X00S6) Psychotic disorder]	7.8% (54)	0.7% (5)	2.4% (18)
	Personality Disorders [(XE2b6) Personality disorder]	67.7% (466)	1.8% (13)	5.0% (37)
COMMON MENTAL DISORDER IN PAST WEEK	Mixed Anxiety and Depression [(X00Sb) Mixed anxiety and depressive disorder]	20.8% (144)	21.5% (159)	26.8% (198)
	Generalised Anxiety Disorder [(E2002) Generalised anxiety disorder]	8.8% (61)	9.6% (71)	10.6% (78)
	Depressive Episode [(X00SO) Depressive disorder]	10.4% (71)	6.4% (47)	18.4% (136)
	Phobias	7.1% (49)		
	Obsessive Compulsive Disorder [(E203.) Obsessive-compulsive disorder]	7.8% (54)	0.3% (2)	0.9% (7)
	Panic Disorder [(XE1Y7) Panic disorder]	3.8% (26)	0.8% (6)	2.0% (15)
SELF-HARM AND SUICIDE	Suicide Attempts (Past Week) [(Ua18F) Suicide attempt]	0.5% (4)	0.1% (1)	4.7% (35)
	Suicidal Thoughts (Past Week) [(1BD1.) Suicidal thoughts]	6.1% (42)	18.7% (138)	27.2% (201)
	Non Suicidal Self-Harm [(YX020) Prisoner has tried to harm themselves (in prison)]	6.5% (45)	27.9% (206)	36.3% (268)

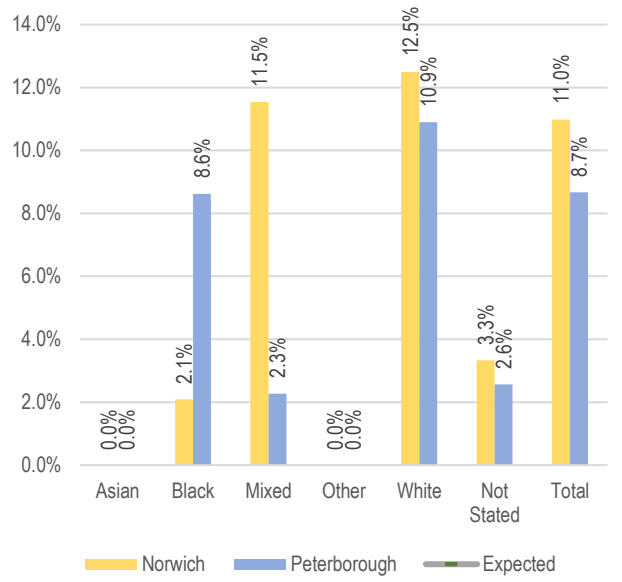
The following tables provides a summary of the prevalence of the mental health QOF register as at January 2019.

Figure 3.1.3: QOF prevalence; age.



	Under 21	21 - 29	30 - 39	40 - 49	50 - 59	60+	Total
Norwich							
Population	71	200	240	123	62	42	738
Mental Health	3	20	30	20	4	4	81
Expected							-
Peterborough							
Population	47	288	292	121	62	9	819
Mental Health	2	21	30	12	5	1	71
Expected							-

Figure 3.1.4: QOF prevalence; ethnicity.



	Asian	Black	Mixed	Other	White	Not Stated	Total
Norwich							
Population	13	48	26	13	608	30	738
Mental Health	0	1	3	0	76	1	81
Expected							0
Peterborough							
Population	48	58	44	13	578	78	819
Mental Health	0	5	1	0	63	2	71
Expected							0

CURRENT PROVISION

HMP NORWICH
The mental health team is part of Virgin Care. In April 2019, Norfolk and Suffolk NHS Foundation Trust will become the mental health provider. The mental health team is an integrated primary and secondary mental health team. Norfolk and Suffolk NHS Foundation Trust also provides local liaison and diversion services and the wellbeing team within the prison.

Job Title	Number
Team Manager	1
Support Worker	2
RMN	6
Administrator	1
Consultant Psychiatrist	0.3
Psychologist	Vacant

NEED/PROVISION	HMP NORWICH
NEED	
PROVISION	
NEED	
PROVISION	Patients with a personality disorder can be managed on the caseload of the mental health team. When the psychologist was in post, patients with suspected personality disorders could have been given a diagnosis. The psychologist also had a role in highlighting to the prison when a patient should be on the prison personality disorder pathway. The mental health team also attend the CCIP (complex case) meeting run by the prison. Mental health practitioners provide advice to the prison on the management of patients. The management of patients with personality disorder can be the biggest disruption for the prison. Mental health staff assist by adding to prisoners' management plans.

NEED/PROVISION	HMP NORWICH
NEED	
PROVISION	The IAPT service offer interventions to patients with mild to moderate mental health conditions.
NEED	
PROVISION	There is no counselling provision in the prison.
NEED	
PROVISION	Previously there was a substance misuse nurse within the mental health team. This nurse ran joint groups with Phoenix Futures. The mental health team manager believed that these groups were a good resource and would like to restart them. Patients attending the group required a joint needs assessment to be completed by the mental health team and Phoenix Futures.
NEED	
PROVISION	There are currently 15 listeners in the prison.
NEED	
PROVISION	There is a consultant psychiatrist who visits the prison for one and a half days a week. The psychiatrist had previously been in the prison on a Friday too, although this time has been reduced. The team manager stated that the team have adjusted to the reduced psychiatry time. There

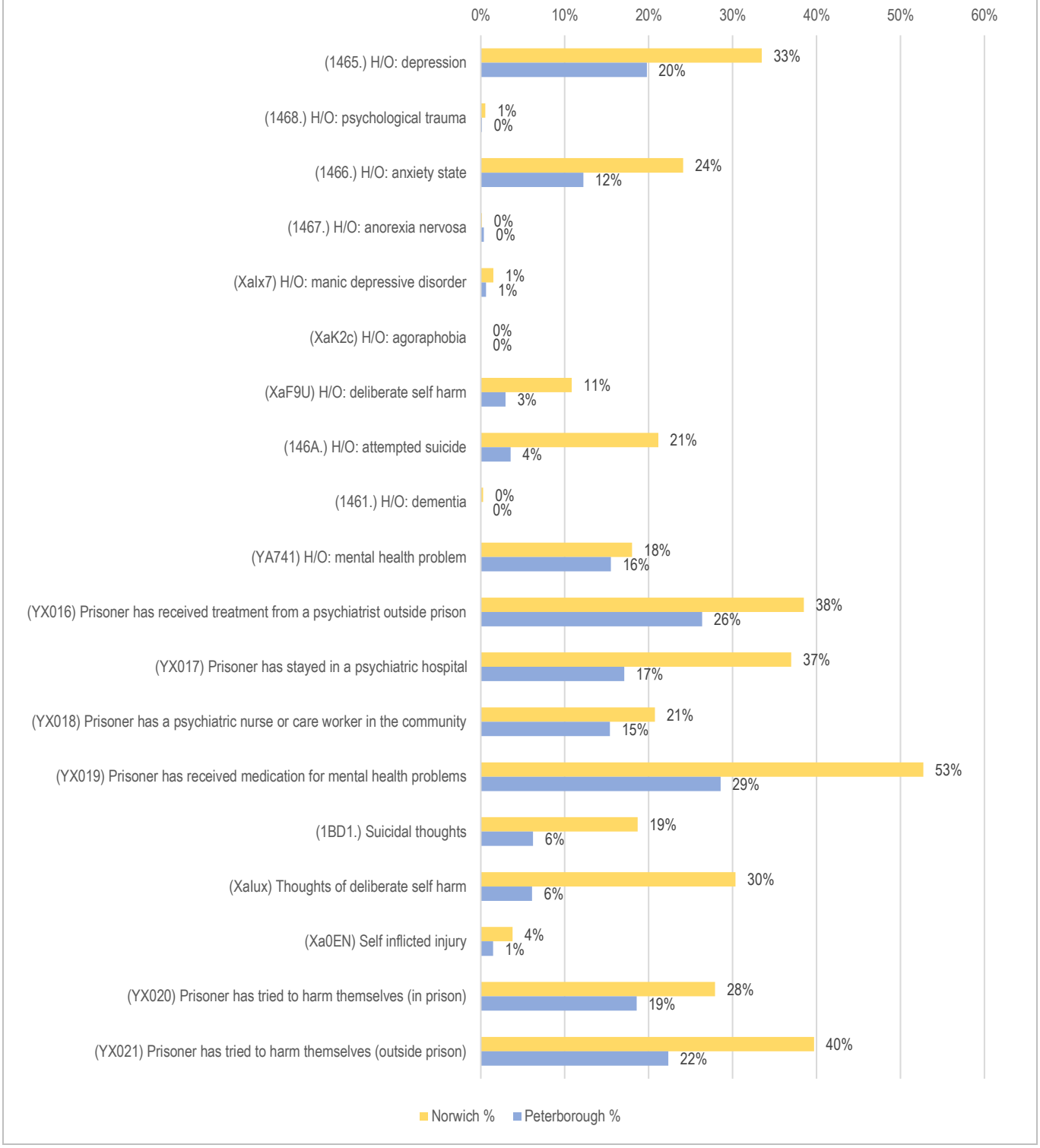
NEED/PROVISION	HMP NORWICH
	is now a more efficient managing of psychiatry appointments.
NEED	
PROVISION	Data regarding patients who have suffered childhood sexual abuse is not collected, however the psychological therapist said that 9 out the 10 clients on their caseload have suffered some form of child sexual abuse. There is no counselling provision in the prison. The IAPT service does not cover those requiring help with childhood sexual abuse. When in post, the psychologist held a caseload of patients including those suffering from trauma related issues.
NEED	
PROVISION	There is no training from the mental health team.
NEED	
PROVISION	There is a vacant psychology position. This position is not likely to be filled prior to the provider changing in April 2019. When in the post, the psychologist worked with the prison on the management of patients with a higher risk. The psychologist was also able to help with diagnosing conditions such as personality disorders. The psychologist also had a role in highlighting to the prison when a patient should be on the prison personality disorder pathway. The psychologist also had a role in completing staff training and supervision.

NEED/PROVISION	HMP NORWICH
NEED	
PROVISION	The number of patients transferred to a mental health secure unit has increased. There is a dearth of local beds, which meant that patients could be sent to units further away from Norwich. Between April 2018 and December 2018, there were a total of 14 mental health secure assessments in HMP Norwich, up from 9 over the same period of the previous year. None of the 8 patients transferred to a secure unit between April 2018 and December 2018 were within the recommended target of 14 days. In comparison, the previous year saw 3 of the 7 transfers done within 14 days.
NEED	
PROVISION	Patients with dementia tend to be managed on L-wing in the prison. L-wing is staffed by experienced nurses and health care assistants and also has a visiting dementia charity.
NEED	
PROVISION	

RECEPTION

Questions relating to mental health are included in the reception screening process in both prisons. As shown in figure 3.1.5, the questions asked in both prisons are similar. The following information looks at the mental health related READ codes collected at reception and the prevalence of the current population. Across the range of codes, the prevalence is higher in HMP Norwich than in HMP Peterborough.

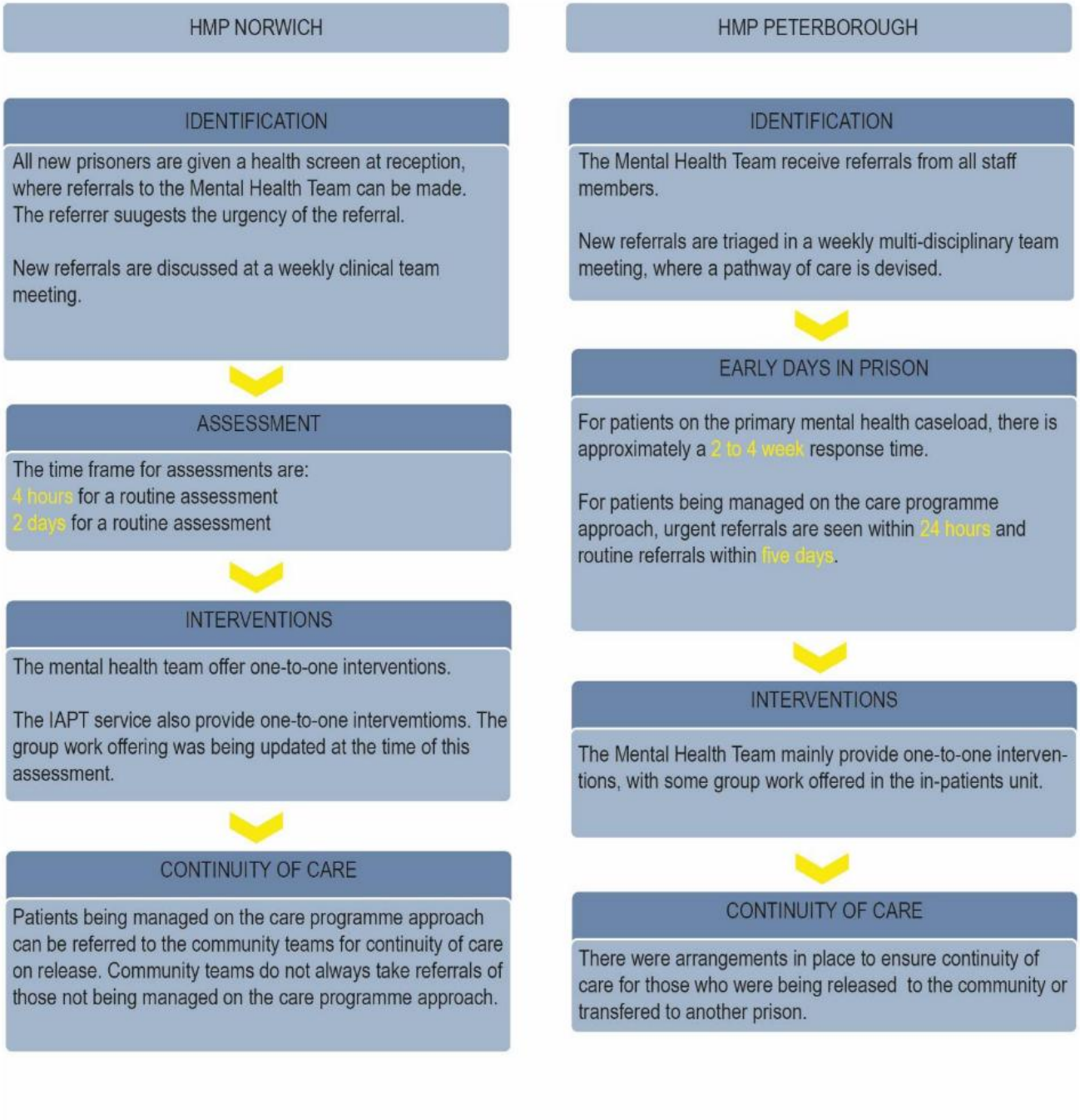
Figure 3.1.5: Mental health related READ codes from the reception screen; prevalence of the current population.



	Norwich		
READ Code	Reception Screen	Norwich #	Norwich %
(1465.) H/O: depression	Y	247	33%
(1468.) H/O: psychological trauma	Y	4	1%
(1466.) H/O: anxiety state	Y	178	24%
(1467.) H/O: anorexia nervosa	Y	1	0%
(Xalx7) H/O: manic depressive disorder	Y	11	1%
(XaK2c) H/O: agoraphobia	Y	0	0%
(XaF9U) H/O: deliberate self-harm	Y	80	11%
(146A.) H/O: attempted suicide	Y	156	21%
(1461.) H/O: dementia	Y	2	0%
(YA741) H/O: mental health problem	Y	133	18%
(YX016) Prisoner has received treatment from a psychiatrist outside prison	Y	284	38%
(YX017) Prisoner has stayed in a psychiatric hospital	Y	273	37%
(YX018) Prisoner has a psychiatric nurse or care worker in the community	Y	153	21%
(YX019) Prisoner has received medication for mental health problems	Y	389	53%
(1BD1.) Suicidal thoughts	Y	138	19%
(Xalux) Thoughts of deliberate self-harm	Y	224	30%
(Xa0EN) Self-inflicted injury	Y	28	4%
(YX020) Prisoner has tried to harm themselves (in prison)	Y	206	28%
(YX021) Prisoner has tried to harm themselves (outside prison)	Y	293	40%

TREATMENT PATHWAY

The diagram below shows the mental health treatment pathway for the two prisons.



HMP NORWICH
All new prisoners are given a health screen at reception, where referrals to the mental health team can be made. The referrer suggests the urgency of the referral. There is a weekly clinical team meeting where new referrals are discussed. The meeting is attended by mental health staff and the psychiatrist. Patients who do not meet the criteria for the mental health team can be referred to the wellbeing team.
There is always a mental health nurse available to run assessments. The time frame for assessments is four hours for an emergency and two days for a routine assessment. The mental health team manager said that they were seeing more complex mental health needs within the team. This could be related to a lack of community care.

INTERVENTIONS

INTRODUCTION

In March 2017, NICE released guidance for the treatment of adults with mental health problems in contact with the criminal justice system.[53] The document does not give specific recommendations for interventions, but instead refers practitioners to existing NICE guidance. The new guidance makes the point that there is a need "to modify the delivery of psychological interventions in the criminal justice system" and "to ensure continuity of the psychological intervention (for example, transfer between prison settings or on release from prison)".[54]

Prevalence figures indicate that there is a high need in prison relating to all mental health disorders (see figure 3.1.1). The table below is taken from NICE guidelines and shows the stepped care model for people with common mental health disorders including the recommended interventions. The table also includes a column showing how the provisions are met in HMP Norwich and HMP Peterborough

Focus of the intervention	Nature of the intervention		
Step 3: Persistent subthreshold depressive symptoms or mild to moderate depression that has not responded to a low-intensity intervention; initial presentation of moderate or severe depression; GAD with marked functional impairment or that has not responded to a low-intensity intervention; moderate to severe panic disorder; OCD with moderate or severe functional impairment; PTSD.	**Depression:** CBT, IPT, behavioural activation, behavioural couples therapy, counselling*, antidepressants, combined interventions, collaborative care**, self-help groups.		HMP Norwich
		CBT	CBT interventions are offered by the IAPT service.
		IPT	This is not offered in the prison.
		Counselling	This is not offered in the prison.
		Antidepressants	The psychiatrist and GP can prescribe medication where necessary.
		Self-help groups	There is no group work focussed on those who are on step 3 of the stepped care model.
	GAD: CBT, applied relaxation, drug treatment, combined interventions, self-help groups.	CBT	CBT interventions are offered by the IAPT service.
		Applied relaxation/ Self-help groups	There is no group work focused on those who are on step 3 of the stepped care model.
		Drug treatment	The psychiatrist can prescribe medication where necessary.
	Panic disorder: CBT, antidepressants, self-help groups.	CBT	CBT interventions are offered by the IAPT service.

[53] NICE, (2017), Mental health of adults in contact with the criminal justice system [NG66]
[54] NICE, (2017), Mental health of adults in contact with the criminal justice system [NG66]

		Antidepressants	The psychiatrist and GP can prescribe medication where necessary.
		Self-help groups	There is no group work focussed on those who are on step 3 of the stepped care model.
	OCD: CBT (including ERP), antidepressants, combined interventions and case management, self-help groups.	CBT including ERP	CBT interventions are offered by the IAPT service.
		Antidepressants	The psychiatrist and GP can prescribe medication where necessary.
		Self-help groups	There is no group work focused on those who are on step 3 of the stepped care model.
	PTSD: Trauma-focused CBT, EMDR, drug treatment.	Trauma-focused CBT	CBT interventions including trauma focused CBT are offered by the IAPT service.
		EMDR	This is not offered in the prison
		Drug treatment	The psychiatrist can prescribe medication where necessary.
	All disorders: Support groups, befriending, rehabilitation programmes, educational and employment support services; referral for further assessment and interventions.	Support groups	There is no group work focused on those who are on step 3 of the stepped care model.
Step 2: Persistent subthreshold depressive symptoms or mild to moderate depression; GAD; mild to moderate panic disorder; mild to moderate OCD; PTSD (including people with mild to moderate PTSD).	**Depression:** Individual facilitated self-help, computerised CBT, structured physical activity, group-based peer support (self-help) programmes**, non-directive counselling delivered at home†, antidepressants, self-help groups.	Individual facilitated self-help	The IAPT service run facilitated self-help interventions.
		Computerised CBT	
		Group-based peer support programmes	There are limited group work interventions for those on step 2 of the stepped care model.
		Antidepressants	The GP can prescribe.

		Self-help groups	There are limited group work interventions for those on step 2 of the stepped care model.
	GAD and panic disorder: Individual non-facilitated and facilitated self-help, psychoeducational groups, self-help groups.	Individual facilitated/ non-facilitated self-help	The IAPT service run facilitated self-help interventions.
		Psychoeducational groups/ Self-help groups	There are limited group work interventions for those on step 2 of the stepped care model.
	OCD: Individual or group CBT (including ERP), self-help groups.	Individual/group CBT	One to one CBT interventions are offered.
		Self-help groups	There are limited group work interventions for those on step 2 of the stepped care model.
	PTSD: Trauma-focused CBT or EMDR.	Trauma-focused CBT	CBT interventions including trauma focused CBT are offered by the IAPT service.
		EMDR	
	All disorders: Support groups, educational and employment support services; referral for further assessment and interventions.	Support groups	There are limited group work interventions for those on step 2 of the stepped care model.
Step 1: All disorders – known and suspected presentations of common mental health disorders.	**All disorders:** Identification, assessment, psychoeducation, active monitoring; referral for further assessment and interventions.		

MENTAL HEALTH TRANSFERS

Between April 2018 to December 2018, there were a total of 14 mental health secure assessments in HMP Norwich, which is up from 9 over the same period of the previous year. None of the 8 patients transferred to a secure unit between April 2018 to December 2018 were transferred within the recommended target of 14 days. In comparison, the previous year saw 3 of the 7 transfers carried out within 14 days.

Figure 3.1.6: Mental health transfer activity based on HJIPs.	HMP Norwich		HMP Peterborough	
	Apr-17 to Dec-17	Apr-18 to Dec-18	Apr-17 to Dec-17	Apr-18 to Dec-18
Mental Health Secure Assessment	9	14	21	15
Awaiting 2nd Assessment	-	4	-	18
Awaiting Transfer	-	10	-	7
Triage/ Initial Assessment Activity	-	759	-	57
Treatment Activity	-	1181	-	776
Continuity of Care	-	11	-	53
MH Secure Transfer - <=14 days	3	0	14	0
MH Secure Transfer – between 15 days & 28 days	1	5	0	5
MH Secure Transfer – between 29 days & 56 days	3	2	1	3
MH Secure Transfer – between 57 days & 84 days	0	1	1	1
MH Secure Transfer – between 85 days & 140 days	0	0	0	0
MH Secure Transfer – > 140 days	0	0	0	0

IAPT SERVICES

INTRODUCTION

In HMP Norwich, there is a separately commissioned IAPT service. The IAPT service in HMP Norwich is provided by Norfolk and Suffolk NHS Trust. The trust will take over provision of the Mental Health Team in April 2019.

Previously, the IAPT service covered the three Norfolk prisons, with practitioners working across all three prisons. Now, there are dedicated staff members in each of the prisons. This has reduced the amount of time lost to travelling between establishments.

The IAPT team in HMP Norwich is made up of:

1 x Psychological therapist

2 x Practitioners

REFERRALS

Referrals can come from any source, including self-referrals. The majority of referrals come to the IAPT team via the mental health team.

ASSESSMENTS

The IAPT team aim to complete assessments within 28 days of the referral being received. When the service is particularly busy, this time frame can be breached.

INTERVENTIONS

The IAPT service provide interventions to those on Step 2 and Step 3 on the mental health stepped care model. The IAPT team predominantly offer one-to-one interventions. Group work is currently being updated, and there is a plan for there to be more group work offered following the change in healthcare provider in April 2019.

Patients receiving Step 2 interventions receive six to eight 40-minute sessions. Some step 2 groups are run on an ad hoc basis.

Patients receiving Step 3 interventions receive 12-20 1-hour sessions.

New one-to-one interventions have been developed to specifically meet the needs of those in prison. There are work books covering:

- Coming to prison
- Leaving prison
- Anxiety and depression
- Sleep

For patients with trauma, the IAPT service runs CBT-based interventions.

SELF-HARM

INTRODUCTION

The incidence of self-harm in prison is rising across the prison estate, particularly among older adult males.[55] A 2018 HMPPS rapid evidence assessment[56] on self-harm by adult men in prison was run in order to understand:

- Why do adult men in prison self-harm?
- What works to reduce and/or manage self-harm among adult men in prison?

The report reiterated a number of risk factors for men who self-harm in prison. It also found that there is "very little evidence on protective factors and limited research exploring the relationships between risk and protective factors."[57] Risk factors for men who self-harm include-

Socio-demographic factors:

- Age – younger men have a higher rate of self-harm than older men in prison, but older men (30+) who self-harm tend to do so in ways that result in more serious injury
- Ethnicity – self-harm rates are higher among white men
- Educational background – increased risk of self-harm among those lacking in formal education
- Relationship status – increased risk of self-harm among those who are single and/or have experienced a recent breakdown of relationship
- Accommodation – increased risk of self-harm among those who have no fixed abode

Custodial/prison-related factors:

- People are at increased risk of self-harm in their early days in prison
- There are higher rates of self-harm in prisoners who are on remand or unsentenced and those serving a life sentence
- Higher rates of self-harm are seen in local prisons, high security prisons, and Young Offender Institutes
- There are higher rates of self-harm in prisoners who have a high number of disciplinary infractions

Psychological/psychiatric factors:

- History of self-harm – having a history of self-harm is a good predictor of future self-harming behaviour both prior to and in custody
- Depression/hopelessness
- Borderline personality disorder (BPD)
- Substance misuse

In December 2013, the results of the largest ever study of self-harm and suicide in prison was published by The Lancet.[58] The report found that in England and Wales, standardised mortality ratios for suicide are five times higher in male prisoners than in the general population.

[55] HMMPS, (2018), Self-harm by adult men in prison: A rapid evidence assessment (REA)
[56] HMMPS, (2018), Self-harm by adult men in prison: A rapid evidence assessment (REA)
[57] HMMPS, (2018), Self-harm by adult men in prison: A rapid evidence assessment (REA)
[58] Royal College of Psychiatrists (2011), Prison transfers.

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

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

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

LOCAL PROVISION

<table>
<tr><th>HMP NORWICH</th></tr>
<tr><td>There are good links between the prison and healthcare relating to the care of patients with self-harm problems.</td></tr>
<tr><td>HMP Norwich had an up-to-date self-harm and suicide prevention policy. The policy was due to be reviewed in August 2019.</td></tr>
<tr><td>The pathway for suicide and self-harm is detailed in the self-harm and suicide prevention policy. The role of healthcare in self-harm prevention is detailed in the self-harm and suicide policy.</td></tr>
<tr><td>At the time of this assessment, there were 28 open ACCT documents.

There are approximately 50 new ACCT documents opened per month. ACCT documents are most commonly opened on A-wing, which includes the induction unit and the IDTS wing.

There is good mental health staff attendance at ACCT meetings. Mental health staff attend all ACCT reviews for clients on their caseload. The head of safer custody said that the mental health staff provided valuable input into how to work with patients with self-harm needs.

Mental health staff write development plans for patients with complex needs. Patients with complex needs are discussed by prison staff at a weekly safety intervention meeting.

HMP Norwich are piloting a new ACCT document on behalf of the prison system. The pilot will start in January 2019.

There is a monthly safer custody meeting, which is attended by Listeners when possible. Due to staff shortages, Listeners are not able to be escorted to the safer custody meeting.

The table below shows the number of open ACCT documents since 2016:

<table>
<tr><th>Year</th><th>ACCTs Opened</th></tr>
<tr><td>2018</td><td>536</td></tr>
<tr><td>2017</td><td>576</td></tr>
<tr><td>2016</td><td>548</td></tr>
</table>
</td></tr>
</table>

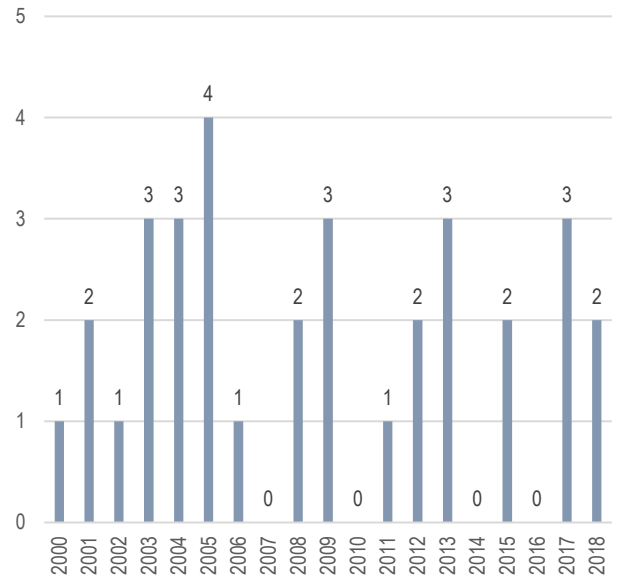
There are currently 15 Listeners in the prison which meets the recommended number of 1 per 50 population. Listeners were mainly based on M and C-wing. There are no listeners based on A or B-wing, where the majority of ACCT documents are opened. There are two reception orderlies who oversee reception.

There are Samaritans phones on each unit. There are some issues relating to phone reception on some of the wings, however the Samaritan phones work in the listener suites.

Self-harm issues and trends are analysed at the monthly suicide and self-harm meetings. Cutting and ligatures are the main methods of self-harm.

From local data, between 1 January 2018 until 11 December 2018, there were 433 incidents of self-harm. MoJ statistics show that there were 319 incidents for the 12 months to June 2018, which is an increase on previous years. This is also highlighted in the performance digest.

Figure 3.2.2: Number of self-inflicted deaths in HMP Norwich.



SELF-HARM INCIDENTS - NORWICH

Below are the number of self-harm incidents recorded in HMP Norwich as reported in the MoJ statistics[59]. Data for HMP Peterborough is not available by the female and male prisoner population and therefore have not been included.

Figure 3.2.4: Number of incidents; 12 months to June of year.

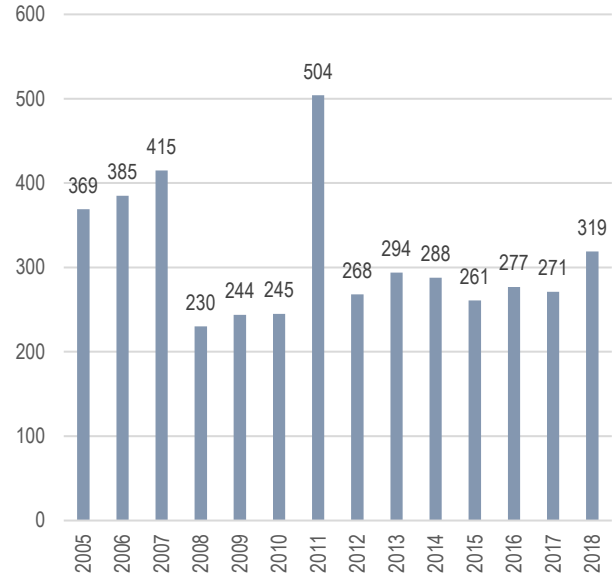


Figure 3.2.5: Number of incidents requiring hospital attendance; 12 months to June of year.

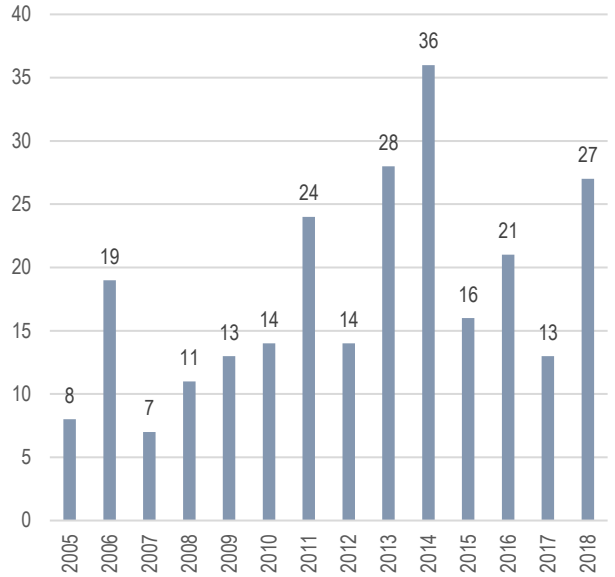
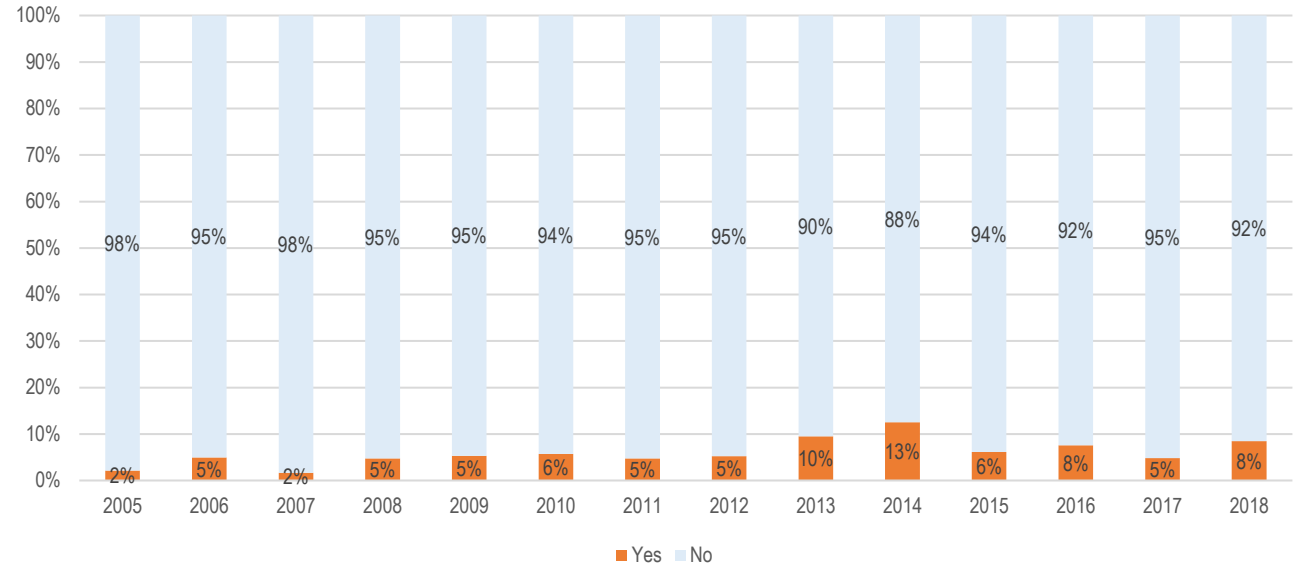


Figure 3.2.7: % of incident requiring hospital attendance; 12 months to June of year.



[59] 12 months to June of year.

HMP NORWICH
There is no lead for the management of learning disabilities. This post was previously covered by the mental health team manager (as learning disability lead for the cluster). Patients with learning disabilities are managed by the mental health team. The team can liaise with the regime regarding the management of the patient within the prison. Those with learning disabilities often need help with safety, orientation, adjustment, and work. There are two patients with learning disabilities in the healthcare unit. There is also one patient with possible learning disabilities. This patient is confrontational and has been a victim of bullying.
The earlier a patient is identified with a learning disability, the more assistance the mental health team can provide. Those with learning disabilities are asked the Cardiff health screen.
In HMP Norwich, the rate of prisoners on the learning disabilities QOF register at the time of this HSCNA was 29 (3.9%), which is lower than the expected rate of 7.0%.
For those managed on the caseload of the mental health team, case workers liaise with offender managers to ensure that where necessary, license conditions are explained clearly.

INTRODUCTION

LEARNING DISABILITIES OR LEARNING DIFFICULTIES?

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

The Foundation for People with Learning Disabilities defines learning difficulties as "unlike a learning disability, a learning difficulty does not affect general intelligence (IQ). An individual may often have more than one specific learning difficulty (for example, dyslexia and dyspraxia are often encountered together), and other conditions may also be experienced alongside each other." [60]

[60] http://www.learningdisabilities.org.uk

The *No One Knows*[61] report recommends that no strict classification is adopted. Instead, the focus should be on those who have difficulties with certain activities that involve thinking and understanding and who need additional help and support in their everyday living.

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

Recent reports include the *Bradley Report*[62] and the *No One Knows* report. Both reports highlighted the need to identify and support the prison population with learning disabilities and learning difficulties.

Some of the key findings include:

- This cohort will need additional support during their time in prison. For example, support for daily living such as filling in forms, communicating with prison staff, and reading prison information.
- The *No One Knows* report also highlighted that prisoners with learning disabilities have higher levels of anxiety and depression and face victimisation and bullying.
- Prisons have a lack of resources, and inadequately trained staff to deal with prisoners with learning disabilities.
- Children with learning disabilities and other impairments are more likely to go to prison than other young people because the youth justice system is failing to recognise their needs, according to a major survey of youth offending team (YOT) staff.
- This group of offenders are at risk of re-offending because of unidentified needs and subsequent lack of support and services.
- This group of offenders are targeted by other prisoners when in custody.

[61] Prison Reform Trust (2008), No One Knows.
[62] Department of Health (2009), The Bradley Report.

PREVALENCE

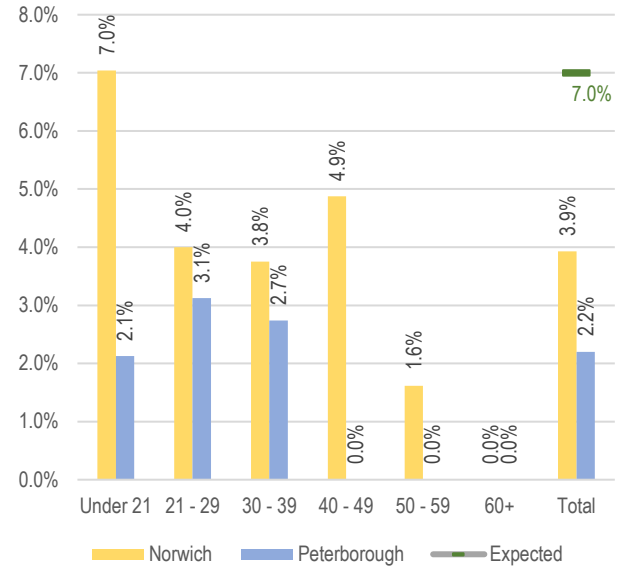
Among the prison population, the prevalence of those with learning disabilities is approximately 7%. The number with learning difficulties is higher, with the *No One Knows* report suggesting that those with either a learning difficulty or a learning disability is between 20-30%. This estimate gives an indication as to the proportion of prisoners who need additional support in their everyday living due to problems with thinking and understanding.

Prisoners with learning disabilities are particularly vulnerable to bullying and predation so may require safeguarding and orientation work. The recent joint inspection report by prison and probation inspectorates found that there were gaps in the identification of those with learning disabilities throughout the criminal justice pathway[63]. In light of these gaps, it is important for prisons to have robust identification procedures in place to ensure that those with learning disabilities are not missed when they enter prison.

In HMP Norwich, the rate of prisoners on the learning disabilities QOF register at the time of this HSCNA was 29 (3.9%), which is lower than the expected rate of 7.0%. The current rate of 3.9% is slightly higher than the 3.5% (27 prisoners) reported in the 2016 HSCNA.

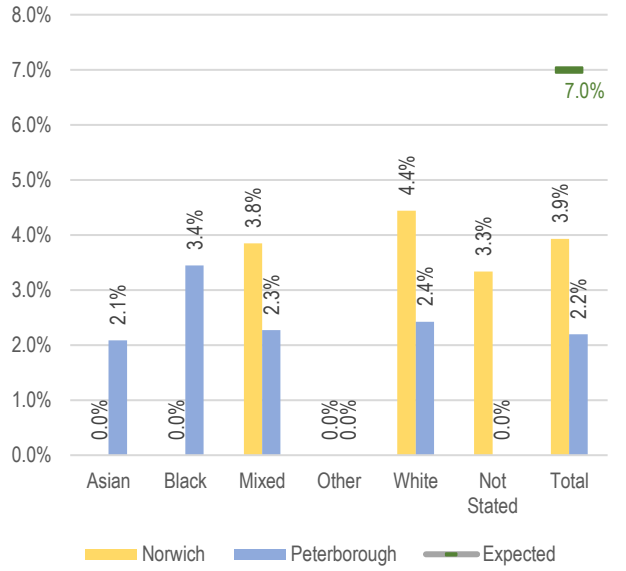
The analysis by age shows that the under-21 age group in HMP Norwich is the only age group that meets the expected 7% prevalence. The analysis by ethnicity shows no prisoners in HMP Norwich of Asian or of Black ethnicity are on the learning disabilities QOF register.

Figure 3.3.1: QOF prevalence; age.



	Under 21	21 - 29	30 - 39	40 - 49	50 - 59	60+	Total
Norwich							
Population	71	200	240	123	62	42	738
Learning Disabilities	5	8	9	6	1	0	29
Expected							52
Peterborough							
Population	47	288	292	121	62	9	819
Learning Disabilities	1	9	8	0	0	0	18
Expected							57

Figure 3.3.2: QOF prevalence; ethnicity.



	Asian	Black	Mixed	Other	White	Not Stated	Total
Norwich							
Population	13	48	26	13	608	30	738
Learning Disabilities	0	0	1	0	27	1	29
Expected							52
Peterborough							
Population	48	58	44	13	578	78	819
Learning Disabilities	1	2	1	0	14	0	18
Expected							57

[63] Criminal Justice Joint Inspection, (2015), A joint inspection of the treatment of offenders with learning disabilities within the criminal justice system

IDENTIFICATION

NORWICH

There is a question on learning disabilities and learning difficulties in the reception screen, which is found in the Disability section of the template, where there is the option to tick 'Learning difficulties'. There are no questions in the secondary screen.

SOCIAL CARE

INTRODUCTION

THE CARE ACT

RESPONSIBILITY

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

The Care Act addresses the existing social care provision in prisons, which has been described as "variable, sparse and non-existent"[64].

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

"Social care services are important for people in the criminal justice system who have care and support needs. It supports their rehabilitation and may positively impact on the likelihood of reoffending and the person's ability to rebuild their lives on release."[65]

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

ELIGIBILITY CRITERIA

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

CONTINUITY OF CARE

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

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

DIFFERENCES FOR PRISONERS

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

- Prisoners will not be entitled to direct payments for their care and support.
- Prisoners will not be able to express a preference for particular accommodation except when this is being arranged for after their release from prison.
- The Care Act clarifies that people will not be regarded as carers if they provide care as part of voluntary or paid work, and almost all care provided by prisoners is expected to fall within these exclusions.

[64] Department of Health (2015), *Fact Sheet 12: The Care Act – Prisoners and people resident in approved premises*
[65] Ibid.

- Prisons and approved premises will still be responsible for the safety of their detainees. This means that Safeguarding Adults Boards do not have a duty to carry out enquiries or reviews where a prisoner with care and support needs may be, or have been, at risk of abuse and neglect. However, the boards can provide advice to prison governors and staff.

PRISON SERVICE INSTRUCTIONS

There are three Prison Service Instructions that relate to a prison's roles and responsibilities relating to social care:

- PSI 15/2015 – Adult Social Care: explains how the implementation of the Care Act 2014 impacts on prisons and details NOMS responsibilities resulting from the new requirements. The PSI also clarifies the responsibility of local authorities to ensure that social care for adults in prisons is provided on the basis of equivalence to people living in the community.
- PSI 16/2015 – Adult Safeguarding in Prison: describes the processes that prisons must put in place to ensure that prisoners receive a level of protection that is equivalent to that provided to adults in the community with care and support needs who are at risk of abuse and neglect.
- PSI 17/2015 – Prisoners Assisting Other Prisoners: describes the principles that apply to all formal arrangements for prisoners to provide assistance, including certain needs for care and support, to other prisoners. The PSI requires prisons to have the ability to mobilise assistance from other prisoners should it be needed for a prisoner who has a care and support plan.

LOCAL PROVISION

HMP NORWICH
A new integrated health and social care service has been commissioned and will start from April 2019. The service will provide a service in the three Norfolk prisons. At the time of this assessment, there was no memorandum of understanding in place regarding social care processes in the prison. There were no specific dementia services in the prison.
ASSESSMENTS Social care assessments are carried out by Norfolk County Council social care staff. A number of social workers and occupational therapists have been vetted and security cleared for access to the prison. These staff have various specialities including learning disabilities, mental health and the sensory impairment team. INTERVENTIONS There is no equipment store in the prison, instead equipment is supplied by the same provider that the local authority uses in the community.
There were no prisoner carers in the prison.

HMP NORWICH – L-WING

L-wing in HMP Norwich has a 15 bedded unit which is set up to house older and infirm prisoners. The social care need on this wing is much higher and full-time staff are present to provide care and support to those on the unit.

All beds on L-wing are single cell with a toilet. There is an accessible bathroom on the wing which has a bath and separate shower with a hoist, patients have access to an activities room where they interact with other prisoners, watch TV, play games and pool, and have group activities. They also have access to a garden and greenhouse with some of the patients taking responsibility for looking after the plants.

There are four HCAs employed full time on L-wing to carry out personal care tasks for patients. Tasks include washing, feeding, dressing, and completing physiotherapy with patients. All patients receive a bath at least once a week. They also assist the trained nurse to carry out her duties and are responsible for attending all emergencies across the prison as they occur. Staff on the wing work to the Gold Standard Framework.

The patients on L-wing suffer from a range of acute and complex health conditions. At the time of this assessment, patients on L-wing had or had recently had:

- Cardiovascular accident
- Dementia
- Various long-term conditions including diabetes, COPD, Asthma, CCF, neurological conditions, incontinence, post-operation recovery (hip), idiopathic neuropathy, Parkinson's, and cancer.

Seven patients on the wing are in wheelchairs, with another four needing a mobility aid.

At the time of this assessment, there was one terminal patient on the end of life care pathway. One patient was extremely frail and was about to be visited by the palliative care team. Five patients were suffering from dementia.

Occasionally, patients detoxing from opiates or alcohol are placed on the wing and mental health patients needing care when refusing medical help and nutrition.

The majority of patients on L-wing are elderly, however, recently there have been a number of younger patients on the wing suffering from severe burns, mental health, and detoxing from opiates or alcohol.

There are a number of visiting services that visit L-wing including Forget-me-not which is a dementia charity. Nutritionists, occupational therapists, social workers, podiatrists, dentists, GPs, physiotherapists and Age Concern can visit patients on the wing.

For patients being released from the prison, the lead nurse on L-wing liaises with the multi-disciplinary team including social service regarding the needs of patients in the community. For example, patients with no fixed abode who have complex needs and patients being released compassionately who need a comprehensive care package. Consideration is taken on the patients' family circumstances.

At the time of this assessment, there were eight patients on other wings waiting to be transferred on to L-wing.

SUBSTANCE MISUSE

INTRODUCTION

Current government policy on the drug misuse and dependency of offenders states that the government aims to:

- Make the Drugs Intervention Programme (DIP) more flexible so that local areas can adapt it to suit their local communities.
- Launch new recovery wings in prison to help prisoners become drug free before they move back into the community.
- Fund a programme to support prisoners who have recovered from drug dependence when they move back into the community, so that they are less likely to go back to misusing drugs.

The government also wants the promotion of integrated recovery pathways that capitalise on the potential for a prison to be a relatively safe and supportive environment where offenders can take their first steps towards recovery.

In line with the vision set out in the National Drug Strategy (2010)[66], the government's Alcohol Strategy (2012)[67], and the Patel Report (2010)[68], all commissioned services should be fully integrated, recovery-orientated, and outcome-focussed.

Current evidence points towards clinical treatment being effective when accompanied by psychosocial services, including life skills work, mutual aid, and couples and families work. Drug treatment in secure settings must manage risks such as: suicide and self-harm following reception related to drug withdrawal; post-release fatal overdose due to loss of opioid tolerance; and the possibility of simultaneous access to illicit medication.

Substance misuse is a big issue among the prison population. Drug users report engaging in much higher levels of criminal activity than non-drug users, and several studies have found that drug use appears to intensify, motivate, and perpetuate offending behaviour. [69]

Compared to the wider prison population, problem drug-using offenders are a group with particularly complex and intractable problems, which means they will be more challenging to treat, rehabilitate, and reintegrate into society.

The 2005/06 Arrestee Survey[70] found that among arrestees who used heroin and crack at least once a week:

- Almost 25% had slept rough in the past month (compared with less than 10% of other arrestees).
- Half (50%) said they had left school before they were 16, 58% said they had been temporarily excluded at some time, and 36% had been permanently excluded (the equivalent figures for other arrestees are 32%, 39%, and 21% respectively).
- Only 10% were in employment (compared with almost half of other arrestees).
- 29% had been in local authority care at some time (compared with 15% of other arrestees).

[66] Home Office (2010), *Drug Strategy 2010*
[67] Home Office (2012), *Government Alcohol Strategy*
[68] OHRN (2010), *The Patel Report: Prison Drug Strategy Review*
[69] UK Drug Policy Commission (2008), *Reducing drug use, reducing re-offending, London*
[70] MoJ (2014), *Surveying Prisoner Crime Reduction*

BEST PRACTICE

NALOXONE

In an evaluation of the take-home naloxone programme for people being released from Scottish prisons, it was found that there was a reduction in deaths among former detainees who had been given naloxone to take home[71]. In addition, Public Health England has produced a fact sheet on promoting naloxone for opioid overdose in people who use drugs.

PSYCHOACTIVE SUBSTANCES (PS)

Public Health England has released guidance for commissioners on commissioning a PS service.

ALCOHOL

The government recommends including an alcohol risk assessment in the NHS Health Check for adults aged 40 to 75.

PHE TOOLKIT

Alcohol and drugs misuse are complex issues. In the community, the number of people with a serious drugs dependency is relatively small, with larger numbers dependent on alcohol or drinking at risky levels. However, prevalence rates in the prison population are much higher because both are strongly associated with crime and reoffending. The PHE toolkit recommends measuring prevalence using the Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study of prisoners conducted by NOMS.

METHODOLOGY

In addition to the assessment of treatment services in the prison, this chapter will explore the wider picture of substance misuse including drug supply and demand.

The assessment has used published literature and best guidance to assess the management of substance-related issues in the prison. The following table provides an overview of the sources used.

Figure 3.5.1: Data sources and guidance used for the substance misuse chapter of this HSCNA.

Name of Source	Organisation	Year	Overview
Drugs in Prison	The Centre for Social Justice	March 2015	The publication is broken into four chapters: 1. Drug-fuelled prisons 2. Tackling supply 3. Holding prisoners accountable 4. Full recovery in prison The study provides key findings of the issues and makes recommendations.
Changing patterns of substance misuse in adult prisons and service responses	HM Inspectorate of Prisons	December 2015	The thematic report examined "the changing extent and patterns of drug misuse in adult prisons and assessed the effectiveness of the response to it".
2017 Drug Strategy	HM Government	July 2017	The drug strategy was published in 2017 and focuses on key themes: Reducing Demand, Restricting Supply, Building Recovery, and Global Action.

This document has used the key themes and areas from figure 3.5.1 to provide a framework of assessment as shown below.

[71] Strang, J. (2014), 'Take-Home Emergency Naloxone to Prevent Heroin Overdose Deaths after Prison Release', BMJ 2014;349:g6580.

DRUGS IN PRISONS

- Changing patterns of substance misuse in the community and in prisons.
- Availability of drugs in HMP Norwich and HMP Peterborough

DRUG SUPPLY REDUCTION

- Dogs.
- Security.
- Intelligence.

DEMAND

- Reduce violence and bullying.
- Provision of purposeful activity.
- Timely access to health services.
- Effective treatment.

TREATMENT AND RECOVERY

- Treatment System.
- Exits.

DRUGS IN PRISON

OVERVIEW

- Numerous research pieces have highlighted a historical trend for the use of illicit substances in prison. Drugs typically taken in prison are those which provide depressant effects, such as cannabis and heroin, and to a lesser extent, diverted medications (e.g. benzodiazepines, opioid analgesics)[72]
- The 2015 HMIP Thematic Report into substance misuse in prisons highlighted the changing trends in drug use among prisoners. Drug use in prisons is mirroring changes of drug use in the community, for example falling use of illicit drugs, particularly opiates. In prisons, the misuse of synthetic cannabis and diverted medication is a major issue.
- There are limited studies available analysing current drug use in prison, particularly psychoactive substance (PS) use. Studies that estimate PS use in prison show figures from 33% of prisoners to 90% of prisoners using PS.[73]
- Researchers have identified a number of reasons explaining drug use in prisons. These include[74]:
    - A response to the tedium of institutional life.
    - Drug use can pass the time.
    - Drug use can help form social networks and foster solidarity.
    - Drug use can increase status within the prison.
    - Some vulnerable prisoners are exploited and influenced to use drugs for financial gain.
- Similar motivations have been found to explain consumption of psychotic substances. Reasons include boredom, killing time, and addiction.[75] Prior to 2017, PS were not detectable in drug tests administered in prison. This was one of the possible motivations for prisoners using PS.

[72] See Edgar & O'Donnell (1998); Penfold, Turnbull, & Webster (2005); Singleton, Meltzer, & Gatward (1998); Wilkinson et al. (2003).
[73] Centre for Social Justice, *Drugs in Prison* (2015); *User Voice* (2016); *Spice: The Bird Killer* (2016).
[74] Wheatley, M. (2007). Drugs in prison. In: Jewkes, Y. (Ed.), Handbook on prisons (pp. 399–422).
[75] Ralphs, R et al. (2017), 'Adding Spice to the Porridge: The development of a synthetic cannabinoid market in an English prison', *International Journal of Drug Policy* 40 (2017) 57–69

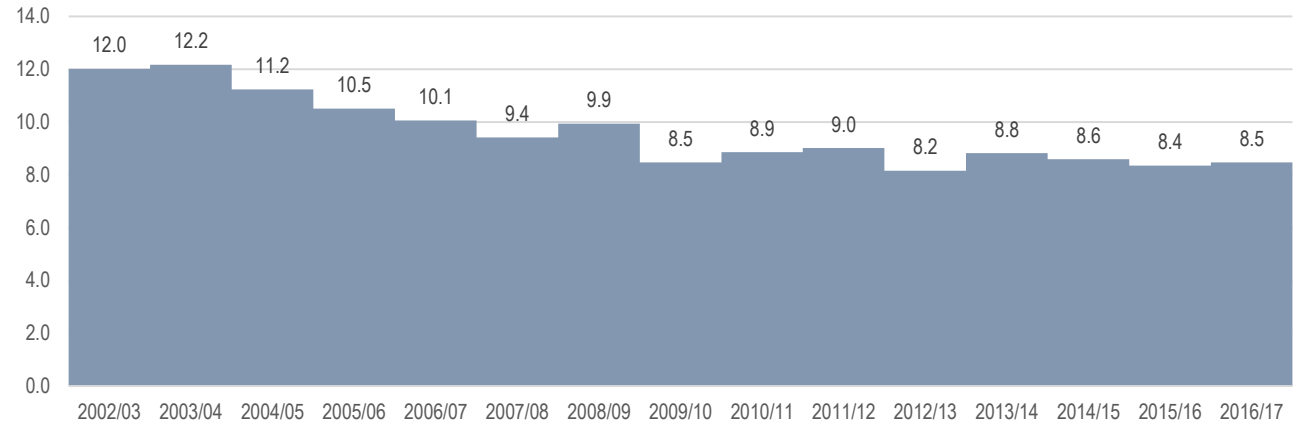
- The increase in the use of new psychoactive substances has been linked to a number of negative trends within prisons in the UK. "Synthetic cannabis has caused or is still causing wide-ranging problems, including medical emergencies, deaths, bullying, violence and debt."[76]
- There are also a range of health and wellbeing harms associated with the consumption of new psychoactive substances. These include addiction, aggression, agitation, depression, hallucinations, muscle spasms, paranoia, psychosis, self-harm, 'fitting', seizures, and suicidal thoughts.[77] Research from the International Journal of Drug Policy notes that there is limited research into the health impacts of PS use in prison, where there are higher rates of mental health problems than in the community.
- In addition to direct health impacts on users of PS, there are also indirect health impacts. Previous needs assessments carried out by the researchers have found health services to be detrimentally affected by the high number of emergency health call-outs related to PS use. Emergency call-outs can impact the running of regular services such as clinics and medication administration. At least two prisons in the West Midlands have begun employing a paramedic to assist with emergency medical issues in prisons, in addition to routine healthcare tasks.
- While most PS-related cases will be discharged within a few hours of presentation, there may be opportunities for medical staff to provide screening, brief advice, and referrals to community support.[78]

TRENDS IN THE COMMUNITY

The HMIP *Changing Patterns* report states that "changing patterns of drug use in the community provide a useful context for understanding drug misuse in prisons". The report uses the 2014-15 Crime Survey for England and Wales, however at the time of this HSCNA the data for the 2016-17 Crime Survey for England Wales was available. The key findings include:

- The percentage of adults using illicit drugs year on year has remained stable for the past eight years and is lower than the years prior to 2008-09.

Figure 3.5.2: % of adults using drugs[79].

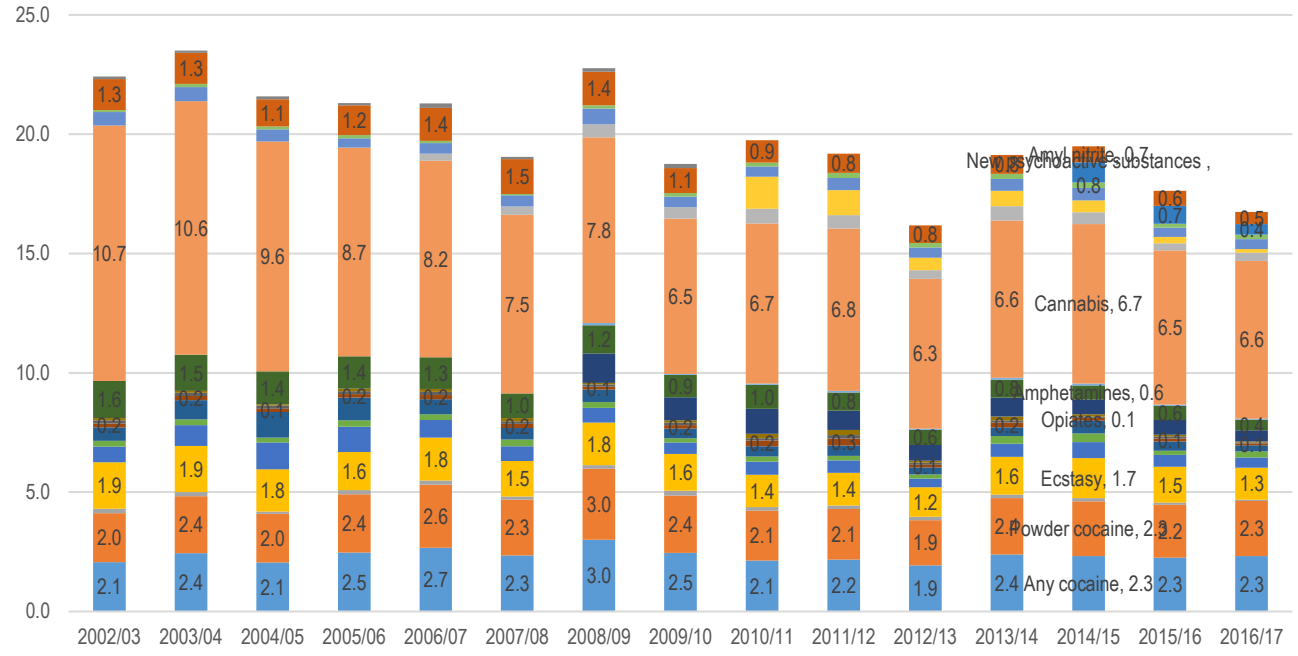


- Cannabis is the most widely used drug in the community; however, the 6.6% in 2016-17 who said they had used the drug in past year is a lower percentage than the rates seen 10 years ago. The use of amphetamines and amyl nitrate has also decreased.
- The level of usage for powder cocaine and ecstasy has remained relatively stable.

[76] HMIP (2015), *Changing patterns of substance misuse in adult prisons and service responses*
[77] Ralphs, R et al. (2017), 'Adding Spice to the Porridge: The development of a synthetic cannabinoid market in an English prison', *International Journal of Drug Policy* 40 (2017) 57–69
[78] http://www.emcdda.europa.eu/system/files/publications/2933/NPS%20health%20responses_POD2016.pdf
[79] CSEWs

- The use of PS was first included in the report from 2014-15 and has declined since then.
- The use of opiates in the community is low.

Figure 3.5.3: % of adults using substances.



AVAILABILITY OF ILLEGAL DRUGS

As part of the 2018 HMIP Inspection Report for HMP Peterborough, a survey was conducted exploring a wide range of areas, including drugs and alcohol. The results for HMP Norwich have not been included as the last HMIP Inspection Report was in 2016. The following charts show the results of the survey for a select number of questions. In addition, figure 3.5.8 provides an analysis of how these results compare against the comparator prisons and against the last HMIP in 2015.

The key points are:

1. 36% said that it was very easy, and an additional 16% said that it was easy to get illegal drugs in the prison.
2. The combined rate of 52% that said it is very easy or easy to get illegal drugs in the prison is similar to all other local prisons surveyed since September 2017.
3. The combined rate of 34% that said it is very easy or easy to get alcohol in the prison is higher than the 25% for all other local prisons surveyed since September 2017.
4. Of concern is the percentage of prisoners that said they developed a problem with illegal drugs since they have been in this prison. At 21% this is worse than the 3% reported in the last HMIP.

Figure 3.5.4: Is it easy or difficult to get illicit drugs in this prison?

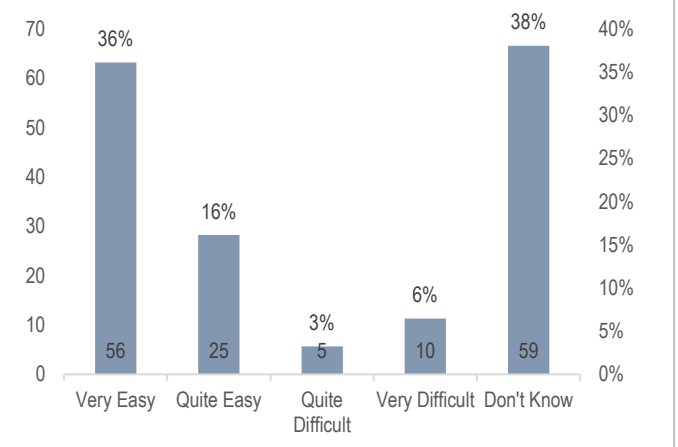


Figure 3.5.5: Is it easy or difficult to get alcohol in this prison?

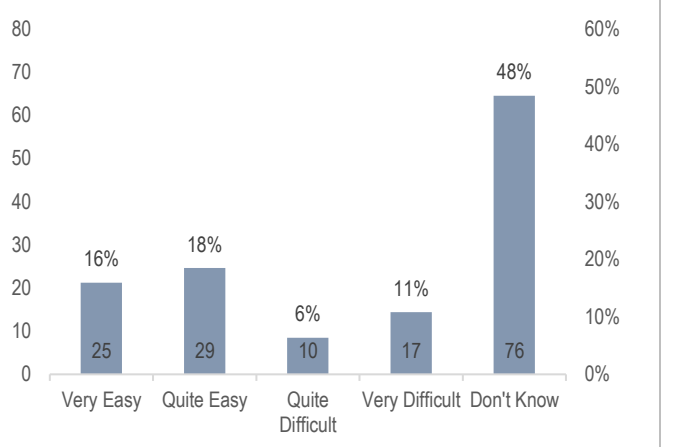


Figure 3.5.6: Have you developed a problem with illicit drugs since you have been in this prison?

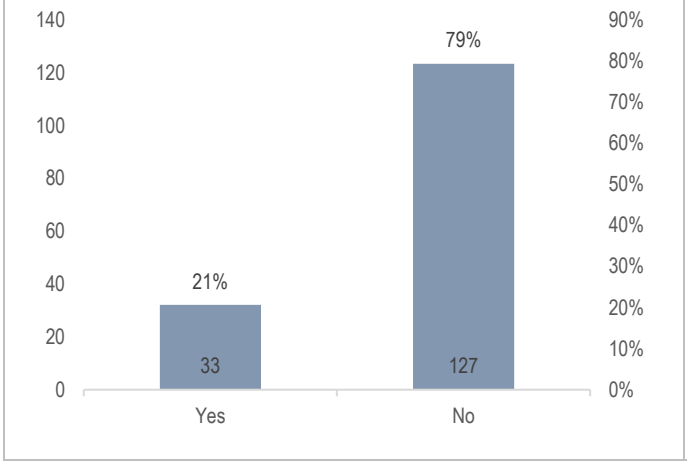


Figure 3.5.7: Have you developed a problem with diverted medication since you have been in this prison?

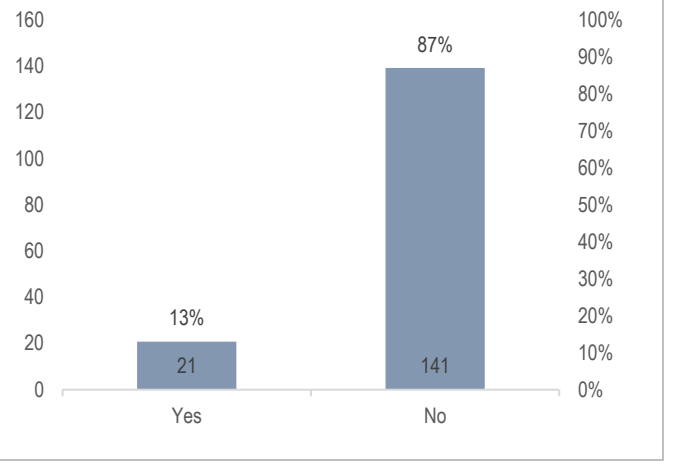


Figure 3.5.8: 2018 HMIP comparison against comparator prisons and against the last HMIP in 2015.

Shading is used to indicate statistical significance*, as follows:

- Green shading shows results that are significantly more positive than the comparator
- Blue shading shows results that are significantly more negative than the comparator
- Orange shading shows significant differences in demographics and background information
- No shading means that differences are not significant and may have occurred by chance
- Grey shading indicates that we have no valid data for this question

** less than 1% probability that the difference is due to chance*

			HMP Peterborough 2018	All other local prisons	HMP Peterborough 2018	All other local prisons surveyed since September 2017	HMP Peterborough 2018	HMP Peterborough 2015
	Number of completed questionnaires returned		172	5,881	172	2,290	172	166
	n=number of valid responses to question (HMP Peterborough 2018)							
ALCOHOL AND DRUGS								
13.1	Did you have an alcohol problem when you came into this prison?	*n=161*	20%	22%	20%	23%	20%	17%
	For those who had / have an alcohol problem:							
13.2	Have you been helped with your alcohol problem in this prison?	*n=30*	33%	55%	33%	61%	33%	67%
13.3	Did you have a drug problem when you came into this prison (including illicit drugs and medication not prescribed to you)?	*n=163*	34%	36%	34%	34%	34%	28%
13.4	Have you developed a problem with illicit drugs since you have been in this prison?	*n=160*	21%	14%	21%	15%	21%	3%
13.5	Have you developed a problem with taking medication not prescribed to you since you have been in this prison?	*n=162*	13%		13%	11%	13%	
	For those who had / have a drug problem:							
13.6	Have you been helped with your drug problem in this prison?	*n=58*	43%	54%	43%	49%	43%	61%
13.7	Is it very / quite easy to get illicit drugs in this prison?	*n=155*	52%		52%	50%	52%	
13.8	Is it very / quite easy to get alcohol in this prison?	*n=157*	34%		34%	25%	34%	

MEDICATION DEPENDENCE

It is estimated that 7% of prisoners develop a problem with diverted medication in prison. [80] In a 2015 report, The Centre for Social Justice believed that medication was being over prescribed in prison, citing the increase in opioid maintenance scripts.[81]

Public Health England and the Royal College of Anaesthetists developed an online resource for patients and clinicians to support the prescribing of opioid medications for pain. The resource does not have specific resources for prescribing in prisons.

In the 2015 thematic report into substance misuse in prisons, the HMIP identified the need for a cohesive national strategy to reduce the misuse of prescription and over the counter medication that includes:

- Monitoring of prescribing trends
- Prompting access for prisoners to cohesive pain management services
- Evidenced based clinical and psychosocial treatment for dependence on illicit medication

HMP Norwich: The 2018 Drug Strategy for the prison does not explicitly mention diversion of medication and how it is to be addressed in the prison.

Minutes from the drug strategy meeting were made available that showed Virgin Care had reported a number of instances of patients being bullied for their prescribed drugs in the medication queues. The minutes showed that the prison has tried to address these concerns.

Healthcare, led by the pharmacy and GP were addressing the prescribing of controlled drugs such as pregabalin and gabapentin. Patients in receipt of controlled drugs were reviewed by the GP.

80 Her Majesty's Chief Inspector of Prisons for England and Wales, Annual Report 2013–14, London: Her Majesty's Inspectorate for England and Wales, 2014, p30 [accessed via: https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/10/HMIPAR_ 2013-14.pdf (19.02.15)]
81 CSJ (2015), *Drugs in Prison*

DRUG SUPPLY REDUCTION

INTRODUCTION

SUPPLY ROUTES

The *Centre for Social Justice Report* from 2015[82] describes the five main routes through which drugs are smuggled into prison:

- Social visits
- Postage
- Corrupt staff
- Thrown over prison walls
- New or returning prisoners (including those on release on temporary licence)

There is limited information on how often each of these routes are used; however, the report includes qualitative information and anecdotal evidence from prison staff giving examples of each method.

DISRUPTING SUPPLY

Regarding disrupting supply, the *Blakey Report* (2008)[83] recommended that the way to stop drugs getting into prison was to:

- Use good practice
- Disrupt the use of mobile telephones
- Use searching
- Use search dogs
- Use legislation
- Develop and use technology
- Develop partnership working with the police
- Use intelligence

The importance of supply reduction was noted in the HMIP thematic review into substance misuse in prisons[84]:

- ”Supply reduction is a key component of prison activity to maintain safety and security, and starts with an effective strategy. The HMI Prisons 2014–15 annual report noted that too many prisons had an inadequate supply reduction strategy; many were out of date, lacked clear actions, were not regularly reviewed and did not adequately reflect key issues (including PS and medication), and frontline staff were often not aware of the key priorities (HM Inspectorate of Prisons, 2015). This will inevitably lead to an inadequate response.”
- ”Supply reduction in prisons requires coordinated, integrated working between all prison departments, including security, residential units and health care, as each have an interlinking role to play in supply reduction. We have seen effective multi-departmental approaches to reducing drug and alcohol supply at several prisons. However, strategies in some prisons were weakened by ineffective communication of key priorities to operational staff, which meant that the strategy was not translated into action. Despite the number of problems associated with synthetic cannabis, we are still finding that most prisons do not have an explicit PS supply reduction strategy, although some prisons do have good strategies.”

82 CSJ (2015), *Drugs in Prison*
83 Blakey (2008), *Disrupting the supply of illicit drugs into prisons: A report for the Director General of National Offender Management Service*

84 HMIP (2015), *Changing patterns of substance misuse in adult prisons and service responses*

- Available evidence and research shows the difficulties in reducing the supply of drugs into prisons. Criminals are attracted by the potential for financial returns from supplying drugs into prisons: "There is growing evidence of carefully organised attempts to traffic drugs into prisons, with great efforts made by criminals to overcome improved security measures in order to exploit the potential profits to be made in doing so. Reducing prison drug supply is a constant battle. As one route is closed, it does not take long for another to open".[85]

LOCAL AND BEST PRACTICE

HMP NORWICH	
DISRUPTING SUPPLY	
The 2018 Drug Strategy includes information on strategies to reduce the supply of drugs into the prison. Initiatives include: • Searching procedures and practices which target the supply and storage of illicit substances. • The use of search dogs. • Intelligence gathering and sharing.	

DRUG DETECTION DOGS

BEST PRACTICE / RECOMMENDATION

- Drug dogs are a solution to reduce the amount of drugs being smuggled into prisons.[86] The CSJ report suggests that "The MoJ should invest more in drug dogs. They are very effective at detecting drugs (including PS) yet, between 2010 and 2014, the number of drug dogs in prison in England and Wales fell by 27% to 328."
- Dogs trained to detect the smell of various substances, including drugs and mobile telephones, are deployed in some prisons and can be useful both in increasing finds and acting as a deterrent to use. Some staff interviewed for this thematic inspection said that drug dogs were a valuable resource, but there were not enough of them and they were not trained to detect new drugs such as spice or other PS. Currently, few prisons have access to dogs trained to detect spice, although more are now being trained (NOMS, 2015b).[87]

LOCAL PRACTICE / EVIDENCE

HMP NORWICH	
DETECTION DOGS	
The 2018 Drug Strategy sets out how search dogs are integrated into the supply and reduction strategy. All visitors are subject to a passive detection dog search prior to entering the visit hall.	

85 HMIP (2015), *Changing patterns of substance misuse in adult prisons and service responses*

86 Centre for Social Justice (2015), *Drugs in Prison*

87 HMIP (2015), *Changing patterns of substance misuse in adult prisons and service responses*

INTELLIGENCE GATHERING

BEST PRACTICE / RECOMMENDATION

- Intelligence forms a key part of any supply reduction strategy. The 2015 HMIP thematic report[88] cites a number of examples where prisons use intelligence reports to build a picture of drug trends within establishments.
- The dissemination of information is important. The report highlights the example of HMP Dovegate where there is "a weekly intelligence meeting with security and other relevant staff" as well as "wing managers carrying out detailed briefings on the wings". The prison received good support from the police.
- Intelligence should be used to inform other parts of the drug reduction process. "Searching, both routine and intelligence led, is an important supply reduction tool."
- The report states that "intelligence-led searching was either very delayed or did not occur, often because of reduced staffing levels". This may because there are a high number of intelligence reports submitted; for example, in HMP Stoke Heath, there were over 2,000 intelligence reports in six months.
- The level of drug finds alone does not accurately reflect the level of use as it is unlikely that all illicit drugs will be found; however, in combination with other measures, including MDT rates, levels of violence and intelligence, it may indicate the effectiveness of supply reduction measures.

LOCAL PRACTICE / EVIDENCE

HMP NORWICH	
INTELLIGENCE GATHERING	
The 2018 Drug Strategy details the procedures in place for the sharing of intelligence relating to illicit substances in the prison. The minutes for the drug strategy meeting show that information is shared between partners.	

JOINT WORKING WITH THE POLICE

BEST PRACTICE / RECOMMENDATION

- A recommendation from the HMIP thematic report states that "It should be ensured that protocols with the police at national and local level establish effective actions to disrupt the supply of illicit substances by visitors, prisoners, staff and other sources."
- One of the examples of how to disrupt supply routes into prison given in the *Blakey Report* is to "develop partnership working with the police".

LOCAL PRACTICE / EVIDENCE

HMP NORWICH	
JOINT WORKING WITH THE POLICE	
There is an embedded police intelligence officer working in the prison. The officer provides information to the prison on all matters relating to illicit substances.	

WASTE WATER ANALYSIS

88 HMIP (2015), *Changing patterns of substance misuse in adult prisons and service responses*

BEST PRACTICE / RECOMMENDATION

- Effective intelligence gathering is a crucial element of the fight against drug smuggling. Waste water analysis (WWA) should be introduced to prisons to provide a clearer understanding of drug use. It should replace the use of random Mandatory Drug Testing (rMDT) for this purpose[89]:
    - WWA analyses waste from prison sewage systems. It can identify not only the type of drugs, but the quantity as well.
    - WWA has been successfully piloted in an Australian prison and is being trialled in a number of other countries, including the United States and Spain. The CSJ heard from researchers that it provides a robust, accurate measure of drug use in prisons.

LOCAL PRACTICE / EVIDENCE

There are no plans for waste water analysis to be undertaken in either prison.

DRUG TESTING

BEST PRACTICE / RECOMMENDATION

- Prisons in England and Wales need a good understanding of which prisoners are taking drugs. This is not currently the case:
- Drug testing is poorly targeted:
    a. The main testing regime – Mandatory Drug Testing (MDT) – is used to gather intelligence on drug use as well as identify individual drug users. As a result, prisons are required to use the majority of their testing budget on random testing;
    b. Yet random testing is one of the most ineffective ways of identifying drug users: only 7% were identified as drug users through random testing last year, compared with 30% for suspicion tests.
    c. Prisoners are rarely tested:
        i. Prisoners are more likely than not to never be randomly tested for drug use in any given year;
        ii. Other forms of testing are being used less frequently. A CSJ FoI request found that suspicion testing is down by more than a fifth in two years;
        iii. The CSJ recommends that the frequency of testing be significantly increased such that a quarter of prisoners are tested every month and that governors be given flexibility on how to test as soon as WWA is introduced to their prison
- The response to positive drug tests also needs to be swift, certain and fair. There is significant evidence that this approach can dramatically increase offender compliance. It has primarily been proven in a community setting, but pilots have also been carried out in US prisons.
- The current approach is not swift: prisoners are often sanctioned weeks, if not months, after testing positive. This can mean that those on short sentences, or near the end of their sentence, can often test positive for illegal drug use and not be sanctioned;
- The current approach is not certain: certainty requires that prisoners have sanctions explained to them clearly in advance, and that sanctions are carried out every single time. Yet we heard from prison officials that the quality of inductions varied hugely across prisons and that, on occasion, sanctions were not being carried out;

89 CSJ (2015), *Drugs in Prison*

- Few officials or prisoners felt the sanctioning regime was unfair, but more can be done to persuade prisoners to plead guilty at the first adjudication to speed up the process. The CSJ recommends that all prisoners who plead not guilty following a positive rMDT test at their first adjudication, and are later found guilty, should automatically be given extra days in prison.

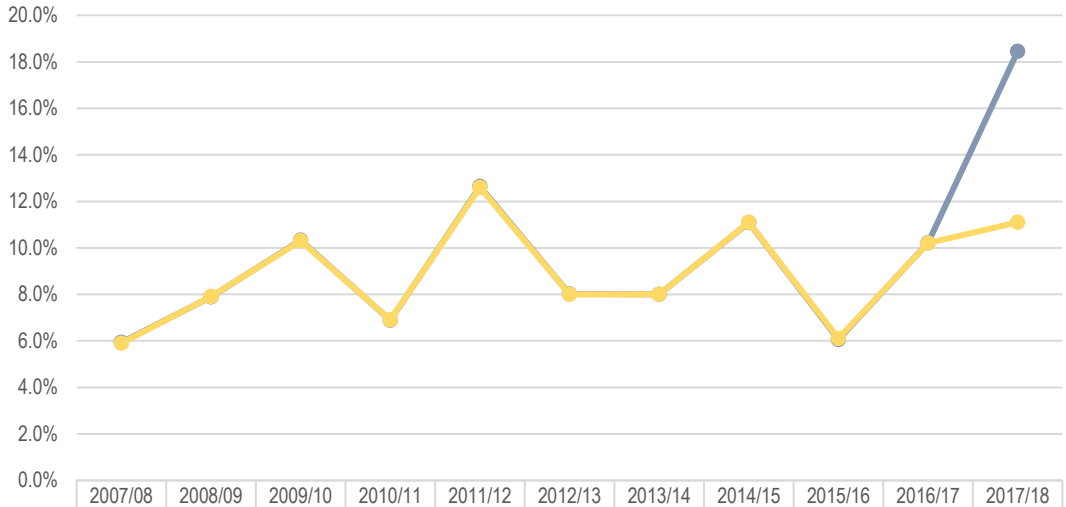
LOCAL PRACTICE / EVIDENCE

HMP NORWICH	
DRUG TESTING	
The Drug Strategy sets out how the MDT programme will run in the prison. It has been agreed that at least 5% of the population will be tested per month. There is also a target of less than 10% of tests to show a positive result.	

In HMP Peterborough, the positive testing rate for traditional drugs (excluding psychoactive substances) for 2017-18 was 19.6 %, which is the highest rate since 2007-08. The increase in positive testing rates for traditional drugs is attributed mainly to the increase for cannabis. Including psychoactive substances, the positive testing rate increases to 37.2%, which is one of the highest rates when compared to other prisons with a similar role.

In HMP Norwich, the positive testing rate for traditional drugs (excluding psychoactive substances) for 2017-18 was 11.1%. Including psychoactive substances, the positive testing rate increases to 18.4%. This is relatively low when compared to other local prisons.

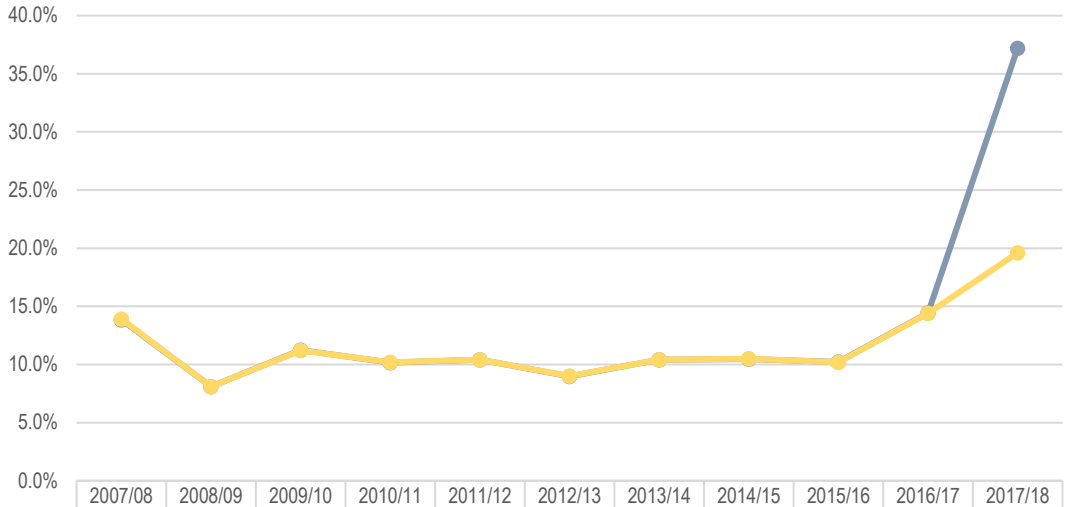
Figure 3.5.9: Positive RMDTs in HMP Norwich, by drug type.



	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Positive %	5.9%	7.9%	10.3%	6.9%	12.6%	8.0%	8.0%	11.1%	6.1%	10.2%	18.4%
Positive % Excluding PS	5.9%	7.9%	10.3%	6.9%	12.6%	8.0%	8.0%	11.1%	6.1%	10.2%	11.1%

Norwich	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Amphetamines	0	0	0	1	0	0	1	0	0	1	1
	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.2%	0.0%	0.0%	0.2%	0.2%
Barbiturates	0	0	0	0	0	0	0	0	0	0	0
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Benzodiazepines	8	13	4	3	11	5	3	4	2	1	2
	2.3%	3.8%	1.0%	0.6%	2.4%	1.1%	0.7%	1.0%	0.4%	0.2%	0.4%
Buprenorphine	0	0	9	17	16	5	11	17	7	12	4
	0.0%	0.0%	2.3%	3.7%	3.5%	1.1%	2.4%	4.1%	1.6%	2.7%	0.9%
Cannabis	3	6	13	7	28	16	9	13	5	20	27
	0.8%	1.8%	3.3%	1.5%	6.1%	3.6%	2.0%	3.1%	1.1%	4.4%	6.0%
Cocaine	0	0	2	0	1	1	0	3	0	1	3
	0.0%	0.0%	0.5%	0.0%	0.2%	0.2%	0.0%	0.7%	0.0%	0.2%	0.7%
Methadone	0	0	0	1	6	1	1	3	6	5	4
	0.0%	0.0%	0.0%	0.2%	1.3%	0.2%	0.2%	0.7%	1.3%	1.1%	0.9%
New Psychoactive Substances	0	0	0	0	0	0	0	0	0	0	0
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Opiates	11	10	17	6	13	14	17	10	11	15	15
	3.1%	2.9%	4.3%	1.3%	2.8%	3.1%	3.8%	2.4%	2.5%	3.3%	3.3%
Psychoactive Substances	0	0	0	0	0	0	0	0	0	0	43
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	9.6%
Positive	21	27	41	32	58	36	36	46	27	46	83
	5.9%	7.9%	10.3%	6.9%	12.6%	8.0%	8.0%	11.1%	6.1%	10.2%	18.4%
Negative	333	315	356	433	401	413	414	369	418	404	367
	94.1%	92.1%	89.7%	93.1%	87.4%	92.0%	92.0%	88.9%	93.9%	89.8%	81.6%
Total Number of Tests	354	342	397	465	459	449	450	415	445	450	450

Figure 3.5.10: Positive RMDTs in HMP Peterborough, by drug type.



	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Positive %	13.9%	8.1%	11.2%	10.2%	10.4%	9.0%	10.4%	10.5%	10.2%	14.4%	37.2%
Positive % Excluding PS	13.9%	8.1%	11.2%	10.2%	10.4%	9.0%	10.4%	10.5%	10.2%	14.4%	19.6%

Peterborough Male	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Amphetamines	0	0	0	0	0	0	0	0	0	1	0
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%
Barbiturates	0	0	0	0	0	0	0	0	0	0	0
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Benzodiazepines	5	8	12	7	3	6	5	3	9	13	14
	1.4%	2.2%	3.4%	1.9%	0.8%	1.7%	1.6%	0.8%	1.7%	2.4%	2.6%
Buprenorphine	0	0	6	4	11	10	5	13	18	21	12
	0.0%	0.0%	1.7%	1.1%	2.9%	2.9%	1.6%	3.5%	3.5%	3.9%	2.2%
Cannabis	19	4	9	15	21	15	20	22	16	37	77
	5.3%	1.1%	2.5%	4.1%	5.6%	4.3%	6.5%	5.9%	3.1%	6.8%	14.4%
Cocaine	1	0	1	1	3	2	0	1	3	5	8
	0.3%	0.0%	0.3%	0.3%	0.8%	0.6%	0.0%	0.3%	0.6%	0.9%	1.5%
Methadone	2	6	5	1	1	0	2	0	9	2	1
	0.6%	1.7%	1.4%	0.3%	0.3%	0.0%	0.7%	0.0%	1.7%	0.4%	0.2%
New Psychoactive Substances	0	0	0	0	0	0	0	0	0	0	0
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Opiates	32	13	17	15	4	3	4	3	6	17	9
	8.9%	3.6%	4.8%	4.1%	1.1%	0.9%	1.3%	0.8%	1.2%	3.1%	1.7%
Psychoactive Substances	0	0	0	0	0	0	0	0	0	0	123
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	23.0%
Positive	50	29	40	37	39	31	32	39	53	78	199
	13.9%	8.1%	11.2%	10.2%	10.4%	9.0%	10.4%	10.5%	10.2%	14.4%	37.2%
Negative	311	329	316	327	336	314	275	334	465	463	336
	86.1%	91.9%	88.8%	89.8%	89.6%	91.0%	89.6%	89.5%	89.8%	85.6%	62.8%

Figure 3.5.11: Comparison against other male local prisons; 2017-18; all drugs.

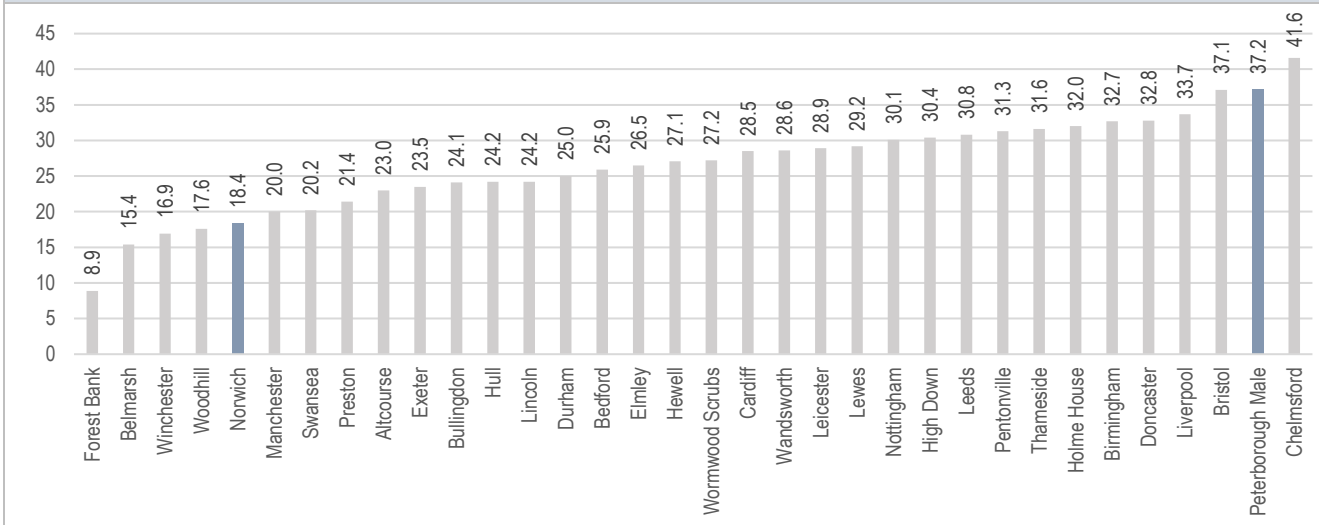


Figure 3.5.12: Comparison against other male local prisons; 2017-18; traditional drugs.

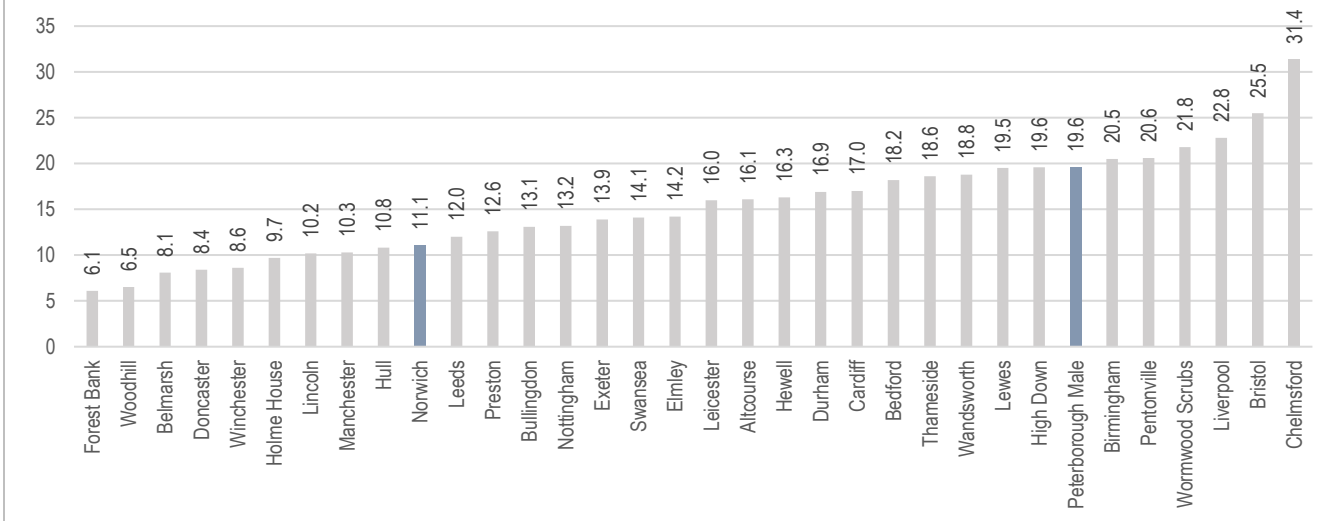
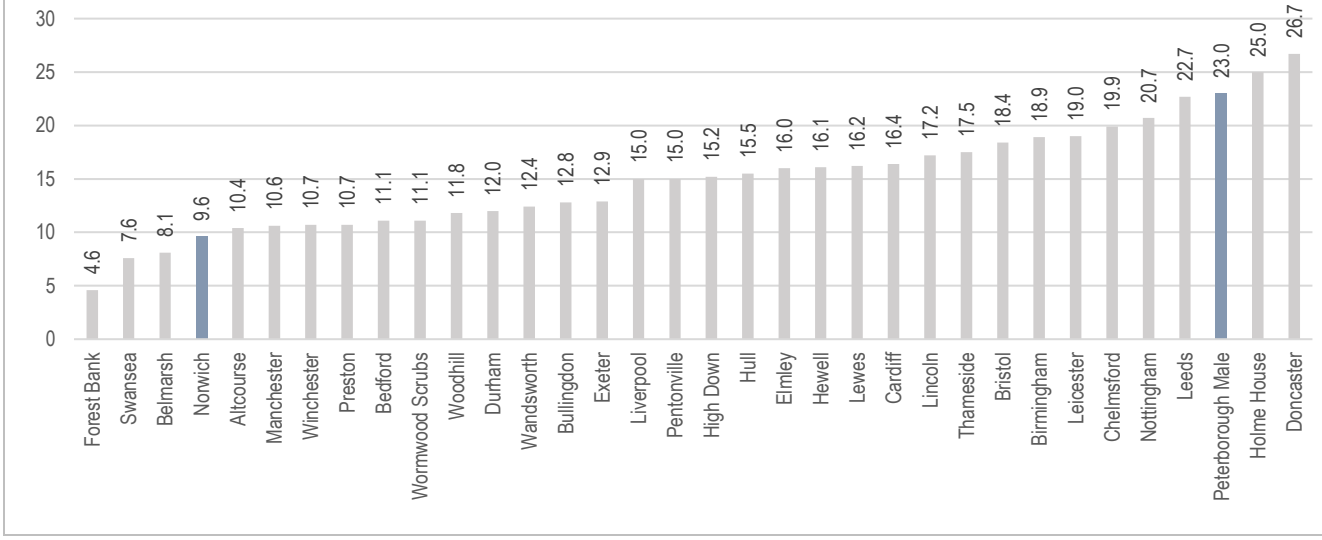


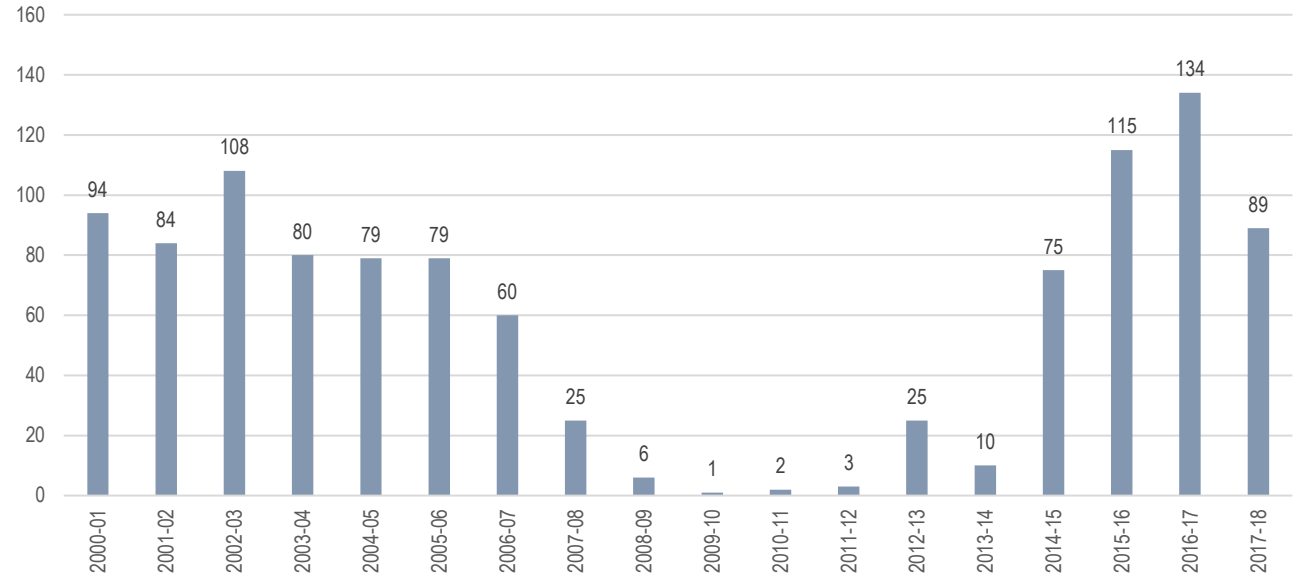
Figure 3.5.13: Comparison against other male local prisons; 2017-18; psychoactive substances.



DRUG FINDS

Following 3 year of increases, the number of drug finds in 2017-18 experienced a decrease compared to previous years. The change included a decrease in the number of finds for cannabis and psychoactive substances.

Figure 3.5.14: Drug finds in HMP Norwich[90].

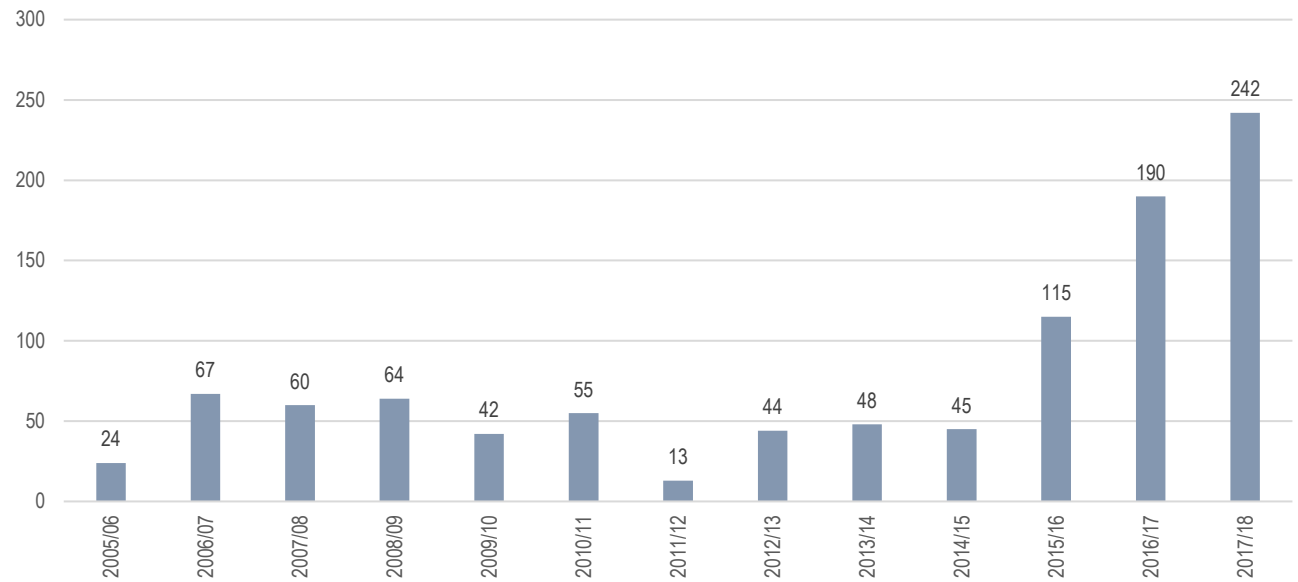


Drug type	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Amphetamine	4	2	5			1								1			2	
Barbiturates		1															1	1
Buprenorphine																4	5	2
Cannabis	54	42	69	64	47	47	36	16	2			2	14	4	13	25	18	17
Cocaine	1	2	4	1	8	1	2	1	1		1		2		5	2		1
Diamorphine (Heroin)	32	34	24	9	15	17	9	4		1			3		5	9	5	2
Gabapentin																	1	
Other	2	2	6	6	9	12	13	4	3		1	1	6	5	52	35	12	6
Pregabalin																	2	1
Psychoactive substances																34	41	31
Steroids																1	9	2
Tranquillisers	1	1				1											2	1
Unknown																5	36	25
Total	94	84	108	80	79	79	60	25	6	1	2	3	25	10	75	115	134	89

[90] https://www.gov.uk/government/statistics/annual-hm-prison-and-probation-service-digest-2017-to-2018

There were 242 drug finds in 2017-18, which is a notable increase on the previous years. Drug finds classified as 'unknown' accounted for a high percentage of the total and has shown a significant increase on 2016-17.

Figure 3.5.15: Drug finds in HMP Peterborough[91].



Drug type	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Amphetamine		1				1		1	2	1			
Barbiturates											1		
Buprenorphine											1	1	2
Cannabis	10	18	19	15	3	18	6	17	17	9	15	10	4
Cocaine		2	4			1					1	2	4
Diamorphine (Heroin)	4	37	21	16	8	6	1	4	6	1	3	3	6
Methadone												1	3
Other	10	9	16	33	31	29	6	22	23	34	22	2	9
Pregabalin											1	2	3
Psychoactive substances											28	64	52
Steroids											1	2	2
Tramadol												2	2
Tranquillisers													2
Unknown											42	101	153
Total	24	67	60	64	42	55	13	44	48	45	115	190	242

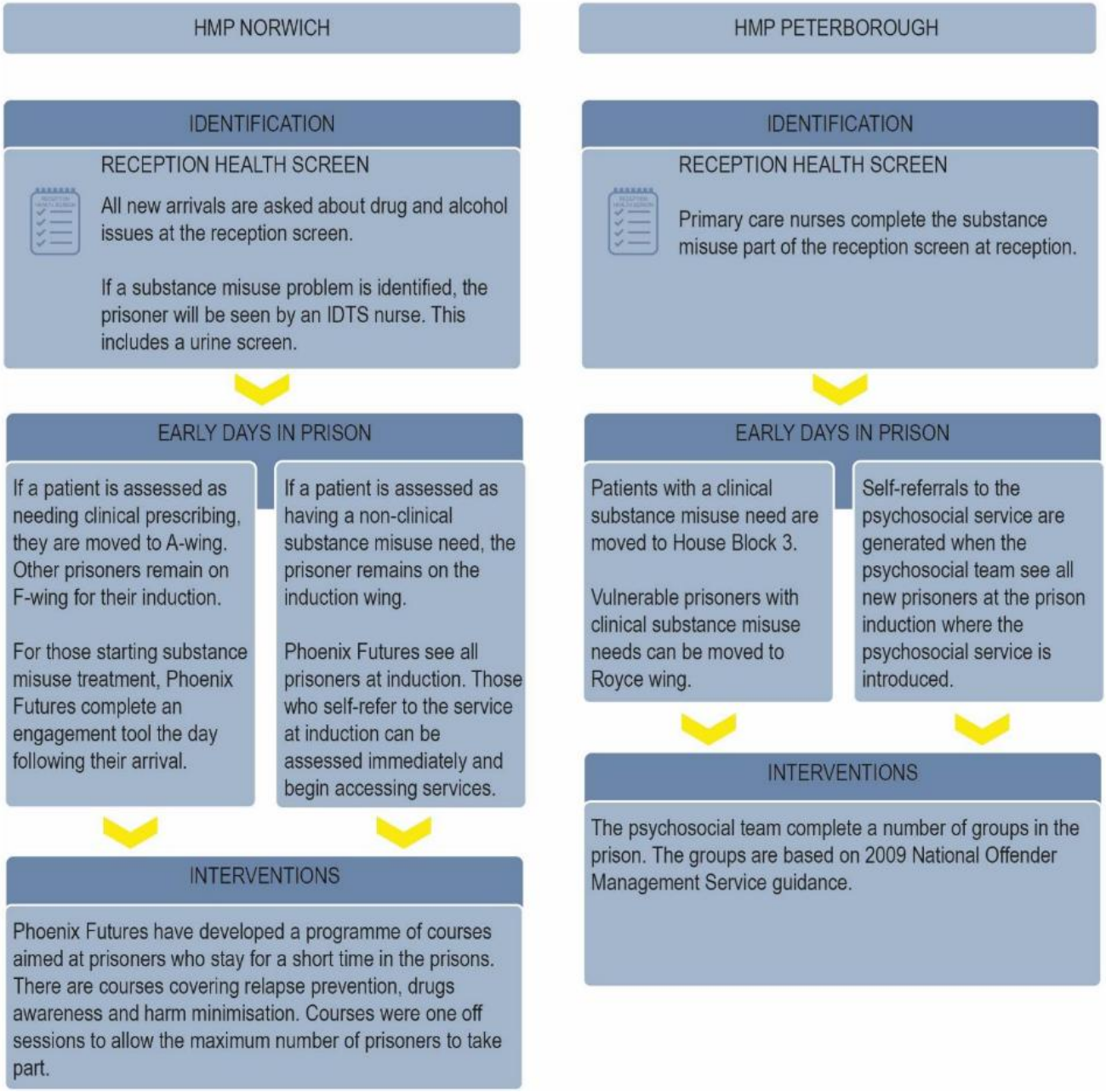
[91] https://www.gov.uk/government/statistics/annual-hm-prison-and-probation-service-digest-2017-to-2018

HMP NORWICH	
INTRODUCTION	
In HMP Norwich, psychosocial provision is provided by Phoenix Futures. Phoenix Futures took over provision from RAPt when the service was recommissioned. Clinical services are provided by Virgin Care.	
STAFFING	

JOB TITLE	NUMBER
CLINICAL	
Nurse	2
HCA	2
Pharmacy Technician	1
PSYCHOSOCIAL	
Service Manager	1
Team Leaders	2
Drug and Alcohol Practitioners/ Substance Misuse Practitioners	8.6
Family Worker	1

TREATMENT PATHWAY

The diagram below shows the substance misuse pathway for the two prisons.



CLINICAL TREATMENT PATHWAY

Below gives an overview of the clinical treatment pathway for both prisons.

HMP NORWICH	
CLINICAL PATHWAY FROM RECEPTION	
Clinical substance misuse staff carry out an assessment and urine screen on all patients who disclose a substance misuse issue at reception. These patients are referred to the IDTS doctor who completes a focused assessment and determines treatment. Patients receiving clinical substance misuse interventions are held on A-wing. The IDTS team and Phoenix Futures are both located on A-wing. In a development since the last HSCNA, IDTS treatment is now offered in the local discharge unit. Five-day reviews are completed by Phoenix Futures and the ISMS nurses. 28-day reviews are completed by the nurse only. 13-week reviews are completed with the ISMS GP, mental health practitioner (if appropriate), nurse, and Phoenix Futures. Healthcare encourages patient-led reductions. Sentenced prisoners are also encouraged to reduce. Naloxone and naltrexone are available in the prison.	

HMP NORWICH	
IDENTIFICATION AND ASSESSMENT	
In HMP Norwich, Phoenix Futures and the clinical provider have developed a process to identify and assess all those beginning clinical substance misuse treatment the day following their arrival in the prison. Phoenix Futures does not carry out a full assessment but has developed an engagement tool that allows a care plan to be developed. This speeds up the assessment process.	
INTERVENTIONS	
Phoenix Futures has developed a programme of courses aimed at prisoners who stay for a short time in the prisons. There are courses covering relapse prevention, drugs awareness and harm minimisation. Courses were one-off sessions to allow the maximum number of prisoners to take part. In HMP Norwich, Phoenix Futures has developed a group with the IAPT service that addresses anxiety and stress related problems.	
PSYCHOACTIVE SUBSTANCES	
In HMP Norwich, Phoenix Futures has an NPS lead and has delivered training on NPS awareness to prison staff.	
PEER MENTORS	
The high turnover of patients created difficulties in retaining trained peer mentors. Phoenix Futures is addressing the issue of retaining peer mentors by altering their roles. Phoenix Futures will reduce the roles of the peer mentors to allow them to be trained more quickly. Phoenix Futures has identified two peer mentor leads among its staff.	

Figure 3.5.16 shows the rate of receptions that started a treatment episode based on NDTMS data. Both prisons have seen an increase in the rate of receptions that have started a reception episode. Across all of the analysed time periods, the rate is higher in HMP Norwich compared to HMP Peterborough. In HMP Peterborough, there is a high rate of opiate users.

Figure 3.5.16: Rate of receptions that started a treatment episode[92].

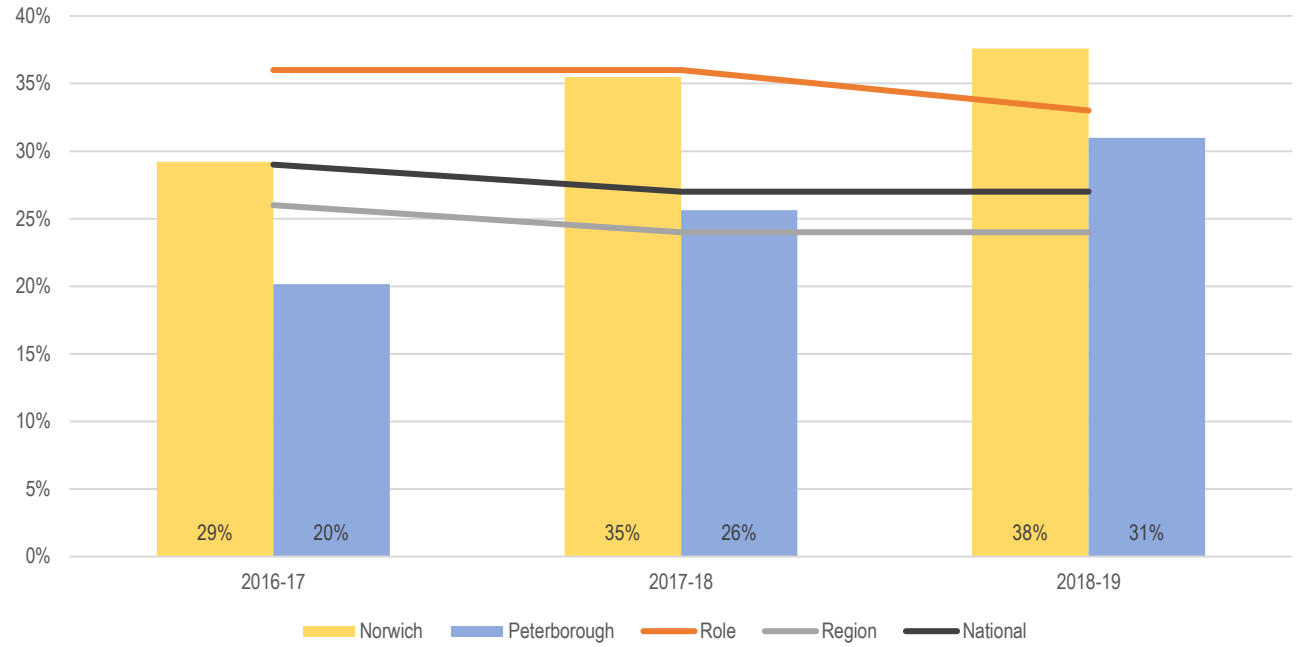
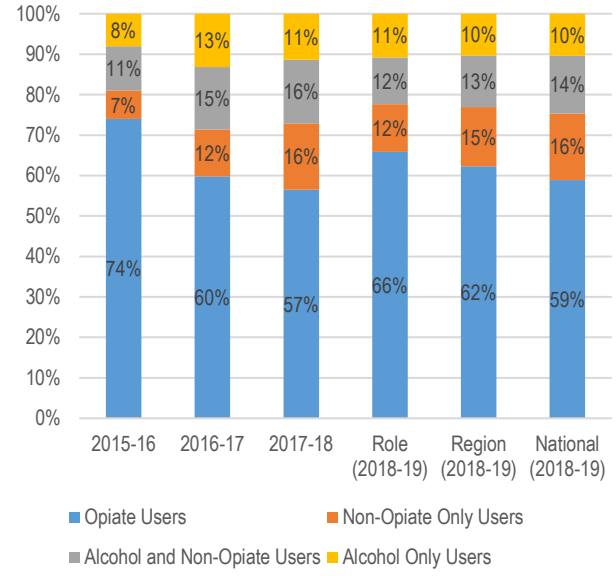
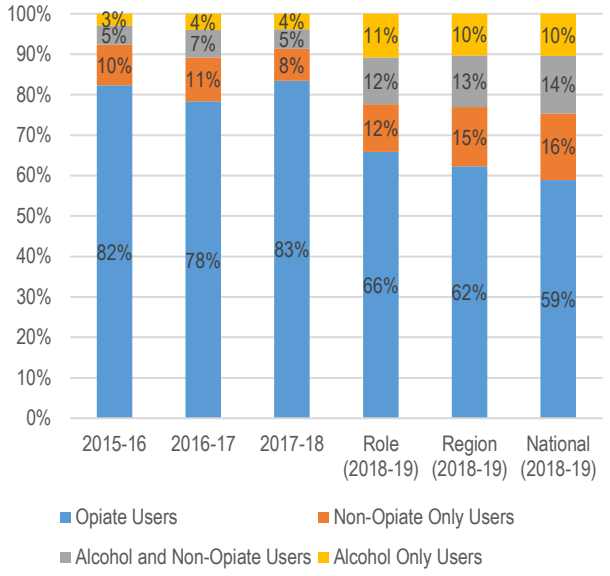


Figure 3.5.17: New treatment entrants broken down by substance citation; HMP Norwich.



Year	2016-17	2017-18	2018-19
New Entrants	895	1039	738
Opiate Users	662	621	417
Non-Opiate Only Users	63	121	121
Alcohol and Non-Opiate Users	98	160	116
Alcohol Only Users	72	137	84

Figure 3.5.18: New treatment entrants broken down by substance citation; HMP Peterborough.



Year	2016-17	2017-18	2018-19
New Entrants	683	770	289
Opiate Users	562	603	241
Non-Opiate Only Users	69	84	23
Alcohol and Non-Opiate Users	32	52	14
Alcohol Only Users	20	31	11

[92] 2018-19 data covers April 2018 to September 2018.

The following charts shows in-treatment profiles based on whether prisoners recorded any of the listed drugs as the main drug, second drug, or third drug.

In HMP Norwich, the main change has been the decrease in those recorded with heroin, and an increase in other opiates.

There has also been a decrease in those in-treatment in HMP Peterborough with the main drug, second drug, or third drug recorded as heroin.

Figure 3.5.19: In-treatment profile based on whether prisoners recorded any of the listed drugs as the main drug, second drug, or third drug; HMP Norwich.

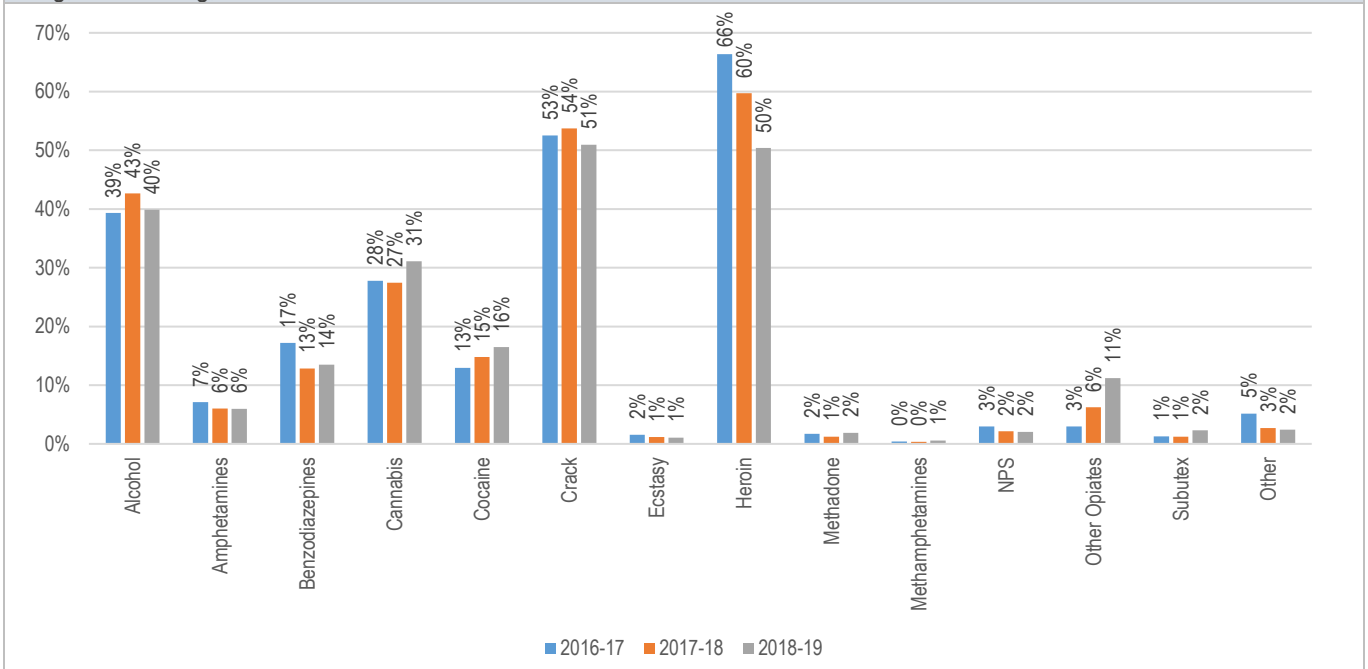
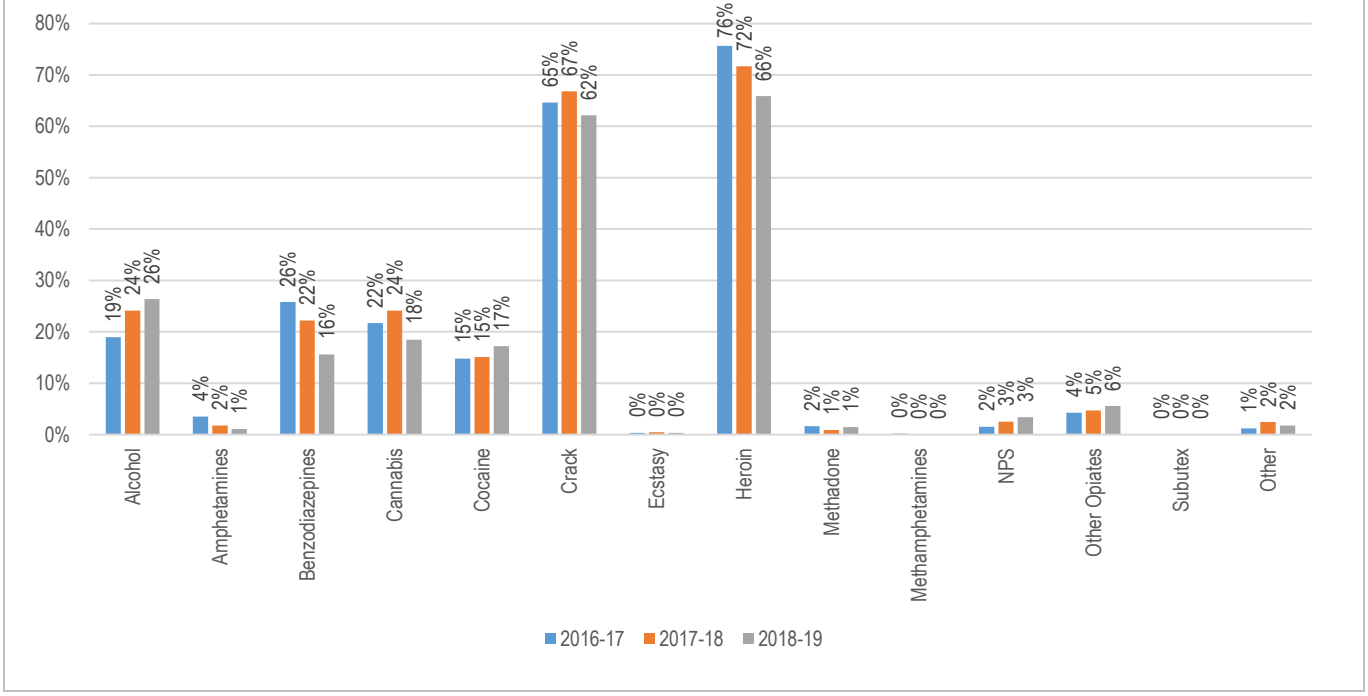


Figure 3.5.20: In-treatment profile based on whether prisoners recorded any of the listed drugs as the main drug, second drug, or third drug; HMP Peterborough.



TRANSFERS TO COMMUNITY

Below shows the number of released prisoners discharged from prison treatment as "Transferred – Not in Custody" between July 2017 and June 2018 and the number of these that commenced a treatment episode with a community treatment provider within 3 weeks of release.

The treatment commencement rate in HMP Norwich was low at 20%. Around half of the referrals were to Norfolk, with this partnership reporting a low commencement rate of 10%.

In comparison, the treatment commencement rate in HMP Peterborough was higher at 40%. A high number of referrals were to Peterborough and Cambridgeshire, both of which had a high treatment commencement rate.

Figure 3.5.21: Transfers to community; HMP Norwich.

Partnership Referred To	Referred	Commenced Treatment	% Commenced Treatment
Norfolk	77	8	10%
Suffolk	48	17	35%
Essex	8	2	25%
Cambridgeshire	4	0	0%
Sheffield	2	1	50%
Other	8	1	13%
Released to Outside England[93]	1		
HMP Norwich	147	29	20%
Role	19419	6230	32%
Region	8260	2646	32%
National	24638	8012	33%

[93] Other = 8 other partnerships. Values are less than 2 referred.

TRANSFERS TO PRISON

Below shows the number of patients transferred to another establishment between July 2017 and June 2018 where it is intended that they will continue treatment (discharge reason = ”transferred – in custody”) and the number of these commencing a treatment episode within 3 weeks of the transfer.

The treatment commencement rate in HMP Norwich at 52% is higher than HMP Peterborough, and similar to prisons of a similar role. Over half of the referrals from HMP Norwich were to HMP Wayland and HMP Highpoint; both of which reporting good commencement rates.

For HMP Peterborough, prisons that report a poor treatment commencement rate include HMP The Mount, HMP Stocken, and HMP Hollesley Bay.

Figure 3.5.23: Transfers to prison; HMP Norwich.

Prison Transferred To	Referred	Commenced Treatment	% Commenced Treatment
HMP Wayland - Phoenix Futures	26	16	62%
HMP Highpoint - Phoenix Futures	10	10	100%
HMP Peterborough (Male)	8	2	25%
HMP & YOI Isis (Addaction/Oxleas)	3	1	33%
IRC Morton Hall 2	2	0	0%
HMP Wayland	2	0	0%
HMP Brixton (Care UK/Forward Trust)	2	1	50%
HMP Chelmsford - Phoenix Futures	2	1	50%
HMP Hollesley Bay - Phoenix Futures	2	0	0%
Other	8	3	38%
HMP Norwich	65	34	52%
Role	11323	6019	53%
Region	5129	2305	45%
National	17285	8319	48%

PRIMARY CARE AND LONG-TERM CONDITIONS

PRIMARY CARE OVERVIEW PAGE 124

ASTHMA PAGE 125

CANCER PAGE 128

CARDIOVASCULAR DISEASE PAGE 130

DIABETES PAGE 132

EPILEPSY PAGE 136

OBESITY PAGE 139

HMP NORWICH	
LONG-TERM CONDITION MANAGEMENT	
In HMP Norwich, care for patients with long-term conditions is managed between the GP, the nurse practitioner, and nursing staff.	

ASTHMA

SUMMARY

HMP NORWICH	
GENERAL	
Patients with asthma are seen by nursing staff in regular clinics. Patients with more complex needs can be seen by the nurse practitioner or the GP. Pulmonary rehabilitation is not offered in the prison.	
A PATHWAY IS WELL DEFINED	
Patients are identified with asthma at the reception screen. They are then seen by a prescriber and reviewed as per NICE guidelines.	
PREVALENCE	
For the current population, the expected prevalence of asthma is the same across both prisons at around 12.5%. The actual prevalence in both prisons is similar to the expected rate.	
MEDICATION	
Patients hold their inhalers in-possession pending an in-possession risk assessment.	
BEST PRACTICE – SPIROMETRY	
There were no nursing staff trained in spirometry in the prison.	
BEST PRACTICE – SMOKING	
Smoking cessation clinics are run by healthcare assistants.	
BEST PRACTICE – EXERCISE	
There is remedial gym available. Patients can be referred by the GP or the Nurse Prescriber.	
NICE GUIDELINES - REVIEWS	
Reviews are completed by nursing staff.	
QOF PERFORMANCE	
The QOF indicators covering asthma shows poor performance.	

INTRODUCTION

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

Asthma can affect almost anyone, although it tends to be worse in children and young adults.[94] Research has also shown that south Asian and Afro-Caribbean people in the UK are significantly more likely to be admitted to hospital for asthma-related problems than those of white ethnicity.[95]

The study by Marshall et al[96] estimated that 13% of the prison population had asthma. This is higher than the general population due to a number of reasons:

- A higher rate of heavy smokers
- A younger population
- Lack of exercise
- Stress
- Prolonged periods being indoors
- Socio-economic status

PHE TOOLKIT

The PHE toolkit provides expected prevalence rates by age group. These rates have been used in this HSCNA.

BEST PRACTICE AND GUIDANCE

The British Thoracic Society / Scottish Intercollegiate Guidelines Network (BTS / SIGN) Asthma Guidance was updated in October 2014.[97]

The guidance makes a number of recommendations relevant to asthma care in a prison:

- Spirometry is the preferred initial test to assess the presence and severity of airflow obstruction in adults.
- Parents with asthma should be advised about the danger of smoking to themselves and to their children with asthma and be offered appropriate support to stop smoking.
- Breathing exercise programmes (including physiotherapist-taught methods) can be offered to people with asthma as an adjuvant to pharmacological treatment to improve quality of life and reduce symptoms.

IDENTIFICATION

In both prisons, the reception screen asks for a current diagnosis of asthma.

[94] http://www.asthma.org.uk/asthma-facts-and-statistics
[95] Gopalakrishnan, N., 'Ethnic variations in incidence of asthma episodes in England & Wales: National study of 502,482 patients in primary care', Respiratory Research, 6:120, (2005).
[96] Marshall, T., Simpson, S. & Stevens, A., Toolkit for health care needs assessment in prisons, (Department of Public Health & Epidemiology, University of Birmingham, 2000).
[97] SIGN (2014), British guidance on the management of asthma.

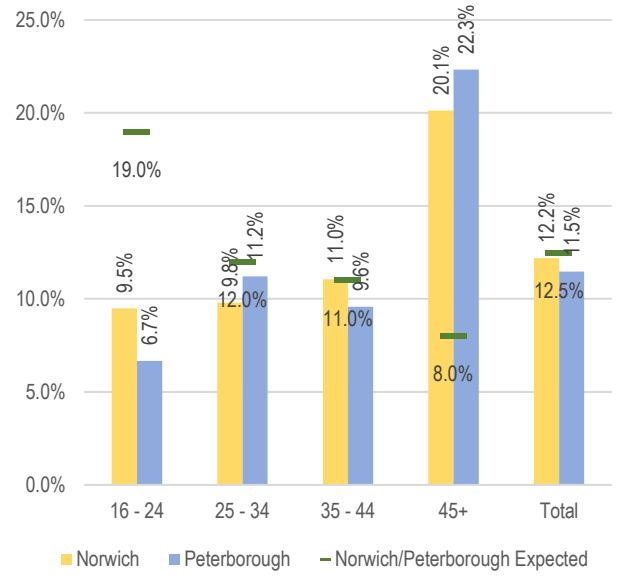
PREVALENCE

The expected prevalence is calculated using the PHE Toolkit and is based on age. This means other factors that affect asthma such as smoking, ethnicity, and exercise was not factored into the calculation.

Figure 4.2.1: Expected asthma prevalence taken from the PHE Toolkit.	
Age Group	Expected Prevalence
16-24	19%
25-34	12%
35-44	11%
45-64	8%
65+	

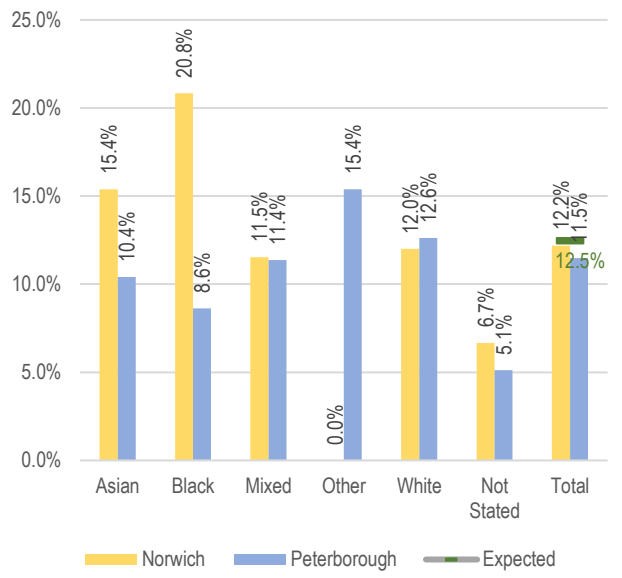
For the current population, the expected prevalence of asthma is the same across both prisons at around 12.5%. The actual prevalence in both prisons is similar to the expected rate. However, an analysis by age shows that that the expected prevalence is highest among the younger age group and lower among the older age group, although the actual prevalence shows an inverse trend.

Figure 4.2.2: QOF prevalence; age.



	16 - 24	25 - 34	35 - 44	45+	Total
Norwich					
Population	158	245	181	154	738
Register	15	24	20	31	90
Expected	30	29	20	12	92
Peterborough					
Population	150	348	209	112	819
Register	10	39	20	25	94
Expected	29	42	23	9	102

Figure 4.2.3: QOF prevalence; ethnicity.



	Asian	Black	Mixed	Other	White	Not Stated	Total
Norwich							
Population	13	48	26	13	608	30	738
Register	2	10	3	0	73	2	90
Expected							92
Peterborough							
Population	48	58	44	13	578	78	819
Register	5	5	5	2	73	4	94
Expected							102

CANCER

SUMMARY

HMP NORWICH	
GENERAL	
There were four patients with cancer in the prison. One of the patients was based on L-wing and was sent out for regular chemotherapy.	
2 WEEK REFERRAL	
There are no issues with the prison escorting patients for their two-week referral.	
PREVALENCE	
At the time of this HSCNA, there were five prisoners on the register. The PHE Toolkit does not provide the expected prevalence.	
BOWEL CANCER SCREENING	
Bowel cancer screening for the prison is managed by the lead nurse based on L-wing.	
END OF LIFE CARE	
There is an end of life care pathway in place. For patients who reach the end stages of life, healthcare has close links with the Priscilla Bacon Lodge Hospice in Norwich. L-wing has been accredited as meeting the Gold Standard Framework in end of life care.	
QOF	
There was one prisoner that qualified for indicator “CAN003 - Review within 6m of diagnosis”, however at the time of this HSCNA, they had not received one.	

INTRODUCTION

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

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

PHE TOOLKIT

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

The PHE Toolkit does not provide prevalence rates for the prison population.

IDENTIFICATION

In both prisons, the reception screen asks for "Malignant tumour (Ongoing Episode)".

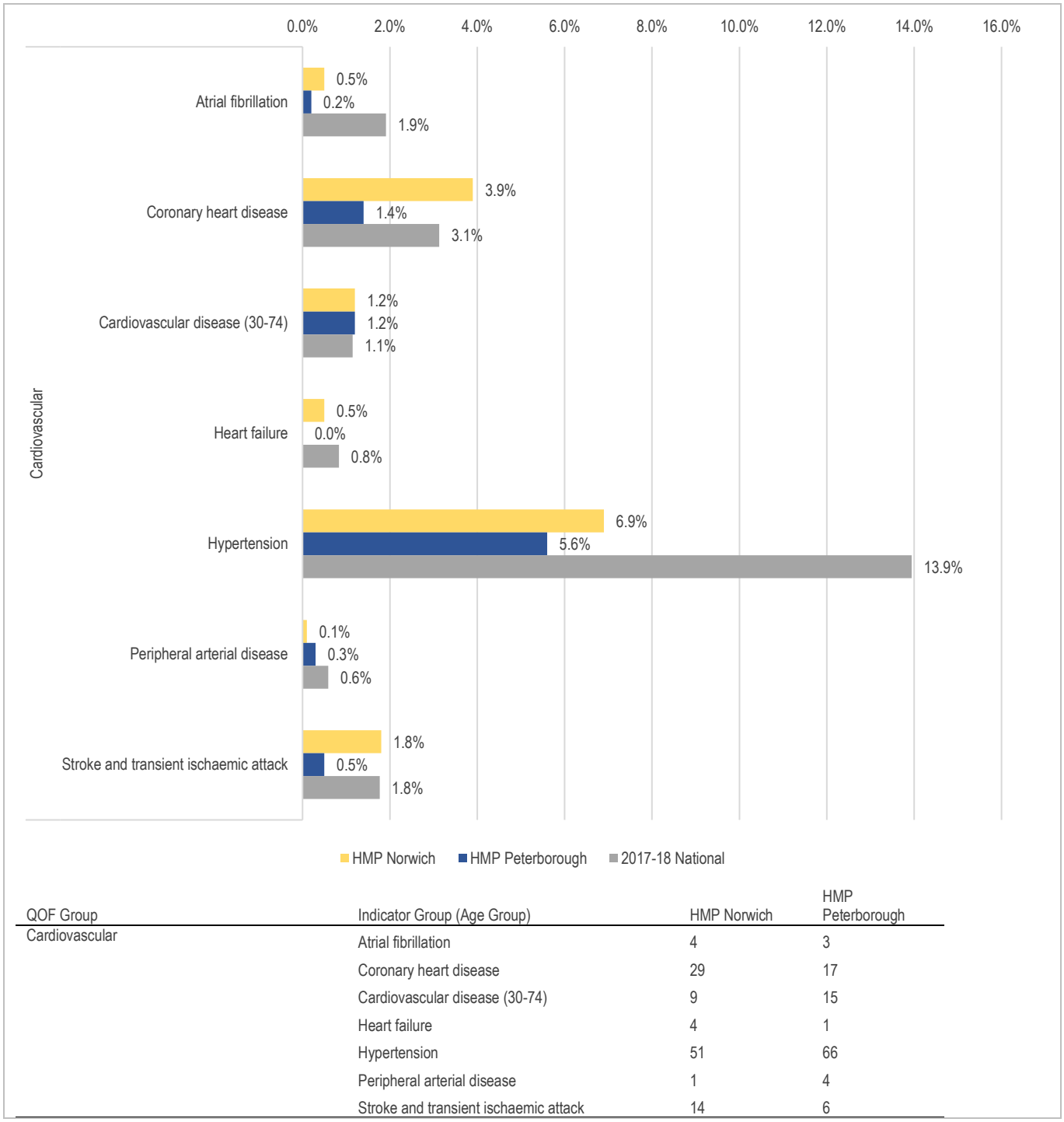
CARDIOVASCULAR DISEASE

SUMMARY

HMP NORWICH	
GENERAL	
Patients with heart problems are seen by nursing staff in regular clinics. Patients with more complex needs can be seen by the nurse practitioner or the GP.	
MEDICATION	
Medication for hypertension and other heart conditions are managed by the GP and the nurse prescriber.	
A PATHWAY IS WELL DEFINED	
PREVALENCE	
There are seven indicators in QOF that are CVD related. In a number of these registers, the rate in HMP Norwich is higher than HMP Peterborough, including hypertension (6.9%; 5.6%) and coronary heart disease (3.9%; 1.4%).	
GYM	
There is no cardio rehabilitation in the prison.	
REVIEWS	
Patients have their reviews completed by nursing staff.	
QOF	
Atrial Fibrillation: Good performance scoring 29 / 29. Secondary Prevention of Coronary Heart Disease: Good performance scoring 31.6 / 35. Cardiovascular Disease Primary Prevention: No prisoners qualified for indicator CVD-PP001 - CVD risk assessment. Heart Failure: Good performance scoring 29 / 29. Hypertension: Good performance scoring 26 / 26. Peripheral Arterial Disease: Good performance scoring 6 / 6. Stroke and Transient Ischaemic Attacks (TIA): 10.3 / 15. An area for improvement is STIA007 - Non-haemorrhagic stroke which scores 1 / 4.	

Below shows the prevalence of CVD related QOF registers in January 2019. In general, the prevalence in HMP Norwich is higher than those in HMP Peterborough.

Figure 4.4.1: Prevalence of CVD related QOF registers.



QOF Group	Indicator Group (Age Group)	HMP Norwich	HMP Peterborough
Cardiovascular	Atrial fibrillation	4	3
	Coronary heart disease	29	17
	Cardiovascular disease (30-74)	9	15
	Heart failure	4	1
	Hypertension	51	66
	Peripheral arterial disease	1	4
	Stroke and transient ischaemic attack	14	6

DIABETES

SUMMARY

HMP NORWICH	
GENERAL	
Patients with diabetes are managed between nursing staff, the nurse practitioner, and the GP. A nurse is currently completing insulin risk training.	
DIABETES PATHWAY	
Patients are asked about existing health problems including diabetes at the reception screen. There is no visiting diabetes specialist. Patients can be referred to the hospital if they are particularly unstable. Patients who are unstable can be moved to healthcare for more intensive care. Diabetes can be identified via the NHS Health Check.	
PREVALENCE	
The actual rate in HMP Norwich at the time of this HSCNA was 5.4% (40 prisoners) which is slightly lower than the expected rate of 6.1% (45 prisoners). In HMP Peterborough there is a significant gap between the actual rate of 2.6% (21 prisoners) and the expected rate of 5.1% (42 prisoners).	
FOOD	
There is a healthy option on the menu of the canteen.	
GYM	
There is remedial gym available. Patients can be referred by the GP or the Nurse Prescriber.	
FEET	
QOF performance indicates that this is an area of need with 9 of the eligible 25 patients achieving “DM012 - Foot examination in last 12 months”. Foot checks are administered by the podiatrist.	
DIABETIC EDUCATION	
There is no structured diabetes education in either prison.	
NICE GUIDELINES – MEDICATION	
NICE* guideline NG57 lists drugs to treat diabetes as medicines which must be given on time to prevent harm. This means that you should not find yourself in a situation where you are not able to take insulin or diabetes medication at the correct time. In both prisons, patients are encouraged to self-manage their medication. Equipment such as a glucometer is issued to patients in-possession, dependent on their risk assessment.	
NICE GUIDELINES – DIARIES	
NICE has released new guidelines for health professionals treating patients in prison. (Guideline NG57). *You should have a pre-release meeting with a healthcare professional to discuss your healthcare after your release. Out of this meeting you should get a copy of your care plan and your action plan. The care plan should list all health and social issues that affected*	

you while in prison, how they were treated and a medications list. Your action plan should include any future appointments after release and help to register with a new GP, if needed. You should receive all your current medication to last for at least seven days, or an FP10 prescription. An FP10 prescription allows you to pick up medication from a community pharmacy without having to pay a prescription charge. This should give you time to register with a GP. Patients have a care plan created on SystmOne.	
REVIEWS	
Reviews are completed by nursing staff.	
QOF	
Performance is generally good with a total score of 70.4 out of 86. Areas of improvement are "DM012 - Foot examination in last 12 months" and "DM014 - Referred to structured education programme", although access to structured education programmes are usually rare in a prison setting.	

INTRODUCTION

It is estimated that in the UK, there are 2.9 million people affected by diabetes, with a further 850,000 undiagnosed. Type 2 diabetes accounts for approximately 90% of all adults with diabetes, with the remaining 10% affected by type 1 diabetes.[98] Although diabetes cannot be cured, the condition can be successfully managed, and the risk of developing further complications such as stroke, blindness, nerve damage, and kidney failure can be reduced.

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

It is argued that the prison environment can provide an opportunity to address the health needs of a "hard to reach" sector of society with diabetes. Research[99] shows that "ethnicity can increase or decrease one's risk of developing diabetes", and that:

- Type 2 diabetes is up to six times more likely in people of South Asian descent.
- Type 2 diabetes is up to three times more likely in African and Afro-Caribbean people.

GUIDELINES

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

Quality standards include:

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

PHE TOOLKIT

[98] Diabetes UK (2012), *Diabetes in the UK 2012*.
[99] Stratton, I.M. (2000), 'Association of glycaemia with macrovascular and microvascular complications of Type 2 diabetes: prospective observational study', *British Medical Journal* 2000; 321: 405-412.

In his 2012-13 annual report, the prison and probation ombudsman wrote that poor, assessment and care planning of diabetes were contributory causes of a number of deaths. This included not measuring blood sugar (via HbA1c measurements) every 3-6 months for those with insulin nondependent diabetes; not actively following up when organ damage was identified such as diabetic retinopathy or renal disease. Diabetes UK has identified nine key care processes http://www.diabetes.org.uk/documents/reports/state-of-the-nation-2012.pdf.

The prison HNA needs to identify levels of compliance with these regular care processes:

i. Blood glucose level measurement
ii. Blood pressure measurement
iii. Cholesterol level measurement
iv. Retinal screening
v. Foot and leg check
vi. Kidney function testing (urine)
vii. Kidney function testing (blood)
viii. Weight check
ix. Smoking status check

IDENTIFICATION

Diabetes is covered as part of the reception screen.

PREVALENCE

Figure 4.5.1 shows the prevalence rates that are provided in the PHE Toolkit. It is understood that the true rates of prevalence are higher, as the information in this table was based on community data for 1996, and the UK rate has increased since then.

An alternative estimate is provided by the APHO (now part of PHE) Diabetes Prevalence Model Estimates. The aim of the model is to "provide robust estimates of the total prevalence of diabetes (including undiagnosed) in England to support effective planning and delivery of services". The model takes into account ethnicity and age. The model also factors in deprivation of the population, for which assumptions were made for the prison population.

Figure 4.5.1: Diabetes prevalence rates

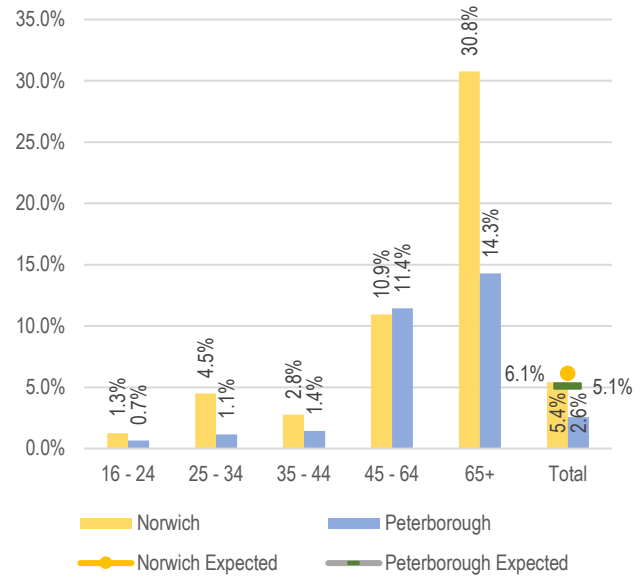
Age Group	PHE Toolkit Prevalence	
	Diabetes Insulin Dependent	Diabetes Non-Insulin Dependent
16-24	0.3%	0.0%
25-34	0.5%	0.1%
35-44	0.6%	0.3%
45-64	0.75%	1.9%
65+	1.1%	4.2%

Applied to HMP Norwich gives a prevalence of 6.1% for the current population. For HMP Peterborough, the rate is lower at 5.1%. The actual rate in HMP Norwich at the time of this HSCNA was 5.4% (40 prisoners) which is slightly lower than the expected rate of 6.1% (45 prisoners). In HMP Peterborough there is a significant gap between the actual rate of 2.6% (21 prisoners) and the expected rate of 5.1% (42 prisoners).

The analysis by age shows a general increase in prevalence in corelation with an increase in age group. Across most age groups, the rates are higher in HMP Norwich in comparison to HMP Peterborough.

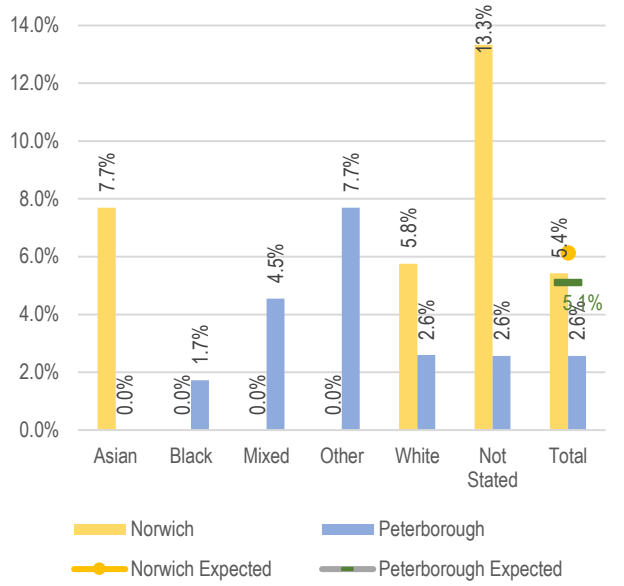
The analysis by ethnicity shows potential unidentified prisoners with diabetes. For example, in HMP Peterborough, no prisoners of Asian ethnicity are on the register. Similarly, in HMP Norwich, no prisoners from either a black, mixed, or other ethnic group are on the register.

Figure 4.5.2: QOF prevalence; age.



	Under 21	21 - 29	30 - 39	40 - 49	60+	Total
Norwich						
Population	158	245	181	128	26	738
Register	2	11	5	14	8	40
Expected						45
Peterborough						
Population	150	348	209	105	7	819
Register	1	4	3	12	1	21
Expected						42

Figure 4.5.3: QOF prevalence; ethnicity.



	Asian	Black	Mixed	Other	White	Not Stated	Total
Norwich							
Population	13	48	26	13	608	30	738
Register	1	0	0	0	35	4	40
Expected							45
Peterborough							
Population	48	58	44	13	578	78	819
Register	0	1	2	1	15	2	21
Expected							42

EPILEPSY

SUMMARY

HMP NORWICH	
GENERAL	
Patients with epilepsy are seen by the GP or the nurse practitioner.	
A PATHWAY IS WELL DEFINED	
Patients have the opportunity to disclose that they have epilepsy at the reception screen. Patients with epilepsy will see the GP for a medication review.	
PREVALENCE	
The prevalence of epilepsy is expected to be around 2% in both prisons. The prevalence in HMP Norwich is 3.8% compared to 2.7% in HMP Peterborough.	
MEDICATION	
Patients who are prescribed epilepsy medication will have their medication reviewed by the GP.	
SAFE LOCATION	
Patients with epilepsy are given a single cell. The reason given for this was that some patients with alcohol induced fits could become violent. Healthcare can provide the prison with recommendations regarding accommodation requirements.	
NICE GUIDELINES - REVIEWS	
Reviews are completed by the GP.	
QOF	
The QOF performance indicators only require for the obesity register to be maintained	

INTRODUCTION

Epilepsy is the most common serious neurological disorder in the world. In the general population, the prevalence of epilepsy is approximately 0.8%[100].

A paper by the Mersey Region Epilepsy Association[101] found that epilepsy in the prison population has a higher rate of prevalence. The paper also shows factors that could trigger a seizure tend to increase in prison for a number of reasons:

- Emotional stress: being in prison is stressful in itself, especially for those entering the system for the first time. In addition, breakdown of relationships with those in and out of the prison could add further stress.
- Alcohol: excessive drinking leads to an increase in seizure pattern because the effectiveness of antiepileptic drugs can be impaired.
- Boredom: research suggests that the regularity of seizures increases when the mind is unoccupied.
- A 2008 audit of healthcare provision for UK prisoners18 with suspected epilepsy found that fewer prisoners than expected achieve seizure control, as collaboration with specialist epilepsy services is poor, and significant discrepancies exist between the healthcare provision in prison and the NICE epilepsy guidelines.
- Prison staff are likely to encounter someone having a seizure at some point during the course of their work. It is therefore essential that all prison staff have the right training and knowledge to act appropriately in the given situation.

IDENTIFICATION

Epilepsy is covered as part of the reception screen.

PREVALENCE

Research into the prevalence of epilepsy in the prison population is limited. Appendix A1 of the PHE Toolkit does not provide an estimated prevalence of epilepsy for male prisoners. However, the PHE Toolkit provides text referring to the estimate from Stewart (2010) stating that "…of all those who were newly sentenced…he found that between 1-2% had diabetes and 2% of men had epilepsy and 5% of women."

Figure 4.6.1 shows a study by Seena Fazel, Evangelos Vassos and John Danesh in the BMJ (2007). A comment from the study is that "...this synthesis of seven surveys involving more than 3000 participants in general prison populations indicates that only about 1% reported a history of chronic epilepsy."

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

In terms of age, research in the UK shows that the incident rates vary with age. The UCL Institute of Neurology found that: "Studies in the industrialised world consistently show a bimodal distribution. There is a very high incidence in the first year of life and in early childhood, with a relative decrease in adolescence. Incidence is at its lowest between the ages of 20 and 40 and steadily increases after age 50, with the greatest increase seen in those over age 80".

"There is evidence that the incidence of epilepsy is now higher in elderly people than children." Figure 4.6.2 shows the incidence of epilepsy in the UK per 100,000 of the population, taken from the Joint Epilepsy Council of the UK and Ireland[102].

The available research for epilepsy rates among different ethnic groups is limited.

[100] 2017-18 QOF

[101] Mersey Region Epilepsy Association, *Epilepsy in Prison*.

[102] http://www.epilepsyscotland.org.uk/pdf/Joint_Epilepsy_Council_Prevalence_and_Incidence_September_11_%283%29.pdf

Figure 4.6.1: Expected epilepsy prevalence in prisons[103]

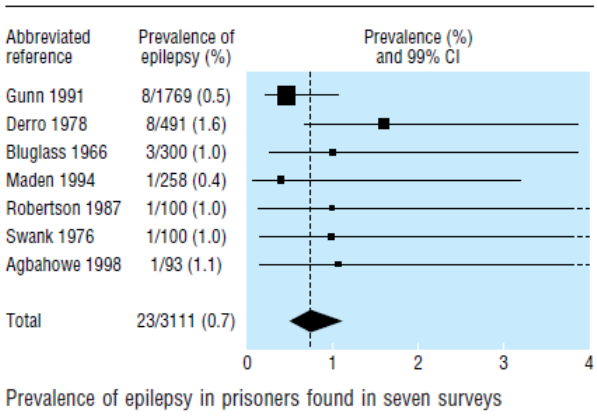
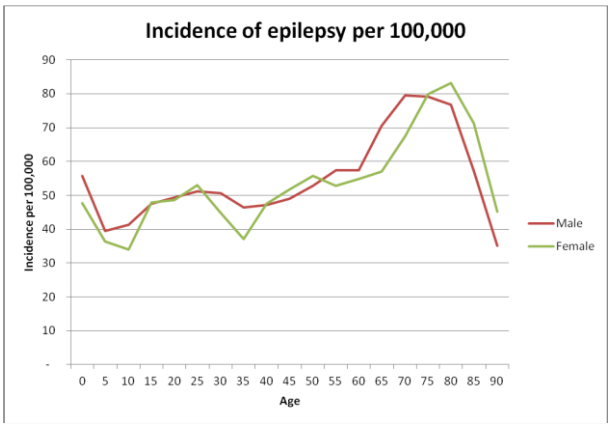
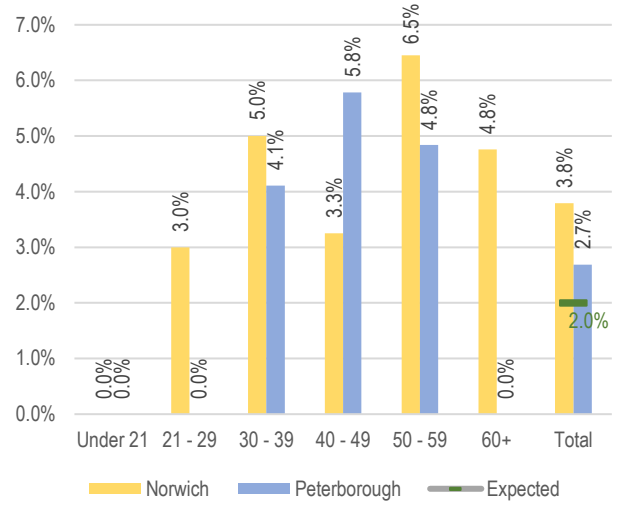


Figure 4.6.2: Incidence of epilepsy[104]



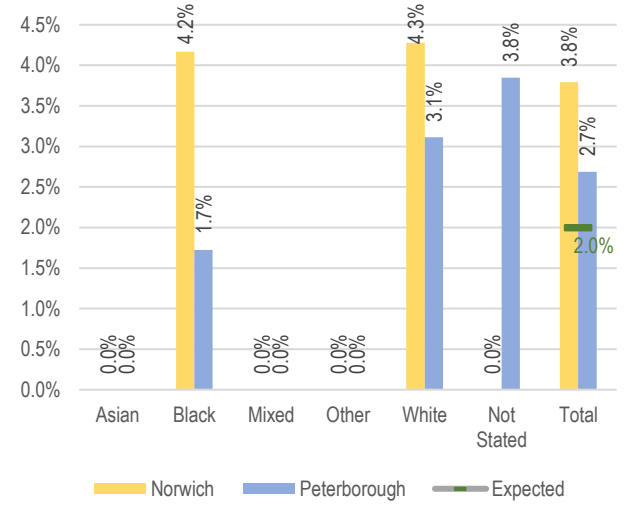
At 3.8%, the actual prevalence in HMP Norwich is higher than both the expected rate and the actual rate in HMP Peterborough of 2.7%. The analysis by demographics suggest that there may be unmet need. For example, in both prisons, none of the under-21 population are on the register. In addition, no prisoners of Asian, Mixed, or Other ethnicity are on the epilepsy register.

Figure 4.6.3: QOF prevalence; age.



	Under 21	21 - 29	30 - 39	40 - 49	50 - 59	60+	Total
Norwich							
Population	71	200	240	123	62	42	738
Register	0	6	12	4	4	2	28
Expected							15
Peterborough							
Population	47	288	292	121	62	9	819
Register	0	0	12	7	3	0	22
Expected							16

Figure 4.6.4: QOF prevalence; ethnicity.



	Asian	Black	Mixed	Other	White	Not Stated	Total
Norwich							
Population	13	48	26	13	608	30	738
Register	0	2	0	0	26	0	28
Expected							15
Peterborough							
Population	48	58	44	13	578	78	819
Register	0	1	0	0	18	3	22
Expected							16

[103] Seena Fazel, Evangelos Vassos and John Danesh

[104] Source: UCL Institute of Neurology

OBESITY

SUMMARY

HMP NORWICH	HMP PETERBOROUGH
GENERAL	
Healthcare runs weight loss clinics where health promotion and healthy lifestyle advice are given. Patients are seen in the clinics every two weeks. There are weighing scales available on the wings.	
GYM	
There is remedial gym available. Patients can be referred by the GP or the Nurse Prescriber.	
PREVALENCE	
The prevalence rates across both prisons based on the QOF register is 13-14%. The analysis by age shows a general increase in prevalence in correlation with an increase in age.	
QOF	
The QOF performance indicators only require for the obesity register to be maintained	

INTRODUCTION

NHS UK lists people eating more calories than they can burn off as the main cause of obesity. Other causes include the modern lifestyle which involves poor diets, stress, and lack of exercise. The risk of obesity is that it can lead to a number of conditions including type 2 diabetes, coronary heart disease, and stroke.

Studies into the prevalence of obesity in the prison population are limited; however, in 2012, a review by the University of Oxford[105] showed that "male prisoners are slimmer than men in the general population".

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

PHE TOOLKIT

Key points taken from the PHE Toolkit are:

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

IDENTIFICATION

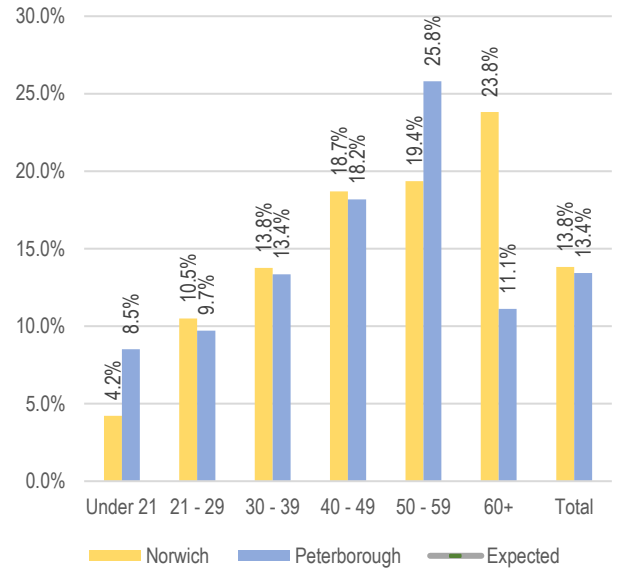
BMI is recorded as part of the reception screen.

[105] HSCIC (2015), *Statistics on Obesity, Physical Activity and Diet*.

PREVALENCE

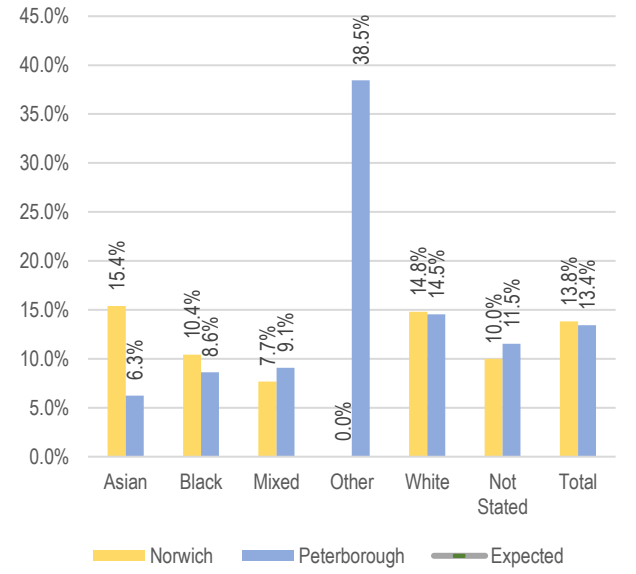
The prevalence across both prisons show a similar rate of 13-14%. The analysis by age also show a similar pattern where an increase in age correlates with an increase in prevalence.

Figure 4.7.1: QOF prevalence; age.



	Under 21	21 - 29	30 - 39	40 - 49	50 - 59	60+	Total
Norwich							
Population	71	200	240	123	62	42	738
Register	3	21	33	23	12	10	102
Expected							-
Peterborough							
Population	47	288	292	121	62	9	819
Register	4	28	39	22	16	1	110
Expected							-

Figure 4.7.2: QOF prevalence; ethnicity.



	Asian	Black	Mixed	Other	White	Not Stated	Total
Norwich							
Population	13	48	26	13	608	30	738
Register	2	5	2	0	90	3	102
Expected							-
Peterborough							
Population	48	58	44	13	578	78	819
Register	3	5	4	5	84	9	110
Expected							-

OTHER SERVICES

PHARMACY PAGE 142

ESCORTS AND BEDWATCHES PAGE 145

CLINICS PAGE 147

PHARMACY

INTRODUCTION

There are various models that support pharmaceutical service delivery in prisons. The 2012 National Prescribing Centre report, *Safe Management and Use of Controlled Drugs in Prison Health in England*[106] agreed on the requirements of a full pharmaceutical service to a prison, regardless of the service model. The requirements were:

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

BEST PRACTICE

The Royal College of General Practitioners document, *Safer Prescribing in Prisons: Guidance for Clinicians*[107], wrote that many prisoners, though not all, are accustomed to using illicit and prescribed drugs to ameliorate or treat symptoms and perceived wants and needs.

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

PHE TOOLKIT

The PHE toolkit states that pharmacy data "provides information about use of drugs. 44% of the prison population reported in 2013 to be taking medication (HoC Justice Committee); 73% in women prisoners (Plugge E. Health of women prisoners 2006)".[108]

"SystmOne records primary care appointments for minor and self-limiting illnesses. Pharmacy data will show levels of prescriptions for analgesics and skin creams. While these problems are minor in that they are not life-threatening and are self-limiting, provision of relief is as important as for the more serious disorders."

[106] National Prescribing Centre, (2012), *Safe Management and Use of Controlled Drugs in Prison Health in England*
[107] Royal College of General Practitioners, (2011), *Safer Prescribing in Prisons: Guidance for clinicians*
[108] Plugge E, Health Care Women Int. 2005 Jan;26(1):62-8, *Assessing the health of women in prison: a study from the United Kingdom*

HMP NORWICH	
OVERVIEW	
The pharmacy in HMP & YOI Norwich supplies medicines to all three prisons in the Norfolk cluster. Pharmacy technicians also dispense medication. There is a plan to increase the size of the pharmacy, to aid with dispensing tasks. The table below shows the staffing for the pharmacy team in the prison: **Job Title / Number** Lead Pharmacist: 1 (Shared between three prisons in the cluster) Pharmacist: 1 Technician: 4 Lead Technician: 1 (Currently on maternity leave) Accredited Checking Technician: 1 (Vacant) The pharmacist monitors the prescribing of patients and can request to have appointments with patients to review their medication. The pharmacy carries out approximately one compliance check per week in the prison. The pharmacist wants to start running medication use review clinics. At the moment, the pharmacist notes patients suitable for a medication review. These are carried out by the GP.	
MEDICATION MANAGEMENT	
Patients who arrive at reception are seen by a substance misuse specialist. Patients being prescribed pain medication are reviewed by the GP within seven days. There were 57 patients being prescribed pregabalin in the prison. These patients were being reviewed by the GP. 11 current prisoners had had their pregabalin discontinued. The pharmacist carried out an opiate audit in August 2018. There was no patient prescribed morphine above 120 mgs. Over the counter medications can be purchased from the prison canteen. There is a printed canteen list. Nurses are able to administer general sales list products and wing medication hatches are stocked with general sales medication.	

IN-POSSESSION MEDICATION	
In-possession risk assessments are completed in reception as part of the reception health screen. In-possession risk assessments are reviewed every six months. Patients who do not comply with their medication or where a risk of diverting is identified have their in-possession risk assessment reviewed. There is an up to date in-possession policy that is due for review in March 2019.	

ESCORTS AND BEDWATCHES

INTRODUCTION

Between October 2013 and September 2014, there were 818,168 escorted journeys of men, women, and children provided by Prisoner Escort and Custody Services (PECS) at a cost of £128.2 million. PECS covers a range of services including the escorting of detainees between police stations, courts and prisons/YOIs, transfers to and from hospital and inter-prison transfers.[109]

A health escort by security officers is necessary when a prisoner attends external healthcare treatment, including scheduled appointments or visits to A&E. When a prisoner is admitted to hospital for stays of at least one night, security staff are required for bedwatches. Most escorts require two officers at any one time, with the exception of high security prisons where three are required, and open prisons where no officers are required.

The majority of escorts are over within four hours, from prisoners leaving the establishment to their return. The majority of bedwatches are over within four days. Both these services are costly. In 2006, the average cost per escort was £140, and the average cost per bedwatch was £3,731.[110] In 2013, the average cost of an escort had risen to approximately £500.50.

HMCIP reports identify three main issues:

- The impact of healthcare escorts and bedwatches on the wider prison regime (in terms of staff availability and costs).
- Cancellation of external healthcare appointments (largely due to unavailability of escorting staff).
- The degree of co-operation between departments within the prison and NHS partners.

Security risks and costs linked with health escorts and bedwatches are high. The following areas of potential service redesign have been identified to help reduce such pressure:

- Addressing the area of injury and other trauma, which is the most common reason for escort and bedwatches. Reducing unnecessary visits to A&E could have a marked effect on the high levels of escorts and bedwatches.
- Providing within the prison a wider range of healthcare treatments and procedures normally provided in the community.
- Providing specific clinics within the prison to provide a more cost-effective service in these specialities.

[109] HMIP, (2014), Transfers and escorts within the criminal justice system
[110] HMIP, (2014), Transfers and escorts within the criminal justice system

ESCORTS

There are three HJIP indicators relating to escorts.

In both prisons, the average number of outpatient appointments a month between April 2018 and December 2018 has increased when compared against the previous financial year, with a high increase for HMP Norwich. As a rate against the snapshot population, both prisons report higher rates than their comparator prison. Note that this calculation covers April 2018 to December 2018 using the average number of escorts and the average snapshot population at the end of each month and does not take into account the turnover rate.

In both prisons, the average number of emergency appointments a month between April 2018 and December 2018 has decreased when compared to the previous financial year, with a more notable decrease for HMP Peterborough. The rate of emergency appointments is similar in both prisons. Additional analysis is available for HMP Norwich.

Figure 5.2.1: Rate comparison[111].

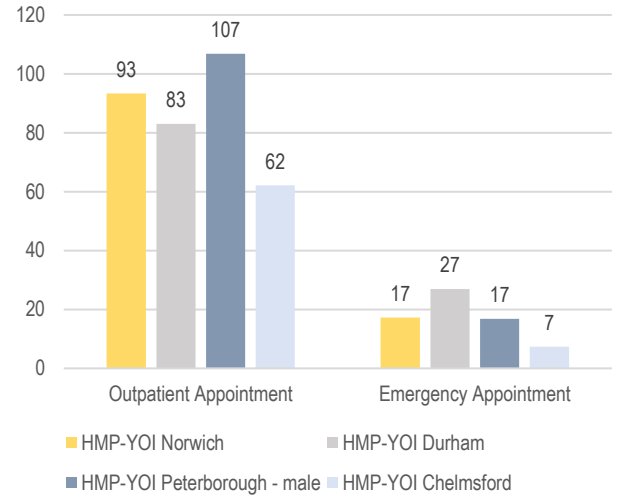


Figure 5.2.2: Outpatient appointments.

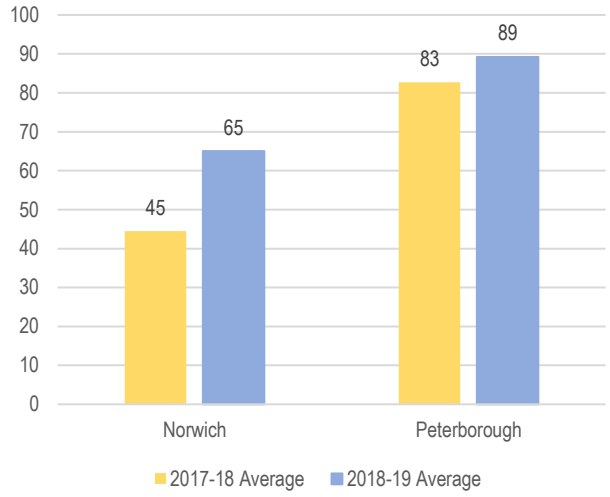


Figure 5.2.3: Emergency appointments.

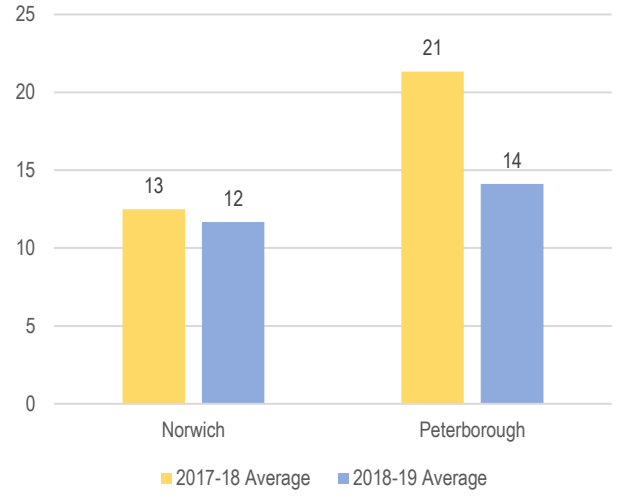
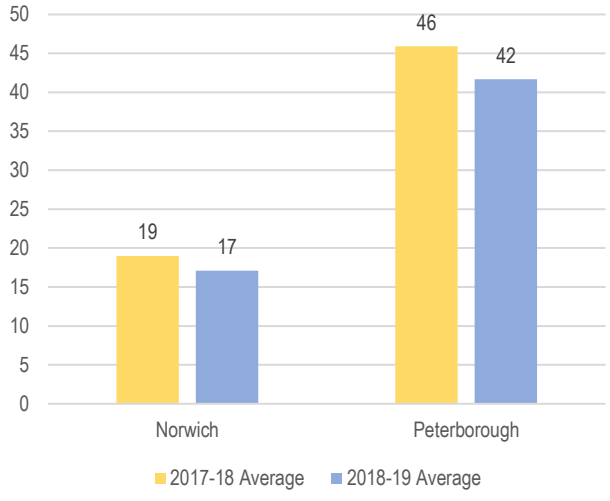


Figure 5.2.4: Cancellations.



BEDWATCHES

Performance indicators relating to bedwatches were removed from the 2017-18 and 2018-19 HJIPs framework.

[111] Based on April 2018 to December 2018 data. Average number of appointments by average end of month snapshot population and does not take into account turnover rate.

CLINICS

OVERVIEW

CLINIC SESSIONS

The table below shows the frequency of clinic sessions in HMP Norwich and HMP Peterborough.

Figure 5.3.1: The frequency of clinic sessions in HMP Norwich and HMP Peterborough	HMP NORWICH			
	Frequency (weekly)	Waiting Time		
Dentist	2.5	4-6 weeks (routine)		
GP	10	1 – 4 days		
Physiotherapist	1	4 weeks		
Podiatry	1	<4weeks		
Optician	1.5[112]	2 weeks		

[112] Approximately 7 per month

DENTIST

INTRODUCTION

Dental health is essential to general health and is a determinant of quality of life. The state of a person's teeth and gums will affect their wellbeing, impacting such things as their speech, appearance and diet. Gum diseases have also been linked to an increased risk of stroke, diabetes and heart disease.

There are regional and socio-demographic differences in dental health across England[113]. Similarly, inequalities exist in dental health between the prison population and the general population. Prisoners generally have poorer dental health, with reports of periodontal disease and or decayed, missing or filled teeth (DMFT) scores approximately four times higher than those of the general population[114].

Dental health needs of people entering prisons are high, with significant levels of unmet dental treatment needs. Research in north-west England showed the DMFT scores of people entering prison are approximately twice as high as those of the general population[115].

Dental health is worse in prisoners because they have detrimental habits that are not conducive to maintaining good oral health, including:

- smoking tobacco
- using illicit substances[116]
- decay-inducing diets
- chaotic lifestyles
- lack of dental health education[117].

High levels of dental health problems can adversely affect a prisoner's quality of life. However, prisoners seek dental care infrequently and will only do so when their teeth or gums are in pain or discomfort.

Dental service provision in prisons has been reported to be insufficient for the needs of the prison population[118]. There are frequent complaints from prisoners about waiting times to see a dentist in prison. In 2014, it was reported that 55% of prisoners waited 6 weeks or less for an examination; 35% waited 6 to 12 weeks; 3% waited over 18 weeks. For treatment, 38% were seen within 4 weeks; 44% waited longer than 4 weeks; and 12% waited more than 10 weeks[119].

Shortcomings in dental care in prisons have been attributed to:

- Infrequent clinical sessions
- Poorly equipped clinical services
- Rising numbers of people in prisons[120]
- The transient nature of the prison population.[121].

113 NHS England (2014), *Improving dental care and oral health*.
114 Harvey, S., Anderson, B., Cantore, S., King, E. and Malik, F. (2005), 'Reforming Prison Dental Services in England – A Guide to Good Practice', *Department of Health*
115 Jones CM, Woods K, Neville J, Whittle JG (2005), 'Dental health of prisoners in the North West England in 2000: Literature review and dental health survey results', *Community Dental Health* 22: 113-17.
116 Heidari E, Dickinson C, Wilson R, Fiske J (2007), 'Oral health of remand prisoners in HMP Brixton, London', *British Dental Journal*; 202.
117 Department of Health and HM Prison Service (2003), *Strategy for modernising dental services for prisoners in England*.
118 Bolin, K. and Jones, D. (2006), "Oral health needs of adolescents in a juvenile detention facility", *Journal of Adolescent Health*, Vol. 38, pp 755-757.
119 Public Health England (2014), *A survey of dental services in adult prisons in England and Wales*.
120 Gerrish and Forsyth (1995), *Prison Dental Services in England and Wales*, Department of Health Publications.
121 National Association for Prison Dentistry United Kingdom (2013), *The status of prison dentistry in England and Wales*.

PHE TOOLKIT

There is an increased use of emergency dental services and irregular dental attendance reported by prisoners at reception, and a significant amount of unmet treatment need.

In recent surveys in Wales, 88% of applications for care were due to pain and other problems. About a quarter (26%) surveyed reported they attended the dentist for regular check-ups compared to 64% in the ADHS 2009 and 17% of prisoners had never been to the dentist before prison (compared to 1% in the wider population). In recent Scottish surveys of prisoners, 59% of the participants had attended the dentist due to pain or discomfort with their teeth or gums, and only 22% attended for routine examination prior to their sentence, a similar number to that found in the Welsh survey. Barriers to accessing dental care include dental anxiety, illiteracy and lower levels of educational attainment, all of which can lead to prisoners not following oral health improvement advice.

Oral health tends to improve the longer a prisoner is in prison, with convicted prisoners having better oral health than short stay remand prisoners. Prisoners who are incarcerated for longer periods may have on-going assessment and treatment that they would not otherwise access outside the prison environment. A survey of remand prisoners showed that they used services more in prison than they did outside and over half (54%) reported that their last dental treatment was during a previous conviction.

In Scotland, survey participants had "surprisingly good" oral hygiene of their teeth and dentures relating to the frequency of tooth brushing and care of dentures and current imprisonment. This may suggest that the routine of prison life provided a supportive environment for the adoption and maintenance of good oral hygiene habits.

Despite this, there is evidence that pain relief and oral hygiene aids (such as dental floss) are restricted in prison environments. Transfer and release of patients can affect continuity of care for those patients who need to return to have laboratory work fitted (e.g. crowns and dentures) or who are in the middle of a course of treatment.

A recent survey of dental services in England and Wales found issues with dental services that are likely to be of interest to those commissioning them.

Prison dentists holding a PDS (personal dental services) contract complete FP17 forms containing patient details and clinical information such as type of treatment undertaken.

LOCAL PROVISION

Dental services in HMP Norwich are provided by John G. Plummer and Associates. The provider will be changing from April 2019 and the current dental staff will be returning to the practice. In HMP Peterborough, dental provision is provided by One Dental House Limited.

In HMP Peterborough, the provider was happy with the equipment and the location they practised in. In HMP Norwich, the provider detailed a number of issues relating to the equipment. The provider said that there were delays related to the replacing of hand instruments and other equipment, caused by disputes about payment. The provider chose to replace items themselves to ensure care was not delayed. The provider stated that light cures needed replacing in both dental suites.

The providers completed a survey that used a selection of questions taken from Public Health England's *A survey of dental services in adult prisons in England and Wales*.[122]

Figure 5.3.2: Response to Public Health England's A survey of dental services in adult prisons in England and Wales.

Questions	HMP Norwich	
THE SURGERY		
Has a Disability Access Audit been carried out on the dental surgery?	Unknown	
Is the dental surgery wheelchair accessible?	Yes	

[122] Public Health England (2014), *A survey of dental services in adult prisons in England and Wales*.

When was the surgery last refurbished?	Pre November 2015, actual date unknown	
When was the surgery last redecorated?	Pre November 2015, actual date unknown	
ABOUT YOU		
What is your role/ job title?	Operational manager for dental services in the Norfolk cluster	
How long have you worked in this prison?	Since November 2015	
What is the total number of clinical sessions worked by all dentists at this prison per week?	On a regular basis there are two days one week and three days the next and then two, then three.	
How long have you worked in prison dentistry?	Since November 2015	
Is there a signed Service Level Agreement (SLA) in place?	I think so	
To your knowledge, has an oral health needs assessment been carried out at this prison?	Unknown	
DENTAL STAFF		
How many dentists are employed in the prison?	Over the Norfolk cluster we have 17	
How many dental nurses are employed in the prison?	Over the Norfolk cluster we have 17-others are on maternity	
Do any of the following work at the prison? *[Hygienist/Dental Therapist/Clinical Technician/Oral Health Promoter/Other]*	1 x hygienist has access but does not work here	
EQUIPMENT		
Does any of the following equipment need to be updated or replaced? *[Dental chair/Delivery system/X-ray Unit/ Cabinetry/ Suction/Compressor/ Handpieces/Hand Instruments/ Autoclave/Disinfection eqpt/Floor covering/ Decoration/Surgical Instruments/Other]*	We have replaced hand instruments when they have needed replacing as there is too much politics regarding the payment of items, which as a service provider would delay care.	
Who is responsible for organising the maintenance of equipment?	Works department-though I have to remind them	
Who is responsible for payment of the maintenance contracts?	Works department-though I have to remind them	
Are maintenance contracts in place for equipment that needs regular certification?	Unknown	
What items are currently without a maintenance contract? *[Autoclave/Washer- disinfector/X-ray equipment/Compressor/Suction/Other]*	Washer disinfectors are not used therefore no contract in place as well as ultrasonic baths	
Are there any items of equipment that urgently need replacing or updating?	Yes	
What equipment urgently needs replacing or updating?	Light cures both sides of the jail	
Any additional comments on The Equipment:	This prison just like the other two prisons; it's an absolute nightmare when it comes to organising repairs or servicing. No one is interested, no one understands the impact or delay broken equipment causes.	

	When something goes wrong there is always a dispute about payment. We have only coped by supplying our own equipment to keep going.	
CROSS INFECTION CONTROL		
When was the most recent HTM 01-05 audit carried out?	Unknown	
What was the result of the HTM 01-05 audit?	Unknown	
Has a full CQC inspection (England) or an equivalent inspection (Wales) been carried out?	Yes	
When was the CQC inspection carried out?	2016/2017	
Any additional comments on Cross Infection Control:	CQC were very happy at all three sites about our processes in place with regards to cross infection control.	
Is SystmOne used in the dental surgery?	Yes	
For which of the following do you use SystmOne?		
How many SystmOne training sessions did you attend?	1	
Is the dental surgery registered with the Information Commissioner's Office (ICO)?	Unknown	
Any additional comments on the technology:	The physical location of PC's in the main side of the Norwich prison are awful, they are not practical. If you ever attend, you will see why. The IT equipment has been set up by a non-dentally minded individual.	
THE DIARY		
Who manages the dental appointment diary?	I manage first referral appointments, staff manage follow ups	
Who manages the dental waiting list?	Dentist	
How long is the waiting list for routine examinations?	<6 weeks	
After the initial examination, how soon is a follow-up appointment for treatment available?	average is six to 12 weeks	
How many patients, on average, are booked into a clinical session?	full day normally consists of about 15 people including treatment patients	
How long do you book for an average new patient exam?	20 minutes	
How quickly are patients requiring emergency dental treatment (trauma, haemorrhage, etc) seen by the dentist or other appropriately trained staff?	<24hrs we have an out of hours plan if we are not present	
How quickly are patients with dental pain normally seen by the dentist or other appropriately trained staff?	<24hrs we have an out of hours plan if we are not present	
On average, how many external dental referrals are arranged each month for specialist dental care outside the prison?	Approximately <2 Norwich is a remand prison therefore patients	

	often move before referral request can be completed.	
For which of the following are referrals made?	Difficult extractions or complex medical history	
Are there any problems with making referrals for specialist dental care in your area or for patients attending these appointments?	No	
What are the problems with making referrals for specialist care in your area or for patients attending these appointments?	N/a	
Are there administrative problems in providing escorts for external referrals?	There are always not enough officers in prison	
How frequently do the following cause DNAs?		
Do you have an issue with patients being transferred or released before laboratory work is fitted?	We try not to start something if we cannot finish.	
Are DMFTs recorded and collated separately from the dental records for epidemiological or monitoring purposes?	No	
SAFETY AND SECURITY		
Any comments on Safety and Security:	Apart from key talk not all staff have been offered formal training due to the limited availability of training and the commitments in other locations such as the practice. Lack of officers and discipline mean that confrontation is rife. High staff turnover noticed in prison and healthcare.	
In what ways is OHP delivered?	We made up enough "goody bags" with samples so that every prisoner benefitted. There was advice about looking after teeth and dentures. All bags had a sample of fluoride toothpaste. We had mixed brands so that one brand was not favoured. OHP is also done in surgery patient by patient if required.	
Is there a specialist smoking cessation team in the prison?	Yes there are other healthcare staff trained in this	
Do you offer smoking cessation advice in the surgery?	If required though since the smoking ban patients have mostly quit or gone to vaping	
COMMUNICATION		
How would you rate cooperation and liaison between the dental staff and other healthcare staff?	Very good	
Does the dental team meet regularly with doctors and nursing staff to discuss healthcare issues?	I do, though if there are issues I raise them as soon as they occur rather than wait for a meeting to bring them up.	

COMPLAINTS		
How many patient complaints have been received in the last 12 months concerning the dental service?	No formal complaints in HMP Norwich.	
Which of the following have been the subject of complaints?		
THE PATIENT JOURNEY		
Is there a patient care pathway in place?	No	
Is there an effective dental triage pathway in place?	Yes	
Are Language Line translation services or an equivalent service available for your use in the surgery?	Yes	

The following performance information uses data from the HJIP reports.

Both prisons have not seen any changes with the monthly average number of patients booked with an appointment when comparing 2018-19 against 2017-18. Despite having a larger population, the number of booked appointments in HMP Peterborough at 94 a month is lower than HMP Norwich at 186 a month.

HMP Norwich has seen an increase from 43% in 2017-18 to 50% in 2018-19 for the percentage of booked appointments attended. The 50% rate is still lower than the 69% in HMP Peterborough, the comparator prison, regional average, and national average.

The waiting times in HMP Norwich varied between two to 28 days in 2018-19. In HMP Peterborough, the waiting time is about 42 days.

Figure 5.3.3: Patients with booked appointments.

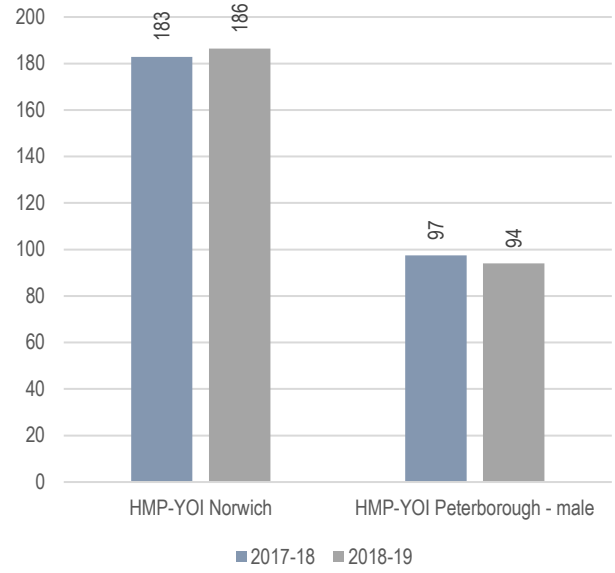


Figure 5.3.4: Patients actually seen.

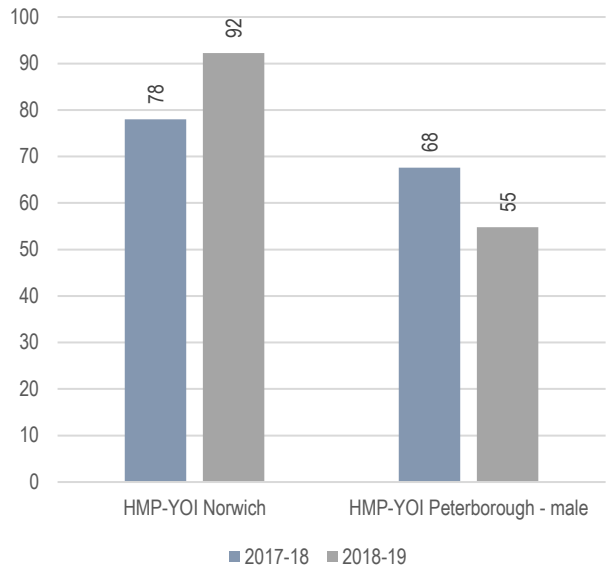


Figure 5.3.3: % of booked appointments attended; comparison[123].

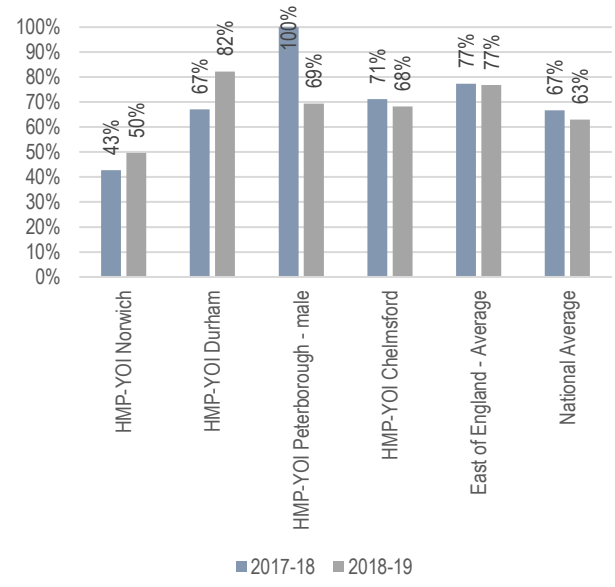
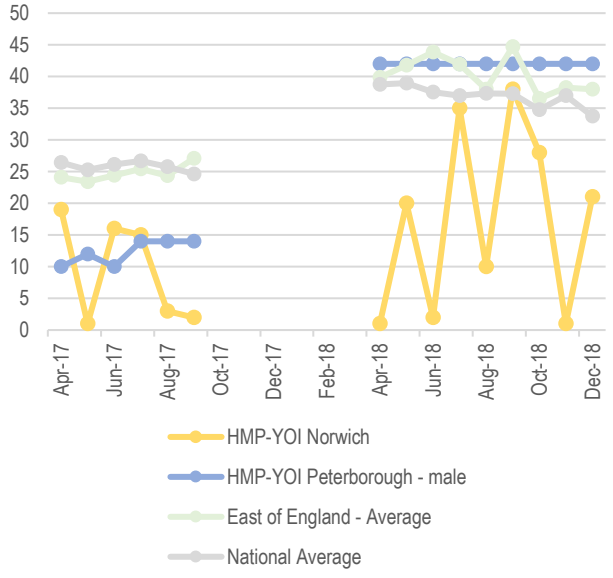


Figure 5.3.4: Wait-times for routine care.



[123] Denominator excludes cancelled appointments by patients/

INTRODUCTION

Prisoners have the same access to healthcare services on the NHS as the general population, including seeing a general practitioner (GP) when needed. However, it is extremely difficult to find an equivalent level of care due to the nature of the prison environment; and higher prevalence of physical and mental health problems among prisoners.

GPs form part of a prison's healthcare team, working closely with healthcare officers and nurses. Depending on the needs of the prison, they are either employed directly by the prison to work full-time or employed to work a set number of sessions within the prison, while also working as an NHS GP within the local community.

Services provided by GPs vary from prison to prison, but will usually include:

- Holding routine clinics to identify and treat common health problems
- Dealing with emergencies on prison wings
- Facilitating referral to specialist services
- Performing surgery
- Writing prescriptions.

GPs working in prisons face challenges different to that outside prison. Per year of imprisonment, male prisoners consult primary care doctors three times more frequently and other healthcare workers 77 times more frequently than men in the general population. Layout of prisons – including the network of stairways, innumerable doors to be unlocked and locked, and restricted space – can make carrying medical equipment around difficult. High prevalence of drug abuse among prisoners mean GPs must be wary when prescribing medication and nutritional supplements.

LOCAL PROVISION

In HMP Norwich, GPs are provided by Anchor Healthcare. There are 10 GP sessions a week. There are 3 additional GP appointments in the segregation unit per week. There is a regular clinic run by a nurse practitioner, who can see patients instead of the GP.

In HMP Peterborough, GPs are provided by Cimarron UK. There were emergency appointments with the GP available on a daily basis. There is no formal pain clinic in the prison, however there is a protocol stating that patients on opiate-based pain medications should be taken off these medications unless they were prescribed by a specialist in the preceding six months.

The following performance information uses data from the HJIP reports.

The number of patients with booked appointments in HMP Norwich has increased greatly from 320 a month in 2017-18 to 451 a month in 2018-19. In contrast, the number of booked appointments per month in HMP Peterborough has decreased from 726 a month to 646 a month. The number of patients actually seen reflects this.

Although the number of booked appointments has increased in HMP Norwich, the percentage of booked appointments attended has decreased from 77% to 69% between 2017-18 to 2018-19 and is now similar to HMP Peterborough.

The waiting times in HMP Norwich varied between one to four days in 2018-19. In HMP Peterborough, the waiting time is about five days.

Figure 5.3.5: Patients with booked appointments.

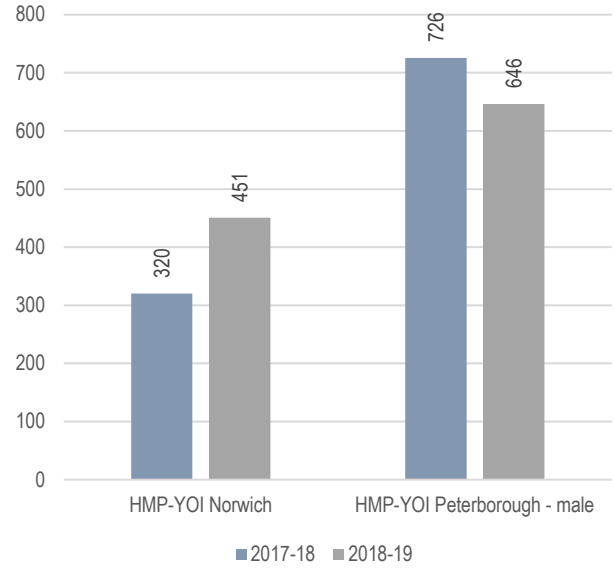


Figure 5.3.6: Patients actually seen.

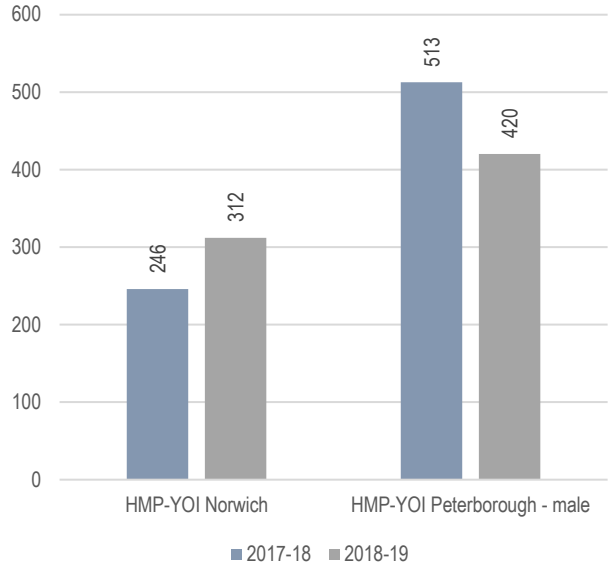


Figure 5.3.7: % of booked appointments attended; comparison[124].

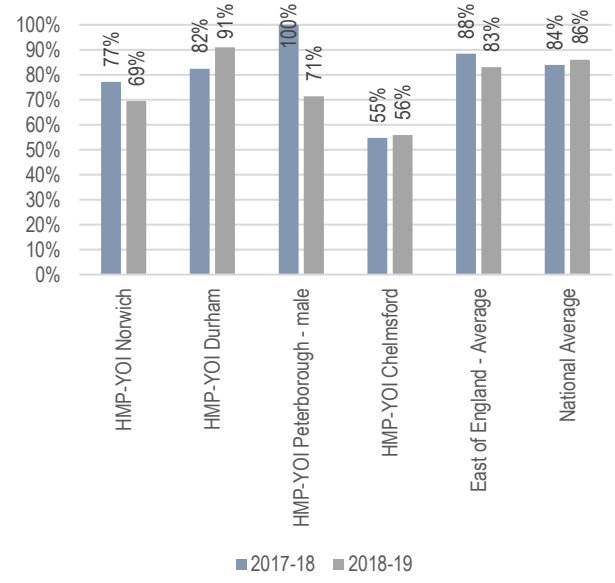
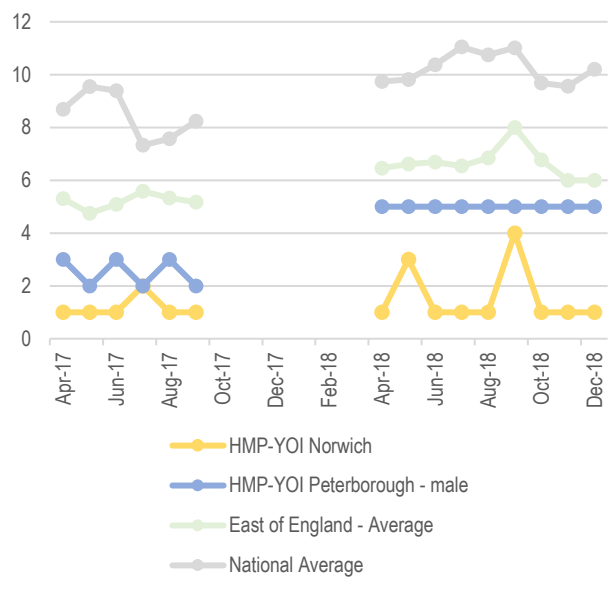


Figure 5.3.8: Wait-times for routine care.



[124] Denominator excludes cancelled appointments by patients/

OPTICIAN

INTRODUCTION

Eyesight changes as people age, increasing the risk of developing:

- Age-related macular degeneration (AMD), commonly affecting people over the age of 50. It is the most common cause of sight loss in people over the age of 65. Smoking has also been shown to double the risk of developing AMD.
- Age-related cataracts, clouding part of the eye and making images less sharp. Smoking increases the risk of developing cataracts in old age.
- Glaucoma, which if not treated early, can lead to permanent vision loss and blindness. It is uncommon below the age of 40 but rises to around five in 100 people over the age of 65. People of African-Caribbean origin are four times more at risk of developing glaucoma than people of European origin.[125]

Sight loss is no longer an inevitable consequence of ageing. If detected early, major sight-threatening conditions such as glaucoma and AMD can be treated, and cataract operations have become routine. In England and Wales, NHS eye tests every two years are free to those aged 60 or over. After 70, annual eye check-ups are free. However, a survey carried out by Age Concern Research for RNIB showed that of 5,000 people aged 60 and over, almost half (47%) did not have annual eye tests. Poorer older people were also less likely to access eye care services.[126]

With an aging prison population, many of whom smoke and come from poorer communities, there will be an increase in demand for seeing an optician.

LOCAL PROVISION

HMP NORWICH	
OVERVIEW	
Optician services in HMP Norwich are provided by Norfolk Ophthalmic Limited. There are approximately seven sessions per month. Most sessions are carried out in the main site of the prison, with one session every four weeks taking place in the LDU. Currently the optician works on a Friday, on which there is a restricted regime so there is no free-flow, which can impact on the DNA numbers. The optician's room is suitable for the optician to practise in, however there is no phone or working printer, which reduces efficiency. The optician manages their own appointments on SystmOne. There is a one to four week wait for a routine appointment.	
EQUIPMENT	
This equipment list for routine eye examinations is from guidance from the College of Optometrists[127]:	

Equipment		

125 http://www.ageuk.org.uk/health-wellbeing/keeping-your-body-healthy/better-sight-/sight-tests/
126 https://www.rnib.org.uk/sites/default/files/Older%20people%20and%20eye%20tests%20Campaign%20report.pdf
127 http://guidance.college-optometrists.org/guidance-contents/annexes/annex-1-equipment-list-for-the-routine-eye-examination/

Amsler charts	Yes	
Tonometer	Yes	
Colour vision test	Yes	
Condensing lens for binocular indirect biomicroscopy with the slit lamp	Yes	
Direct ophthalmoscope	Yes	
Distance and near oculomotor balance tests	Yes	
Focimeter	Yes	
Keratometer	No, we don't do contact lenses as contract dictates not to	
Letter matching card	Yes	
Near vision tests	Yes	
Pen torch	Yes	
Peripheral visual field equipment	Yes	
Retinoscope	Yes	
Slit-lamp biomicroscope	Yes	
Suitable test chart	Yes	
Test for stereopsis	Yes	
Threshold controlled visual field equipment	Yes	
Trial lenses, trial frame and accessories.	Yes	

PHYSIOTHERAPIST

INTRODUCTION

Physiotherapy helps restore movement and function when someone is affected by injury, illness, or disability. A physiotherapist will work closely with a patient, helping them manage pain and use a number of methods to aid recovery[128]. These methods include movement and exercise, and manual therapy techniques.

A physiotherapist will work closely with the prison health team, which includes the GPs, nurses, and psychiatric nurses. They will also run clinics to help educate prisoners on healthier lifestyles, including correct use of gym equipment and smoking cessation[129].

Musculoskeletal disorders (MSDs) cover any injury, disease or problem relating to a person's muscles, bones or joints. They are one of the main causes of years lost to disability among the 20-54 age group in prisons, affecting 25-51% of male prisoners aged 45-64 and 66% aged 65+. They affect 38% of female prisoners overall[130].

MSDs found in the prison population include issues such as lower back pain, neck pain, fractures and tissue injuries that require physiotherapy. Some of these are believed to be prison-specific, due to:

- weight-training culture
- thin mattresses, sagging beds, and hard pillows
- poor posture from unsuitable chairs and long hours lying in bed watching TV
- Reduced activity[131].

With an increase in prison population and an ageing population, the need for physiotherapy in prisons is growing.

LOCAL PROVISION

In HMP Norwich, physiotherapy is provided by Back in Motion. There is no physiotherapy provision in HMP Peterborough.

128 www.nhs.uk.
129 Chartered Society of Physiotherapy, *Inside Story*, www.csp.org.uk.
130 Public Health England (2014), *Health and Justice Health Needs Assessment Template: Adult Prisons* (part 2)
131 Chartered Society of Physiotherapy, *Inside Story*, www.csp.org.uk.

PODIATRIST

INTRODUCTION

A podiatrist provides assessment, treatment, and advice on foot problems such as ingrown toenails, verrucae, athlete's foot, bunions, and flat feet. There are three main groups requiring foot care:

- People with a disease which puts the feet at risk (for example, diabetics)
- People with disabling foot conditions (for example, arthritic conditions)
- People needing basic foot care.

Approximately 50% of qualified podiatrists work in private practice. A podiatrist working within a UK prison forms part of a prison's healthcare team.

LOCAL PROVISION

HMP NORWICH	
OVERVIEW	
Randall's Footcare provides podiatry services in HMP Norwich. There are two half day sessions every two weeks, with approximately nine patients seen per session. The podiatrist manages appointments for their clinics. Clients are booked in on a first come first served basis. There are short waiting times to see the podiatrist, with patients routinely seeing the podiatrist within four weeks of a referral being received. The podiatrist administers foot checks for patients with diabetes, and patients are booked in for a check on an annual basis. Simple nail operations can also be done in the prison. The podiatrist said that there are sometimes a lot of DNAs. If a patient does not attend their appointment, they are removed from the waiting list.	

COMMUNICABLE DISEASES

HEPATITIS PAGE 162

SEXUAL HEALTH PAGE 165

TUBERCULOSIS PAGE 167

HEPATITIS

INTRODUCTION

The prevalence of sexually transmitted diseases and blood-borne viruses (BBVs) is higher in the prison population than in the general population, due to high risk behaviour such as unprotected sex, multiple partners, and injecting drugs[132].

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

A report released by the Health Protection Agency in 2011[133] shows that the increase in prison hepatitis B virus (HBV) vaccinations has significantly reduced the HBV rates for injecting drug users (IDU).

PHE TOOLKIT

Blood-borne viruses (BBVs) often affect a larger proportion of people in prison and other detention centres than the wider population and it has been shown that rates of illegal drug use among prisoners are higher than that of the general population.

Injecting drug use is the main risk factor in the transmission of BBVs for hepatitis C infection in the UK (over 90% of new infections are acquired through this [PHE, 2013xviii]).

There are a number of data sources which measure BBV infection in the prison and detention centre population. These include PHE surveillance systems such as the Public Health in Prisons (PHiPs) monitoring system based with the national Health and Justice Team, the Survey of Prevalent HIV Infections Diagnosed (SOPHID), the Genitourinary Medicine Clinic Activity Dataset (GUMCAD), Sentinel Surveillance of BBV testing and also other external systems such as the Health and Justice Indicators of Performance (HJIPs), which have replaced the previous Prison Health Performance Quality Indicators (PHPQIs) commissioned by NHS England. All surveillance systems monitor different elements of BBVs but together help provide an understanding of BBV infection among this population.

The Sentinel Surveillance of BBV testing provides useful information on the proportion of people testing positive for a BBV in different settings.

LOCAL PROVISION

HMP NORWICH	
BLOOD BORNE VIRUS TESTING	
HMP Norwich carries out dried blood spot testing at the secondary health screen.	
HEPATITIS	
There is a visiting liver specialist nurse. The nurse visits when required. There are no criteria for who can start treatment. Fibroscans can be administered in house.	

HJIPS

The following section provides a summary of the HJIPs associated with hepatitis. All data covers the 2018 calendar year.

[132] Department of Health (2012), Public health functions to be exercised by the NHS Commissioning Boards.
[133] Department of Health (2011), Tackling Blood-Borne Viruses in Prisons - A framework for best practice in the UK.

HEPATITIS B TESTING OFFERED

Below shows the percentage of patients offered hepatitis B testing, within 7 days of reception.

Figure 6.1.1: Hepatitis B testing offered.	HMP Norwich	
All new receptions and transfers (excluding those already vaccinated)	1633	
Patients with a read code of XaLFK, applied within 7 days of reception	1619	
%	99%	

HEPATITIS B - HBsAg UPTAKE

Below shows the percentage of eligible patients who have undertaken a Hepatitis B (HBsAg) test.

Figure 6.1.2: Hepatatis B - HBaAg uptake.	HMP Norwich	
All new receptions and transfers (less those already vaccinated, diagnosed with, or treated for, Hep B [XaPEy])	1621	
Patients screened for Hepatitis B within 4 weeks of arrival (read code XaEXZ)	352	
%	22%	

HEPATITIS B – REFERRAL

Below shows the percentage of those testing positive for chronic hepatitis B being referred to a specialist service.

Figure 6.1.3: Hepatitis B – referral.	HMP Norwich	
Patients having a positive HBsAg test, XaQe4 (hep B core antibody positive) or 43B4. (hep B surface antigen positive)	3	
Patients referred to specialist service. Referred to Hepatology service – XaLrh	3	
%	100%	

HEPATITIS C OFFERED

Below shows the percentage of patients offered hepatitis C testing, within 7 days of reception.

Figure 6.1.4: Hepatitis C offered.	HMP Norwich	
All new receptions and transfers (in the period, less those already diagnosed with, or treated for, Hep C [XaPLI]).	2187	
Number of patient offered testing within 7 days (read code of XaLDh)	2187	
%	100%	

HEPATITIS C - HCV AB

Below shows the percentage of eligible patients who have a undertaken a Hepatitis C Ab test.

Figure 6.1.5: Hepatitis - C Ab	HMP Norwich	
All new receptions and transfers in the period (less those already diagnosed with, or treated for, Hep C [XaPLI]).	2187	
Patients screened for Hepatitis C within 4 weeks of arrival (read code XaJh4)	580	
%	27%	

HEPATITIS C - HCV PCR

Below shows the percentage of patient's hepatitis C Ab positive, who underwent hepatitis C PCR testing.

Figure 6.1.6: Hepatitis C PCR testing.	HMP Norwich	
Number of patients hepatitis C Ab positive, code XaPLI	64	
Number of patients having undertaken hepatitis PCR screening, read code XaXBp (positive) or XaOvh (negative)	38	
%	59%	

HEPATITIS C – REFERRAL

Below shows the percentage of those testing hepatitis C PCR positive being referred to a specialist service.

Figure 6.1.7: Hepatitis C – Referral.	HMP Norwich	
Number of patients recorded as hepatitis C PCR positive, code XaXBp	51	
Number of patients referred to specialist service. Referred to Hepatology service – XaLrh	41	
%	80%	

SEXUAL HEALTH

INTRODUCTION

Sexually transmitted infections (STIs) include chlamydia, gonorrhoea and HIV. They are passed from one person to another through unprotected sex or genital contact. HIV can also spread through sharing contaminated needles.

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

Higher rates of STIs have been reported among the prison population than the general population – 15% of prisoners in the UK have had or have a STI.[134] This is likely due to a large proportion of the prison population engaging in high-risk behaviours of having unprotected sex with multiple partners, and/or injecting drugs. In 2006, 48% of female prisoners reported having sex without condoms.[135]

Identifying, controlling, and treating communicable diseases and STIs in prisons benefits the general population at large.

Although sex is not permitted in prisons, both consensual and coercive sex does take place. Sexual relationships between prisoners and between staff and prisoners are prohibited, as prisons are classified as public places. However, prisoners should have free access to protection, and condoms must be supplied if prisoners are thought to be at risk of contracting HIV or another STI.

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

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

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

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

PHE TOOLKIT

There is limited coverage of sexually transmitted infections in the PHE toolkit.

LOCAL PROVISION

HMP NORWICH	
OVERVIEW	
Patients with sexual health problems can be seen by nursing staff. The GP sees patients for more complicated sexual health problems.	

[134] NHS Commissioning Board (2012), *Public health functions to be exercised by the NHS Commissioning Board*.
[135] NHS Commissioning Board (2012), *Public health functions to be exercised by the NHS Commissioning Board*.

HJIPS

The following section provides a summary of the HJIPs associated with sexual health. All data covers the 2018 calendar year.

HIV TESTING – UPTAKE

The % of patients that underwent testing of the total patients eligible during the reporting period.

Figure 6.2.1: HIV testing – uptake.	HMP Norwich	
All new receptions and transfers in the reporting period less those already confirmed HIV positive (43C3.)	2216	
Number of patients who have been tested, Xalon (HIV screening test).	568	
%	26%	

HIV TESTING – 2 WEEKS

The % of HIV positive patients seen by a secondary care clinician within 2 weeks of diagnosis.

Figure 6.2.2: HIV testing – 2 weeks.	HMP Norwich	
Number of patients who tested positive. Code 43C3.	2	
Number of HIV positive patients who were seen at local hospital within 2 weeks of referral.	1	
%	50%	

HIV TESTING – OFFERED

The % of patients offered HIV testing, within 7 days of reception.

Figure 6.2.3: HIV testing – offered.	HMP Norwich	
All new receptions and transfers in the period, less those already confirmed HIV positive (43C3.)	2190	
Number of patients offered HIV screening (Read code XaDvy) within 7 days of reception.	2190	
%	100%	

INTRODUCTION

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

Some of the key facts taken from the research include:

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

BEST PRACTICE

NICE systematic evidence reviews[136] established that the most effective approach for identifying TB in high-risk groups such as those in prisons, involves active case finding.[137]Active case finding can be achieved through the use of digital x-ray machines, which have been installed in some prisons across the country. The use of digital x-ray machines can reduce diagnostic delay with cases less likely to be contagious on diagnosis, when compared with passive case detection and symptom screening alone.[138]

In 2017, the Journal of Public Health[139] published an audit of tuberculosis services in prisons and immigration removal centres. 12 healthcare teams within PPD commissioned by NHS England (London Region) were included in the audit. Services were evaluated against the National Institute for Health and Care Excellence standards for TB best practice.

The audit found that none of the health providers with a digital X-ray machine were conducting active case finding in new prisoners and no health providers routinely conduct latent TB infection testing and preventative treatment. Barriers to implementing standards include the lack of staff skills and staff skills mix, structural and technical barriers, and demands of custodial and health services.

PHE TOOLKIT

Coverage of tuberculosis in the PHE Toolkit is limited:

[136] NICE (2012), *Evidence Reviews 1 – 4*
[137] Mehay et al. (2017), 'An audit of tuberculosis health services in prisons and immigration removal centres', *Journal of Public Health*, Volume 39, Issue 2, 1 June 2017, pp 387–394, https://doi.org/10.1093/pubmed/fdw033
[138] Mehay et al. (2017), 'An audit of tuberculosis health services in prisons and immigration removal centres', *Journal of Public Health*, Volume 39, Issue 2, 1 June 2017, pp 387–394, https://doi.org/10.1093/pubmed/fdw033
[139] Mehay et al. (2017), 'An audit of tuberculosis health services in prisons and immigration removal centres', *Journal of Public Health*, Volume 39, Issue 2, 1 June 2017, pp 387–394, https://doi.org/10.1093/pubmed/fdw033

"The prison population has long been recognised as being at risk of TB, due to the overrepresentation of risk factors among people passing through the prison estate. Prisons were identified as a key setting for TB control in the Chief Medical Officer's (CMO) action plan for England, published in 2004."

LOCAL PROVISION

HMP NORWICH	
OVERVIEW	
All new arrivals are given a reception screen which includes a review of any TB symptoms. Any patient identified as at risk or having had contact with anyone with tuberculosis is reviewed by nursing staff.	

HJIPS

The following section provides a summary of the HJIPs associated with sexual health. All data except "Tuberculosis (TB) screening uptake" covers the 2018 calendar year.

TUBERCULOSIS (TB) SCREENING UPTAKE

The % of patients that underwent an initial TB symptom screening (including a medication check) within 48 hours of the total patients eligible during the reporting period.

Figure 6.3.1: Tuberculosis (TB) screening uptake.	HMP Norwich[140]	
All new receptions and transfers	1869	
Patients who underwent a TB symptom screen (including a medication check - with a [read code of 6831.]) within 48 hours of reception.	1859	
%	99%	

TUBERCULOSIS (TB) REFERRAL

The % of patients showing symptoms of TB on initial screening referred for specialist TB assessment during the reporting period.

Figure 6.3.2: Tuberculosis (TB) referral.	HMP Norwich	
Patients screening positive for symptoms of TB within the reporting period	1	
Number of patients referred to a specialist TB assessment service during the reporting period (XaR5F).	1	
%	100%	

TUBERCULOSIS (TB) TREATMENT

The % of patients receiving Directly Observed Therapy (DOT) of the total number of diagnosed patients referred to specialist care.

Figure 6.3.3: Tuberculosis (TB) treatment.	HMP Norwich	
Number of patients referred to a specialist TB assessment service during the reporting period (XaR5F).	1	
Patients receiving Directly Observed Therapy (DOT). Code: XaMGi	0	
%	0%	

[140] April 2018 to December 2018.

APPENDIX

SUBSTANCE MISUSE STRATEGY PAGE 170

SUICIDE AND SELF HARM POLICY PAGE 170

ABBREVIATIONS PAGE 171

SUICIDE AND SELF HARM POLICY

SUBSTANCE MISUSE STRATEGY	
HMP NORWICH	
The embedded files below contain the latest substance misuse strategies for the prisons.	
 Drug Strategy Policy 2018-2019.do  New psychoactive substances Policy 20	

SUICIDE AND SELF HARM POLICY	
HMP NORWICH	
The embedded files below contain the latest suicide and self-harm policies for the prisons.	
 Self Harm and Suicide Prevention F	

ABBREVIATIONS

ACCT	Assessment Care in Custody and Teamwork
ADHD	Attention Deficit Hyperactivity Disorder
ADHS	Adult Dental Health Survey
AMD	Age-related Macular Degeneration
APHO	Association of Public Health Observatories
BAME	Black, Asian and Minority Ethnic
BBV	Blood-borne virus
BMI	Body Mass Index
BPD	Borderline Personality Disorder
BTS	British Thoracic Society
CBT	Cognitive Behavioural Therapy
CMO	Chief Medical Officer
CNA	Certified Normal Accommodation
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CSJ	Centre for Social Justice
CVD	Cardiovascular Disease
DAFNE	Dose Adjustment For Normal Eating
DASA	Defence Analytical Services Agency
DIP	Drug Interventions Programme
DMFT	Decayed, missing or filled teeth
DNA	Did Not Attend
EMDR	Eye Movement Desensitisation and Reprocessing
ERP	Exposure Response Prevention
FNP	Foreign National Prisoner
GAD	Generalised Anxiety Disorder
GP	General Practitioner
GUMCAD	Genitourinary Medicine Clinic Activity Dataset
HAWC	Health and Wellbeing Champion
HBV	Hepatitis B virus
HCA	Health Care Assistant

HJIP	Health and Justice Indicators of Performance
HMIP	Her Majesty's Inspectorate of Probation
HMP	Her Majesty's Prison
HMPPS	Her Majesty's Prison and Probation Service
HSCNA	Health and Social Care Needs Assessment
IAPT	Improving Access to Psychological Therapies
ICO	Information Commissioner's Office
IDTS	Integrated Drug Treatment System
IDU	Injecting drug users
IMB	Independent Monitoring Board
IPT	Interpersonal therapy
LD	Learning Disability
MDT	Mandatory Drug Testing
MoJ	Ministry of Justice
NDTMS	National Drug Treatment Monitoring System
NICE	National Institute for Clinical Excellence
NOMIS	National Offender Management Information System
NOMS	National Offender Management Service
OCD	Obsessive Compulsive Disorder
OHRN	Offender Health Research Network
PECS	Prisoner Escort and Custody Services
PEI	Physical Education Instructor
PHE	Public Health Executive
PHiPs	Public Health in Prisons
PHPQI	Prison Health Performance Quality Indicator
PPO	Probation and Prison Ombudsman
PS	Psychoactive substances
PSI	Prison Service Instruction
PSO	Prison Service Order
PTSD	Post Traumatic Stress Disorder
QOF	Quality and Outcomes Framework
RCGP	Royal College of General Practitioners
REA	Rapid Evidence Assessment
rMDT	random Mandatory Drug Testing

RNIB	Royal National Institute of Blind People
SCMH	Sainsbury Centre for Mental Health
SDTP	Substance Dependency Treatment Programme
SIGN	Scottish Intercollegiate Guidelines Network
SOPHID	Survey of Prevalent HIV Infections Diagnosed
SPCR	Surveying Prisoner Crime Reduction
STI	Sexually transmitted infection
WHO	World Health Organisation
WTE	Whole time equivalent
WWA	Waste Water Analysis
YOI	Young Offender Institution
YOT	Youth Offending Team