Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday 4 February 2021**

Time: **10.00am**

Venue: **Virtual meeting**

Pursuant to The Local Authorities and Police and Crime Panels (Coronavirus) (Flexibility of Local Authority Police and Crime Panel Meetings) (England and Wales) Regulations 2020, the 4 February 2021 meeting of Norfolk Health Overview and Scrutiny Committee (NHOSC) will be held using video conferencing.

Please click here to view the live meeting online: https://youtu.be/BNgl0CLOHmE

Committee Members and other participants: DO NOT follow this link, you will be sent a separate link to join the meeting.

Members of the public or interested parties may, at the discretion of the Chair, speak for up to five minutes on a matter relating to the following agenda. A speaker will need to give written notice of their wish to speak to Committee Officer, Hollie Adams (contact details below) by **no later than 5.00pm on Monday 1 February 2021**. Speaking will be for the purpose of providing the committee with additional information or a different perspective on an item on the agenda, not for the purposes of seeking information from NHS or other organisations that should more properly be pursued through other channels. Relevant NHS or other organisations represented at the meeting will be given an opportunity to respond but will be under no obligation to do so.

Membership

MAIN MEMBER	SUBSTITUTE MEMBER	REPRESENTING
Cllr Penny Carpenter	Cllr Roy Brame / Cllr Ian Mackie / Cllr Graham Middleton / Cllr Haydn Thirtle / Cllr Alison Thomas	Norfolk County Council
Cllr Michael Chenery of Horsbrugh	Cllr Roy Brame / Cllr Ian Mackie / Cllr Graham Middleton / Cllr Haydn Thirtle / Cllr Alison Thomas	Norfolk County Council
Cllr Fabian Eagle	Cllr Roy Brame / Cllr Ian Mackie / Cllr Graham Middleton / Cllr Haydn Thirtle / Cllr Alison Thomas	Norfolk County Council

Cllr Emma Flaxman-Taylor	*Vacancy*	Great Yarmouth Borough Council
Cllr David Harrison	Cllr Tim Adams	Norfolk County Council
Cllr Brenda Jones	Cllr Julie Brociek-Coulton / Cllr Emma Corlett	Norfolk County Council
Cllr Chris Jones	Cllr Julie Brociek-Coulton / Cllr Emma Corlett	Norfolk County Council
Cllr Alexandra Kemp	Cllr Anthony Bubb	Borough Council of King's Lynn and West Norfolk
Cllr Robert Kybird	Cllr Helen Crane	Breckland District Council
Cllr Nigel Legg	Cllr David Bills	South Norfolk District Council
Cllr Laura McCartney-Gray	Cllr Cate Oliver	Norwich City Council
Cllr Richard Price	Cllr Roy Brame / Cllr Ian Mackie / Cllr Graham Middleton / Cllr Haydn Thirtle / Cllr Alison Thomas	Norfolk County Council
Cllr Sue Prutton	Cllr Peter Bulman	Broadland District Council
Cllr Emma Spagnola	Cllr Wendy Fredericks	North Norfolk District Council
Cllr Sheila Young	Cllr Roy Brame / Cllr Ian Mackie / Cllr Graham Middleton / Cllr Haydn Thirtle / Cllr Alison Thomas	Norfolk County Council
CO-OPTED MEMBER (non voting)	**CO-OPTED SUBSTITUTE MEMBER** (non voting)	**REPRESENTING**
Cllr Keith Robinson	Cllr Stephen Burroughes / Cllr Helen Armitage	Suffolk Health Scrutiny Committee
Cllr Judy Cloke	Cllr Stephen Burroughes / Cllr Helen Armitage	Suffolk Health Scrutiny Committee

For further details and general enquiries about this Agenda please contact the Committee Officer:
Hollie Adams on 01603 223029
or email committees@norfolk.gov.uk

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A g e n d a

1. **To receive apologies and details of any substitute members attending**

2. Minutes

To confirm the minutes of the meeting of the Norfolk Health Overview and Scrutiny Committee held on 26 November 2020. (Page **5**)

3. Members to declare any Interests

If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is on your Register of Interests you must not speak or vote on the matter.

If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is not on your Register of Interests you must declare that interest at the meeting and not speak or vote on the matter

In either case you may remain in the room where the meeting is taking place. If you consider that it would be inappropriate in the circumstances to remain in the room, you may leave the room while the matter is dealt with.

If you do not have a Disclosable Pecuniary Interest you may nevertheless have an **Other Interest** in a matter to be discussed if it affects, to a greater extent than others in your division

- Your wellbeing or financial position, or
- that of your family or close friends
- Any body -
    - Exercising functions of a public nature.
    - Directed to charitable purposes; or
    - One of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union);

  Of which you are in a position of general control or management.

If that is the case then you must declare such an interest but can speak and vote on the matter.

4. To receive any items of business which the Chair decides should be considered as a matter of urgency

5. Chair's announcements

Tom McCabe
Head of Paid Service

County Hall
Martineau Lane
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NR1 2DH

Date Agenda Published: 27 January 2021

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Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
Minutes of the meeting held on Microsoft Teams (virtual meeting)
at 10am on 26 November 2020

Members Present:

Cllr Penny Carpenter (Chair)	Norfolk County Council
Cllr Nigel Legg (Vice-Chair)	South Norfolk District Council
Cllr Michael Chenery of Horsbrugh	Norfolk County Council
Cllr Emma Flaxman-Taylor	Great Yarmouth Borough Council
Cllr David Harrison	Norfolk County Council
Cllr Alexandra Kemp	Borough Council of King's Lynn and West Norfolk
Robert Kybird	Breckland District Council
Cllr Richard Price	Norfolk County Council
Cllr Sue Prutton	Broadland District Council
Cllr Sheila Young	Norfolk County Council

Co-opted Members Present

Cllr Judy Cloke	Suffolk Health Scrutiny Committee
Cllr Keith Robinson	Suffolk Health Scrutiny Committee

Substitute Members Present:

Cllr David Bills for Cllr Fabian Eagle	Norfolk County Council
Cllr Julie Brociek-Coulton for Cllr Chris Jones	Norfolk County Council
Cllr Emma Corlett for Cllr Brenda Jones	Norfolk County Council
Cllr Wendy Fredericks for Cllr Emma Spagnola	North Norfolk District Council
Cllr Cate Oliver for Cllr Laura McCartney-Gray	Norwich City Council

Also Present:

Chris Acton	Director, Primary Care Partnership
Hollie Adams	Committee Officer, Norfolk County Council
David Barter	Head of Commissioning, NHS England and NHS Improvement – East of England
Giulia Carderello	Senior Client Relationship Executive, DA Languages
Cllr David Collis	County Councillor for King's Lynn North & Central
Kathy Foley	Practice Manager, St James' Medical Practice
Lana Hempsall	Member of the public
Liz Howlett	Suicide Prevention Lead, Norfolk and Suffolk Foundation NHS Trust
Sally Hughes	Commissioning Manager – Vulnerable People, Norfolk County Council Public Health
Jessamy Kinghorn	Head of Partnerships and Engagements, NHS England & NHS Improvement – East of England
Howard Martin	Locality Director West Norfolk, Norfolk & Waveney CCG (Clinical Commissioning Group)
Kim Mills	British Sign Language (BSL) interpreter
Dr Prabir Mitra	GP Partner, St James' Medical Practice
Autumn Moon	British Sign Language (BSL) interpreter
Catherine McWalter	Primary Care Estates Manager, Norfolk & Waveney CCG
Maureen Orr	Democratic Support and Scrutiny Team Manager, Norfolk County Council
Millie Pateman	Client Relationship Manager, DA Languages
James Skipper	Head of Communications & Engagement, Healthwatch Norfolk

Fiona Theadom	Senior Contract Manager, Primary Care, NHS England and NHS Improvement – East of England
Michael Wordingham	Policy and Campaigns Officer, RNIB (Royal National Institute of Blind People)
Jo Yellon	Associate Director of Mental Health, Norfolk & Waveney CCG

1. Apologies for Absence

1.1 Apologies were received from Cllr Brenda Jones (Cllr Emma Corlett substituting), Cllr Chris Jones (Cllr Julie Brociek-Coulton substituting) Cllr Laura McCartney-Gray (Cllr Cate Oliver substituting) and Emma Spagnola (Cllr Wendy Fredericks substituting). Also absent was Cllr Fabian Eagle (Cllr David Bills substituting).

2. Minutes

2.1 The minutes of the meeting on 8 October 2020 were agreed as an accurate record.

3. Declarations of Interest

3.1 No interests were declared.

4. Urgent Business

4.1 There were no items of urgent business.

5. Chair's Announcements

5.1 The Chair had no announcements.

6. Access to local NHS services for patients with sensory impairments

6.1.1 The Committee received the report examining the experiences of people with hearing impairments and sight impairments when accessing local NHS services and received NHS England and NHS Improvement East of England's plans for engagement with BSL users and others in advance of re-procurement of interpreting services for primary care in 2021.

6.1.2 British Sign Language interpreters were present for this item for people watching on YouTube, secured through the Council's INTRAN contract via Deaf Connexions.

6.2.1 The Head of Communications & Engagement, Healthwatch Norfolk introduced the Healthwatch report to the Committee:

- Focus groups held in Norwich in April 2019 identified the difficulties people had experienced with interpretation services, mostly at GP practices, such as lack of interpreter availability, cancellation of appointments, insufficient standard of interpretation and difficulty communicating with interpreters sometimes due to regional variation in signing.
- Further work was carried out to understand the scope of problems in Norfolk and service user sessions undertaken at Kings Lynn identified similar concerns
- The Healthwatch report was written summarising the feedback from service user

engagement sessions.

- Negative reviews had been received about the service provided by DA Languages from a GP practice manager and service users in the previous 6 months.
- In August 2020 a social media campaign was launched by Healthwatch encouraging Deaf people to submit their experiences with interpretation services in Norfolk.
- There was concern that the inconsistent service would increase medical risk and reduce equitability of access for the Deaf community.
- Videos showing feedback submitted by individuals in the Deaf community via the social media campaign were shown. The concerns raised in these videos were:
  - a visit to the optician where no interpretation service was provided to a gentleman with a sight and hearing impairment.
  - a visit to dentist where an interpreter was not able to attend, and a later appointment where the interpreter arrived late and didn't understand the receptionist sufficiently to interpret for the patient, who subsequently felt the level of interpretation was very poor
  - a GP visit where a male interpreter was provided when a female had been requested, providing issues around privacy for the female patient.

6.2.2 The Policy and Campaigns Officer, RNIB (Royal National Institute of Blind People), spoke to the Committee about issues for the blind community in Norfolk:

- Confidentiality was often compromised if medical letters were not received in a form people could read as others, such as a family member, carer or social worker, would have to read sensitive medical information on their behalf.
- Coronavirus had further reinforced the importance of Public Health information being managed well to keep people safe.
- The Policy and Campaigns Officer, RNIB (Royal National Institute of Blind People) felt that there should be robust training for frontline staff, monitoring and enforcement, and more engagement from stakeholder and participation groups to ensure people with sensory losses informed procedures.

6.3 The Committee heard from member of the public, Lana Hempsall:

- Ms Hempsall spoke to the Committee as coordinator of Norwich Guide Dog Forum.
- She felt that there was a systemic problem with the way information was given to people with sensory losses and stressed the importance of ensuring that all people had the right to privacy and access to information in a format accessible to them.

6.4 The following points were discussed and noted

- The Vice-Chair had letters sent by different departments of the Norfolk and Norwich University Hospital, only one of which mentioned support for people with communication needs. The Head of Commissioning, NHS England and NHS Improvement – East of England, **agreed** to discuss with Norfolk & Waveney Clinical Commissioning Group (CCG) what could be done to ensure a joined-up approach to assist patients with sensory impairments at hospitals in Norfolk.
- NHS England & Improvement representatives acknowledged that more needed to be done to hear from Deaf people during the upcoming procurement process. The contract extension of DA Languages would allow time to listen to service user stories and concerns to inform the new model and contract.
- The Chair noted that the Healthwatch report showed people were not well supported by the current contract. The Senior Contract Manager, Primary Care, NHS England and NHS Improvement – East of England, replied that officers were engaging with Norfolk Deaf Association and Healthwatch to identify problems and improve services. She encouraged people to raise issues with her or through patient forums. Regular review meetings were held with DA languages to review the service and complaints.

- Concerns were raised about the clinical risk if interpreters could not be understood by service users or could not interpret doctors or medical professionals' speech well to service users.
- A Member asked how interpreters were chosen to meet peoples' needs. NHS England & Improvement representatives replied that listening to service users moving forward would ensure services would be commissioned correctly for service users and with more flexible primary care services.
- A Member suggested virtual technology could be used to allow service users to book and view interpreters, and letters emailed to patients so they could read them using interpretation technology.
- A Member was concerned by the reports that some interpreters were reported as not being of a suitable qualification level. The Senior Client Relationship Executive, DA Languages, explained that DA Languages used a pool of linguists based on the bank of national register with the NRCPD (National Registers of Communication Professionals working with Deaf and Deafblind people) starting with local interpreters to mitigate against regional differences in signing.
- It was felt that people should only have to raise their needs once and this should be shared across services, using the "tell us once" policy
- The critical points for commissioning in 2021 were queried and reported as: ensuring the delivery model reflects patient need; a robust contract; quality of service; key performance standards which can be measured effectively; value for money; training of staff within primary care and raising awareness of the accessible information standard and; making adjustments for patients.
- NHS England & NHS Improvement representatives were asked how they would ensure participation and access for people with multiple barriers to inclusion and explained that during the commissioning process work would be undertaken to understand barriers to healthcare; this was noted as an area for improvement.
- The Chair queried whether the service was fit for purpose in its current form.
- It was noted that under the current contract, interpreters were not able to make appointments on the behalf of patients, meaning that to do so people needed to give private information to a family member, friend or carer. The Senior Contract Manager, Primary Care, NHS England and NHS Improvement – East of England, **agreed** to look at what adjustments could be put in place to support practices in the current contract to support people in the short term.

6.5 The Norfolk and Waveney Overview and Scrutiny Committee (NHOSC):

a) **ASKED** NHS England and Improvement representatives:
   - To ensure the 'tell us once' policy is in place and adhered to so that there is improved access for patients with sensory impairments.
   - To ensure that all frontline staff receive training in the requirements and implementation of the accessibility standards.
   - To make a contract variation to enable patients to ask a BSL interpreter to make an appointment for them, to protect their privacy and dignity.
   - To ensure a rapid response to members of the public who are currently having difficulty accessing services.

b) **INVITED** NHS England and Improvement representatives to return to the committee in early spring 2021.

7. Suicide Prevention

7.1 The Committee received the report examining the work to prevent suicides in Norfolk and Waveney, focusing on the action delivered by NHS partners and particularly Norfolk and

Suffolk NHS Foundation Trust (NSFT).

7.2 The following points were discussed and noted

- It was felt that the "First Response" helpline should be better communicated as a source of support for people in distress as well as their friends and families.
- NSFT, CCG and Public Health representatives were working on communications to promote online support apps and resources. If these were not suitable then the First Response helpline had a No Wrong Door policy and would provide people with the opportunity to discuss mental health concerns with a qualified clinician; people would then be directed on to the most suitable service to support them.
- NSFT, CCG and Public Health representatives planned to invest in assist training to give workers confidence in talking to people who felt suicidal
- To support people with learning disabilities, green light champions in each NSFT team attended regular update sessions to discuss adjustments for people with learning disabilities and processes were in place to engage in a way and place that was most comfortable for them ie via text.
- The importance of a consistent relationship with a key professional for a patient's wellbeing was noted; NSFT, CCG and Public Health representatives were asked how many professionals people saw on average during their treatment. The Suicide Prevention Lead, Norfolk and Suffolk Foundation NHS Trust, **agreed** to find out this information and send to the Committee.
- Members **requested** data on how many people contacted the First Response helpline and the outcome of calls, such as which organisations people were directed to.
- Officers were asked what was done to support families bereaved by suicide. The Suicide Prevention Lead, Norfolk and Suffolk Foundation NHS Trust, explained that the Chief Nurse would contact family members to express their condolences and give contact details so they could be in contact if they had any queries. A family liaison officer would also contact bereaved family members to answer any queries about the serious incident review and support them with grieving via third sector organisations.
- NSFT, CCG and Public Health representatives **agreed** to look into making the First Response helpline a freephone number and available via text to make it accessible.
- NSFT, CCG and Public Health representatives were looking at how they could support the Samaritans financially and were minded to ensure third sector providers, including the Samaritans were part of the network of support.
- It was confirmed that the Trust itself reviewed serious incidents which occurred in Norfolk, but the review pane lcame from a different geographic area within the Trust from the one in which the incident occurred..
- Members were keen to find out how many families engaged with liaison officers compared to other areas, and how many families engaged with serious incident reviews. Members also **requested** data on how many people request to come back into service within 3 months of discharge from NSFT.
- The Chair asked if NSFT, CCG and Public Health representatives felt that all partners involved in the strategy were playing their part to reduce suicides in Norfolk. The Associate Director of Mental Health, Norfolk & Waveney CCG, felt that they were; partners liaised regularly, and a multi-agency approach was in place. The suicide rate in Norfolk was reducing but more needed to be done to reduce it further.

7.3 The Norfolk Health Overview and Scrutiny Committee:

a) **ASKED** Norfolk and Suffolk NHS Foundation Trust (NSFT) to increase efforts to advertise of the First Response 24/7 helpline, reaching out to local government and primary care to advertise to their residents and patients.

b) **REQUESTED** a briefing from NSFT and Norfolk and Waveney CCG with the following information:

- Latest information on numbers of suicides.
- The number of changes of healthcare worker that patients are experiencing along their pathway of care.
- Evaluation of the impact of the new NSFT first response 24/7 helpline including:
    - the numbers of patients who have called the helpline that have subsequently been brought into the NSFT service for help.
    - information on development of the helpline service (i.e. freephone; text service; link to NHS 111).
- Numbers of people who are referring themselves back into NSFT's care within 3 months of discharge from the service, and how many of those are accepted back into the service.
- Numbers of Coroner Prevention of Future Death notices received, and action taken.
- If possible, comparison with other Trusts on the number of families who take part in reviews following a Serious Untoward Incident.

7.4 The Committee took a break from 11:55 until 12:10

7.5 Cllr Emma Corlett left the meeting at 11:55

8. St James' Medical Practice, King's Lynn – consultation on proposed relocation

8.1.1 The Committee received a consultation from St James' Medical Practice regarding a proposal for relocation to a new site in King's Lynn

8.1.2 The Director, Primary Care Partnership, introduced the report and gave a presentation to Committee (see appendix A):

- The existing St James' Medical Practice building was not compliant with regulations and would have to close its list if not moved to another location.
- A public consultation had been carried out and 17 sites looked at. Two thousand responses were received to the consultation questionnaire.
- £0.25m funding was available for development of the business case through the Estates and Technology Transformation Fund (ETTF), and £4.9m for building work sourced through private equity funding.
- Norlife carried out a review of capacity of GP services and determined there was a shortage of capacity in North and South Lynn. The proposed move of St James' Practice would resolve capacity in North Lynn. There was a strong case to use £5m of wave 4b funding to resolve the capacity issue in South Lynn and officers would be looking into a business case for a hub model here.

8.2.1 The Committee heard from Cllr David Collis, County Councillor for King's Lynn North and Central division:

- to meet the requirements of the area he felt it would be necessary to have a new surgery in the North and South of the area at the same time, but recognised that this was unrealistic
- Cllr Collis felt the facilities in the existing St James Practice were unsatisfactory and would not fulfil patients' requirements for much longer. Staff were facing difficulties providing services in the existing facilities.
- Cllr Collis felt, having visited all the proposed sites, that the site on Edwards Benefer way had an advantage over others due to being owned by Norfolk County Council. He had queries about access to the site but had been told this could be developed.
- Cllr Collis acknowledged that it could be difficult for some patients to get to the proposed site but on the whole moving the practice would bring positive changes.

8.2.3 The GP Partner and the Practice Manager from St James' Medical Practice spoke to the Committee about issues with the current location. There were ongoing issues at the current practice such as blocked drains, damp, and lack of room to provide primary care services. Due to the lack of space some patients had to be seen in a portacabin located in the carpark

8.3 The following points were discussed and noted

- It was confirmed that the Nar Ouse site would need a second business case.
- The outline business case for the site in North Lynn and site surveyors were ready to go to the next phase; it was hoped a full business case could be completed by February 2021.
- CCG representatives were keen to work with the Local Authority and all partners to develop the full business case as quickly as possible. Any delay to this would impact on efforts to address GP capacity King's Lynn and put investment in the area at risk.
- CCG representatives confirmed that it was a requirement of the full business case to carry out an equalities impact assessment.
- A Member queried whether patients would be able to walk or cycle 2km to the proposed site when ill. The Practice Manager, St James' Medical Practice, replied that the NHS was moving towards a digital model, utilising video conferencing, and home visiting, and with patients coming to the practice only when necessary. Patients without internet access would be offered a phone appointment or a face to face appointment if this was deemed appropriate for their needs.
- It was suggested that a contingency fund should be considered for patients who required it, for example to fund taxi travel to the surgery. The Director, Primary Care Partnership, **agreed** to look into whether this could be provided.
- It was confirmed that a suitable alternative premises could not be found in the existing location.
- The Locality Director West Norfolk, Norfolk & Waveney CCG (Clinical Commissioning Group), confirmed that vulnerable patients would be supported to make suitable alternative arrangements when the practice moved to a new location.
- Further investigation was needed as to whether Southgates Medical Centre had capacity to take on new patients however it was possible that some of their patients may wish to move to the new St James' practice, freeing up capacity for more patients.
- Dialogue with patients at St James' Medical Practice about the proposed move had begun in April 2015, and all patients were confirmed to be aware.
- It was clarified that there was a risk of losing the £0.25m ETTF funding if spending did not start by the end of 2020.
- Cllr David Harrison left the meeting at 13:17

8.5 The Norfolk Health Overview and Scrutiny Committee

- **AGREED** that every reasonable effort has been made on engagement and consultation around the proposed relocation and recognised that it is probably not realistic to expect two new surgeries to be delivered concurrently.
- **RECOMMENDED** to the CCG:
    - That a business case for provision of a second new surgery in King's Lynn, to serve the south of the town, should be taken forward as quickly as possible.
    - That the scope for facilitating a primary care hub in the central area, which could assist in service integration and ease pressure across all the town's practices, should be explored.
    - That meetings should be held with local councillors to pick up issues around:
        - Mitigating the effect of the relocation to Edward Benefer Way on vulnerable patients, including suggestions made by NHOSC Members at the meeting

on 26 Nov 2020.
    - Progress of the business case for a second new surgery in King's Lynn.
- **ASKED** The CCG and St James' Medical Practice to report progress to NHOSC.

9. Forward work programme

9.1 The Norfolk Health Overview and Scrutiny Committee received and reviewed the forward work programme.

9.2 Provision of dental surgeries in Kings Lynn was raised. The Democratic Support and Scrutiny Team Manager agreed to follow up on the letter sent to the Department of Health and Social Care on 29 September 2020 and speak to NHSE&I about the immediate issue arising from closure of the MyDentist surgery in King's Lynn.

9.3 The Norfolk Health Overview and Scrutiny Committee **AGREED** the forward work programme with the following additions and amendments:

- For the NHOSC Agenda:
    - Access to local NHS services for patients with sensory impairments
    - As the contract for interpreting services is to be re-procured in 2021 the timing of this item to be discussed with NHSE&I; aiming for early spring 2021.
- For the NHOSC Briefing:
    - Suicide prevention – information briefing from NSFT & CCG (see item 7 above)
    - Primary care developments in King's Lynn (see item 8 above)
- Information to be sought from commissioners and passed on to Members before the next meeting:
    - What re-provision has been made for people affected by the closure of the MyDentist dental practice in King's Lynn?
    - Phlebotomy in Lowestoft – what can be done about the situation whereby the hospital and GP practices are not processing each other's blood tests for patients.

Chairman

The meeting ended at 13.29

Prison healthcare – access to physical and mental health services

Suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager

Examination of health services provided to prisoners at mainstream prisons in Norfolk.

1. Purpose of today's meeting

1.1 To examine commissioning and delivery of physical and mental health services provided at the three mainstream prisons in Norfolk; HMP Norwich, HMP Bure and HMP Wayland.

1.2 NHS England and NHS Improvement (NHSE&I) commissions all health services for the prisons, including drug and alcohol services but excluding emergency and out-of-hours services, which are provided by the services the CCG commissions for the whole community including the prison population.

NHSE&I has been asked to provide a report including:-

- Details of the providers of the health services in each of the three prisons
- Description of the services provided
- Performance information – details of the performance indicators and information on how the services are performing against the expected standards
- Information on whether staffing within the services is at the expected level
- Information on how prisoner health records are transferred as they are moved from prison to prison and on release into the community.
- Details of how services have adjusted during the Covid 19 pandemic.
- Numbers of complaints received at the three prisons and information on which subjects / services receive the most complaints.

NHSE&I's report is attached at **Appendix A** and a representative will attend the meeting to answer NHOSC's questions. NHSE&I is responsible for commissioning the services and for ensuring that providers deliver them in line with the contracts.

2. Background information

2.1 The three mainstream prisons

2.1.1 There are three male mainstream prisons in Norfolk and no female prisons. Women offenders from Norfolk generally go to HMP Peterborough.

HMP Norwich - located in central Norwich and serving East Anglia. The prison is a multifunctional local prison holding remand and sentenced category B, C and D[1] adult prisoners as well as remand and sentenced young adults. Comprising three adjacent but separate sites, the establishment includes: the local reception prison site, holding convicted and unconvicted category B and category C prisoners; the local discharge unit (LDU), a training facility holding category C prisoners; and an open resettlement facility, Britannia House, holding category D prisoners. The prison has operational capacity for 773 prisoners..

HMP Wayland - a category C training establishment located in rural Norfolk near Thetford and was built over 30 years ago. The vast majority of prisoners at Wayland are serving lengthy sentences. The prison has operational capacity for 953 prisoners.

HMP Bure - situated on the former RAF Coltishall base in Norfolk and opened in 2009, HMP Bure is a category C training prison and a national resource for convicted sex offenders. The prison has operational capacity for 653 prisoners.

2.1.2 The healthcare providers at the three prisons are set out in NHSE&I's report at **Appendix A.**

Members will note that Practice Plus Group is listed as the current provider of physical and mental healthcare at HMP Wayland and HMP Bure but in other appendices to this report Care UK is mentioned as the provider. Care UK adopted the name Practice Plus Group in late 2020; it is not a change of provider.

2.2 Local Independent Monitoring Boards – reports

2.2.1 Every prison is monitored by an Independent Monitoring Board (IMB) appointed by the Secretary of State from members of the community in which the prison is situated. They are required to report annually on how well the prison has met the standards and requirements placed on it and have right of access to every prisoner, every part of the prison and prison records. Their reports include comments on healthcare.

2.2.2 **HMP Norwich** IMB annual report for 2019-20 is available on the IMB website:- IMB HMP Norwich 2019-20 report

[1] Cat B – Prisoners for whom the very highest conditions of security are not necessary, but for whom escape must be made very difficult.
Cat C – Prisoners who cannot be trusted in open conditions, but who do not have the resources and will to make a determined escape attempt.
Cat D – Prisoners who present a low risk; can be reasonably trusted in open conditions and for whom open conditions are appropriate.

Comments relating to healthcare are set out as extracts in **Appendix B.**

Overall the Board considered that healthcare provided in the prison was broadly comparable to that available in the community, within the confines of the necessary security controls. However, some GP and dentistry clinics had been cancelled at short notice and while waiting times two years ago for medical, dentistry and optician appointments were at least comparable to elsewhere in primary care, waiting times for dentistry under the new contract had become unsatisfactory.

The IMB expressed a significant concern about its ability to monitor healthcare provision at the prison effectively. This was because IMB members were no longer permitted to attend contract meetings and had not been receiving any minutes. It appeared that this was connected to a change of healthcare contract and new providers who started in April 2019.

2.2.3 **HMP Wayland** IMB annual report 2018-19 (the most recent published) is available on the IMB website:
IMB HMP Wayland 2018-19 report

Comments relating to healthcare are set out as extracts in **Appendix B.**

Overall the Board considered that up until April 2019 the standards for prisoners were generally equivalent to those in the community, although under greater stress. After a change of provider from 1 April 2019 it noted that there has been a greater emphasis on mental health, with a seven-day service and the psychiatrist coming in two or sometimes three times a week. It also noted that at the change-over of contractor there was no dentist in place, there was one GP short, and no nurse practitioner in post. This under-supply of staff had increased the treatment and appointment waiting times in excess of that in the general community.

The IMB also noted that since the change of healthcare provider in 2019 its members had been excluded from attending healthcare meetings, which made it difficult to monitor healthcare as closely as the IMB would like and to get accurate healthcare statistics.

2.2.4 **HMP Bure** IMB annual report 2019-20 is available on the IMB website:
IMB HMP Bure 2019-20 report

Comments relating to healthcare are set out as extracts in **Appendix B.**

The report was positive overall, noting that good staffing levels had been maintained and the number of GP visits had increased.

2.3 HM Inspectorate of Prisons – reports

2.3.1 HM Inspectorate of Prisons (HMIP) works in conjunction with the Care Quality Commission (CQC) and other bodies when conducting its wide-ranging prison

inspections. Findings on health, well-being and social care in prisons are available within its reports. The expected standard is:-

> *Patients are cared for by services that assess and meet their health, social care and substance use needs and promote continuity of care on release. The standard of provision is similar to that which patients could expect to receive elsewhere in the community.*

2.3.2 Short scrutiny visits

In April 2020 HMIP developed a short scrutiny visit (SSV) model as a way of minimising the burden of inspections during the unprecedented operational challenge of the Covid 19 pandemic. It involves two to three inspectors spending a single day in an establishment and focusing on a small number of issues that are essential to the safety, care and basic rights of those detained in the current circumstances.

At the time of writing HMP Wayland is the only mainstream prison in Norfolk known to have received an SSV, in July 2020. The report of the visit has not been published on HMIP's website.

2.3.3 Full inspections

The latest report for **HMP Norwich** relates to an unannounced inspection from 21 October – 1 November 2019, published on 27 Feb 2020. It is available on HMIP's website along with the action plan submitted in response in May 2020:- HMP/YOI Norwich (justiceinspectorates.gov.uk)

The introductory summary noted a general deterioration at the prison (not specifically related to healthcare):-

'*We last inspected Norwich in 2016, when we found an improved prison delivering reasonably good outcomes across all four of our tests of a healthy prison (safety, respect, purposeful activity and resettlement (now rehabilitation and release planning)). At this inspection, managers told us that since that time they had faced considerable difficulties and that the prison had deteriorated significantly. They were also keen to tell us that the deterioration had been reduced with some recent improvement over the last year. Outcomes and assessments, which at this inspection were not sufficiently good against any of the four tests, to an extent confirmed this narrative*.'

The introductory summary in relation to healthcare was:-

'*Healthcare was satisfactory, with some good practice in the provision of social care and palliative care, but with notably poor outcomes in dentistry*.'

The fact that there had been six self-inflicted deaths at the prison since the last inspection in 2016 was noted and the introductory summary said:-

'*Work to individually review the activity allocation and time out of cell of those identified as being in crisis was very positive and the prison had begun piloting new case management (ACCT) arrangements. That said, we found many weaknesses in case management practice, although the prisoners themselves told us they felt well cared for.*'

The specific findings and actions relating to physical and mental health are set out as extracts in **Appendix C**.

In addition to recommendations in the report the CQC also issued a Requirement Notice to Community Dental Services CIC to improve cleaning of areas of the dental suite.

2.3.4 The last full inspection report for **HMP Wayland** related to an unannounced inspection from 19 – 30 June 2017, published on 24 October 2017. It is available on HMIP's website along with the action plan submitted in response in January 2018:-
HMP Wayland (justiceinspectorates.gov.uk)

The introductory summary noted improvement at the prison (not related specifically to healthcare):-

'*We last inspected in Wayland in late 2013, when we found a prison that was stretched as a consequence of budgetary constraints, but was reasonably safe and delivering some good outcomes for those detained. At this inspection the prison was emerging from recent difficulties, but was improving and continuing to sustain broadly reasonable outcomes despite some concerns about safety, which was its key priority.'*

The introductory summary in relation to health was:-

'*The delivery of health services was variable, with improvements required to key services*.'

The specific findings and actions relating to health are set out as extracts in **Appendix C**.

In addition to the recommendations in the report the CQC issued a Requirement Notice to Virgin Care Services Limited to increase staff numbers and improve the care offered to prisoners with long term conditions.

2.3.5 The latest report for **HMP Bure** relates to an unannounced inspection from 27 March – 7 April 2017, published on 15 August 2017. It is available on HMIP's website:-
HMP Bure (justiceinspectorates.gov.uk)

The introductory summary said (not specifically related to healthcare):-

'This is our third report on Bure. At previous inspections we have always reported positive findings and this visit was no exception.'

and in relation to health

'*prisoners were positive about their experience of health care'*

The specific findings relating to health are set out as extracts in **Appendix C.**

2.4 **Offender health profile and needs assessment**

2.4.1 Norfolk Public Health produced an 'Offender Health Profile for Norfolk' in November 2014. The 203-page report provides useful background information and is available on the Norfolk Insight website via the following link:-

Offender_Health_Profile_Final_26Nov14.pdf (norfolkinsight.org.uk)

The report noted that offenders are more likely to smoke, misuse drugs and/or alcohol, suffer mental health problems, report having a disability, self-harm, attempt suicide and die prematurely compared to the general population. It referenced research studies going back to the 1990s which had found the prisoners were several times more likely to have psychosis and major depression, and about ten times more likely to have antisocial disorder than the general population. (All source material is cited in the report).

One of the key findings in relation to mainstream prisons was that offenders are often not identified as having a learning disability and it was thought that many offenders may fall into this group (having an IQ of below 70). This meant that they were often treated inappropriately in prison. It was recommended that screening for learning disabilities be improved.

The report noted the enormous potential of the NHS Health Check scheme to provide preventative health benefits to prisoners. It was an opportunity for unhealthy lifestyle behaviours such as smoking to be picked up and managed.

2.4.2 The latest Health and Social Care Needs Assessments were carried out for NHSE&I in 2019, when reports covering groups of prisons were produced. Three separate documents relating to the three Norfolk prisons can be found on the committee page of Norfolk County Council website via the following link:-

Health and Social Care Needs Assessments, 2019

These are extracts from larger health and social care needs assessments reports. The reports are very detailed, giving an overview and comparison between prisons including prisoner demography and background, results of staff and prisoner surveys and focus groups and covering all of the health needs and services provided:-

- Screening services - retinopathy, bowel cancer, aortic abdominal aneurysm, NHS Health Checks,

- Specialist pathways - mental health, self-harm, learning disabilities, social care, substance misuse
- Primary care and long term conditions - asthma, cancer, cardiovascular disease, chronic obstructive pulmonary disorder, diabetes, epilepsy, obesity)
- Other services - pharmacy, bedwatches & escorts, clinics
- Communicable diseases.

The extracts alone run to 558 pages.

Recommendations from the report for HMP Norwich are set out in **Appendix D**. There were no recommendations included in the extracts provided for HMP Wayland and HMP Bure.

2.5 **Healthwatch Norfolk research on diabetes care in prison (HMP Bure)**

2.5.1 Healthwatch Norfolk was commissioned by the East of England Diabetes Clinical Network to look into how prison residents with type 1 and type 2 diabetes can access care whilst serving a sentence. The study focused on two prisons, HMP Bure and HMP Littlehey in Cambridgeshire. Healthwatch was asked to examine:-

- How the needs of residents with diabetes are managed in prisons (such as dietary screening and glucose monitoring)
- What education is available to both staff and residents in relation to diabetes
- What education programmes are made available for all residents with diabetes
- What prevention arrangements are in place (such as access to exercise, dietary options, in-house screening of eyes, feet, diet and diabetes treatment)

The full report of the findings, published in March 2020, is available on Healthwatch Norfolk's website at:
https://healthwatchnorfolk.co.uk/report/diabetes-care-in-east-of-anglia-prisons/

Summary information on Healthwatch's findings and recommendations is attached at **Appendix E**.

3. Suggested approach

Members may wish to discuss the following areas with NHSE&I:-

3.1 **Mental health and learning disabilities**

(a) The 2014 Offender Health Profile noted that prisoners are often not identified as having a learning disability and are therefore treated inappropriately. What steps have NHSE&I taken to address this issue?

(b) Thorough mental health screening when offenders arrive at prison is considered an important measure. What is commissioned to ensure that this happens?

(c) HMP Norwich appears to have high and escalating levels of self-harm. What steps have the commissioners considered with the mental health and substance misuse healthcare providers to address this issue?

Staffing levels

(d) Staffing levels within the healthcare services for the prisons have been an issue, as they have in the wider community. Which services are currently understaffed at which prisons and what are the plans to address this?

Dentistry

(e) HMP Inspectorate of Prisons has highlighted significant concerns about dentistry for prisoners at HMP Norwich. NHOSC is also aware of significant difficulties with access to NHS dentistry in the community. What more can NHSE&I do to address the issue in the prison and reduce waiting times?

(f) Does NHSE&I set waiting time standards for prisoners' access to dental treatment? What is the commissioned standard and how did performance compare before Covid 19 and now?

Access for independent monitoring

(g) The latest Independent Monitoring Board reports for HMP Norwich and HMP Wayland note that the IMB has been excluded from healthcare meetings since a change of contract in April 2019. What is the explanation for this and what are the implications?

Complaints

(h) Can prisoners use the Prisoner Formal Complaint process (which ultimately leads to the Prisons and Probation Ombudsman) to make a complaint about healthcare?

Inpatient unit

(i) HM Inspectorate of Prisons report on HMP/YOI Norwich (Appendix C) refers to an inpatient unit at the prison but mentions that it does not have clear admission or discharge criteria.
- What does NHSE&I commission prison inpatient units to provide?
- Do they have 24-hour healthcare cover?
- Is NHSE&I assured that the local hospitals are clear on what level of care prison inpatient units can provide when considering whether to discharge patients from hospital back to the prison?

Covid 19

(j) How often does NHSE&I expect prisoners and staff to be tested for Covid 19?

(k) What policies are in place to manage prisoners' health and wellbeing in prisons where there are outbreaks?

4. Action

4.1 The committee may wish to consider whether to make comments or recommendations as a result of today's discussion.

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Confidentiality:

Meeting/Committee:	Norfolk County Council Health Overview and Scrutiny Committee
Venue:	MS Teams
Date:	February 2021

For further information contact:

Name	Claire Weston

1. Introduction

NHS England was contacted by the democratic support manager with a request to provide specific information about the healthcare commissioned for the three Norfolk prisons, which is answered below. The health needs assessments for each prison were also requested, and have been provided.

NHS England has responsibility for commissioning healthcare for people in custody under the health and Social Care Act 2021. The commissioning team collaborates with other commissioners in relation to services for people in prison (for example, the social care commissioner in the prisons).

2. Details of the providers of the health services in each of the three prisons

The providers of healthcare services in the prisons are as follows:

Prison	**Healthcare**	**Mental healthcare**	**IAPT**	**Substance misuse**	**Dental**
HMP Norwich	Virgin	NSFT	NSFT	Phoenix Futures	CDS
HMP Bure	Practice Plus Group	Practice Plus Group	NSFT	Phoenix Futures	CDS
HMP Wayland	Practice Plus Group	Practice Plus Group	NSFT	Phoenix Futures	CDS

Contract review meetings are held regularly to ensure that issues relating to delivery of the contract are discussed, enabling issues are explored and future developments of the services are reviewed. Partnership board meetings provide a forum for representatives of all healthcare services to discuss together the delivery of services and issues which they share.

3. Description of the services provided

Prison healthcare services are largely primary care services, with the exception of mental health where the secondary care service is also provided. If prisoners require secondary care (an appointment or treatment at a general hospital), they are referred by the prison healthcare team and taken out to hospital accompanied by prison officers. Although there is a range of healthcare providers in the Norfolk prisons, they work together within each prison to ensure that people receive care to support their health needs while in prison.

The mental health service in HMP Norwich, a remand prison, is provided by the same provider as the liaison and diversion service (which operates in police custody, identifying people with vulnerabilities at the point of contact with the criminal justice system, and aims to ensure that people are identified as vulnerable, and signposted to appropriate services). Commissioning a service which integrates the liaison and diversion service with the prison mental health service in the remand prison joins up the mental health care pathway and aligns it with the criminal justice pathway.

4. Patient voice

A range of different sources are available to understand the experience of people using the services. The registration of prison healthcare services by the CQC includes regulation 17, good governance, which states that '*systems and processes must… seek and act on feedback from relevant persons …. on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services'*. This means that in order to remain the registered provider of healthcare within a prison, providers must have systems in place that show that they ask people about their experiences of the services and use the information provided to develop services. This is reviewed when an inspection takes place, and in advance of an inspection, there is a survey of service users to ask for their views and experiences, and these are recorded as appendices to

inspection reports.

When NHS England makes quality visits to services, we look for evidence that this is in place and suggest ways to increase access to service users' experiences. During a quality visit we also look at the complaints arrangements, checking that they are confidential (separate to complaints and comments relating to the operating of the prison, and sent direct to healthcare), and at the ways in which providers quality assure responses to complaints.

5. Performance information – details of the performance indicators and information on how the services are performing against the expected standards

Data for a range of indicators is reported quarterly and was provided to the committee in 2019. Reporting was suspended at the start of the pandemic, to allow maximum capacity within services for service delivery, and has not yet been resumed. The data is used to contribute to an overall understanding of service delivery, but is not in itself an absolute indicator of satisfactory service delivery. Some of the indicators have a target. An understanding of the effectiveness of services is derived from a range of sources, which include

- HJIPs
- Inspection reports
- Incident reports
- Reporting against the quality schedule of the contract

The inspection of prisons includes the inspection of prison healthcare. Healthcare is inspected by the inspectorate of prisons and also by the Care Quality Commission, usually on a 2-3 year cycle. During the pandemic, the inspectorate has suspended its routine cycle of inspections and has replaced this with short scrutiny visits (SSVs). Further details can be found on the HMIP website.

The dates of last inspections for the Norfolk prisons are as follows:

HMP Norwich – full inspection	October 2019
HMP Wayland – SSV	July 2020
HMP Bure – full inspection	April 2017

The NHS England health and justice commissioning team makes visits to prisons to directly observe delivery of services and discuss issues with clinical staff. A structured approach is used, to look at specific areas of service delivery. Quality visits have not been possible during the last 12 months, as a result of covid 19. The HJIPs data for the prisons for the period April 2020 to date is attached at appendix 1.

6. Information on whether staffing within the services is at the expected level

Staffing models are expressed in bids to provide the services at the time they are procured. Once appointed, the provider is responsible for ensuring that services are delivered safely and effectively, and for submitting a quarterly report relating to workforce, which allows NHS England to identify any issues relating to staffing. The Norfolk prisons services experience broadly the same issues as community NHS services in respect of clinical staffing; it is challenging to recruit and retain staff, and this is made even more difficult due to the remote rural locations of two of the prisons. Our expectation is that providers will deliver services as described in their contracts and while we acknowledge that problems may be experienced from time to time, providers are asked to propose action plans to resolve access issues, and if they are agreed, to deliver the action plan.

At the start of the pandemic, all healthcare services were suppressed, and many staff have been off sick or isolating since March 2020. This issue is far more significant than vacancies relating to substantive roles. When service return to normal functioning after the pandemic, the review of workforce and staffing will resume.

7. Information on how prisoner health records are transferred as they are moved from prison to prison and on release into the community.

Prisoner records are not transferred from one prison to another. When someone is received into prison, their clinical record can be accessed and will be updated as required during their stay in that prison. A programme to upgrade the clinical system in use in prisons is underway which will produce a range of benefits. This programme includes a workstream which ensures that people are registered with a GP in the community, before they are released from prisons, and will also allow their record to be accessed by the community GP. Currently, the prison healthcare provider may confidentially provide a summary of relevant information to the persons' community GP.

8. Details of how services have adjusted during the Covid 19 pandemic.

During the pandemic, all prisons were subject to nationally-determined measures to limit the spread of infection, restricting all activities in order to preserve life; this includes health services. The Ministry of Justice has published information about how the pandemic is being managed in prisons[1]. . In order to provide care, some providers offered services in different ways. Some examples are

- Telemedicine: prisons have been provided with webcams and tablets to allow them to link with local hospitals for secondary care appointments
- In-cell packs: wellbeing can be supported through use of 'distraction packs' to focus attention and stimulate people during long periods of isolation
- Wing-based care (instead of healthcare sessions in the healthcare centre)
- Direct care provided in cells: nurses and therapists have provided advice and in some cases, treatments, to patients in cells
- Use of in-cell phones to communicate with prisoners and provide advice
- Maximise use of posters, leaflets and in cell TV to remind people of health advice and support

Many services have necessarily been limited to the most urgent assessments and treatments. Triage has been put in place to ensure that these are not overlooked, and there has been proactive contact with people to try to prevent people from being left without care.

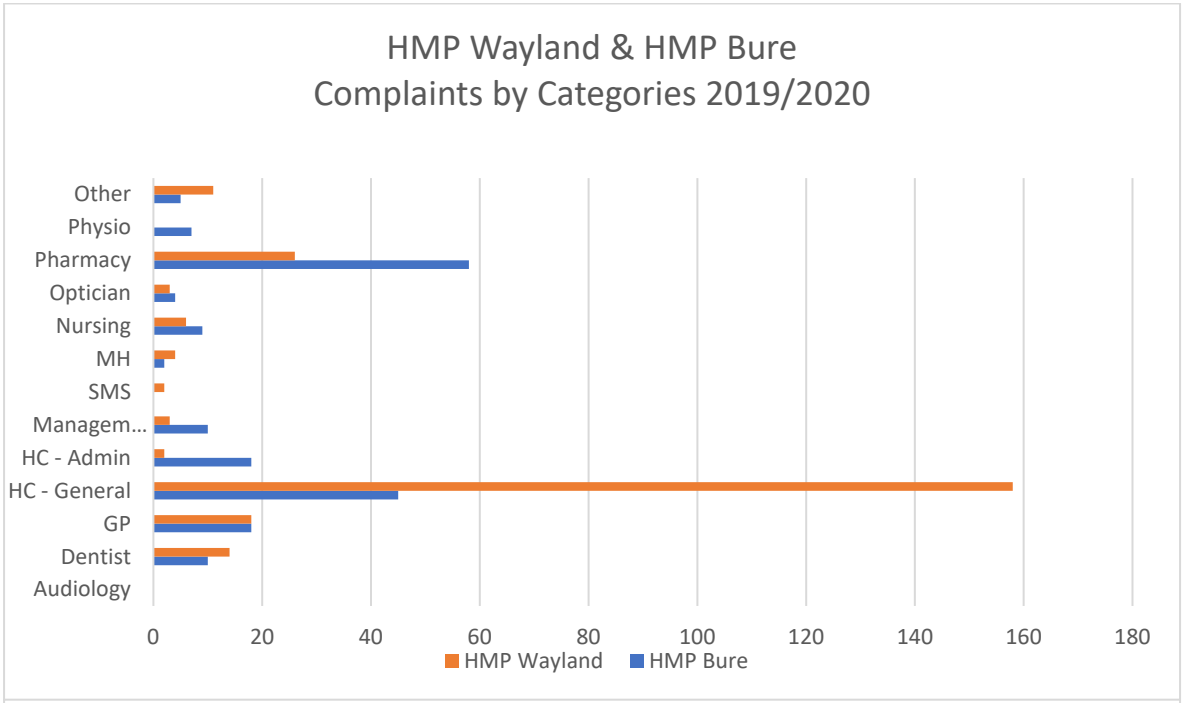
9. Complaints received and subjects of complaints

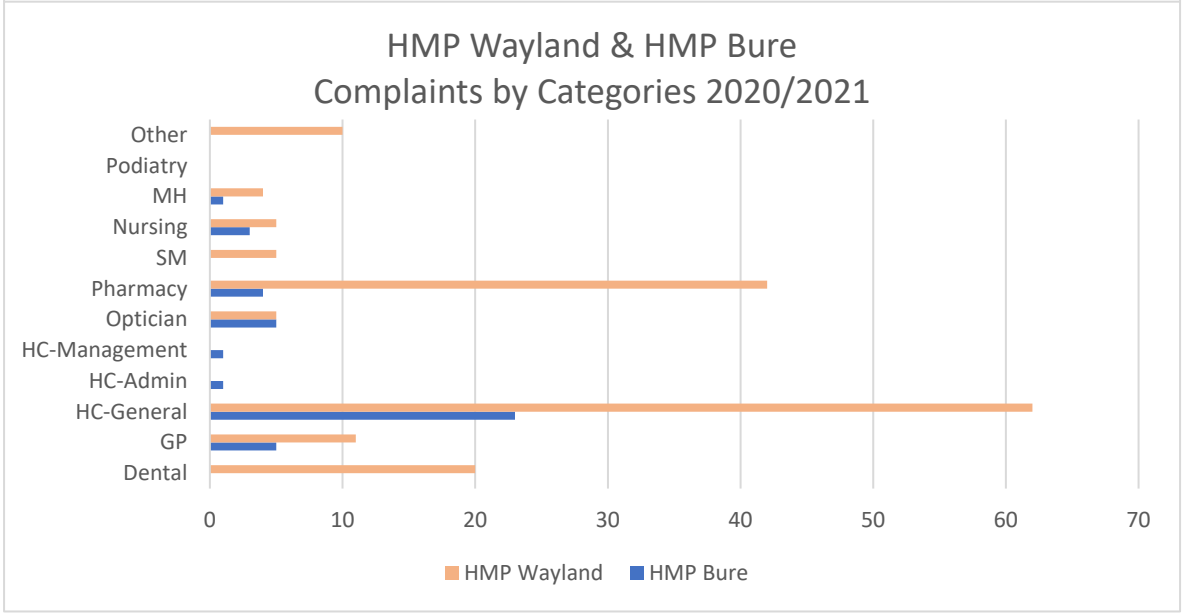
The table below shows the total numbers of complaints/concerns received direct by healthcare providers at HMP Bure, HMP Wayland & HMP Norwich.

Prison	**2019/20 Total Complaints/Concerns Received**	**2020/21 Total Complaints/Concerns Received (up to Sept 2020)**
HMP Bure	165	43
HMP Wayland	268	164
HMP Norwich	165	115

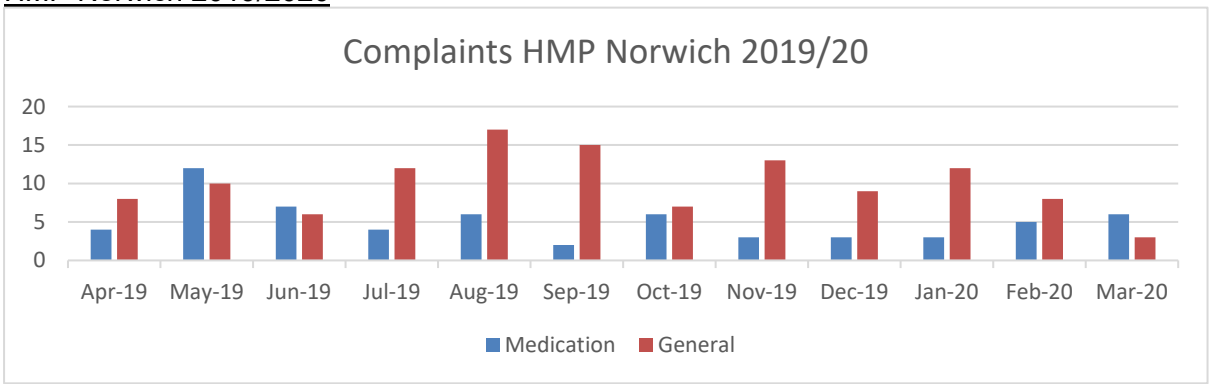
Categories of complaints received

[1] https://www.gov.uk/government/news/managing-the-pandemic-in-prisons





HMP Norwich 2019/2020



HMP Norwich 2020/2021

The information received from HMP Norwich within their Quality Report submitted to NHSEI shows complaints in 2020/21 to September 2020, which mainly relate to Dental Treatment, Medication and GP Appointments. Patients feel their problems are not being addressed sometimes as they are not physically seeing a GP.

Complaints received direct by to NHS England

Patients have the option of making a complaint direct to NHS England. If someone uses this route, the healthcare provider will be asked to investigate in the same way as if the complaint was received direct, and NHS England will review the response before sending a reply to the complainant. A total of 8 complaints were received direct by NHS England (East) Complaints Team from people in the Norfolk prisons.

Prison	2019/20 Total Complaints/Concerns	2020/21 Total Complaints/Concerns (up to Sep 2020)	Subject of Complaints
HMP Bure	3	0	Clinical treatment - Appropriateness of care provided
HMP Wayland	2	2	Clinical treatment - Appropriateness of care provided
HMP Norwich	1	0	Clinical treatment - Care provided

Of the complaints received directly in to NHESI East of England Complaints team from the Norfolk prisons during the period 2019 to Sept 2020:

- 4 complaints - Not Upheld
- 2 complaints - Upheld
- 1 complaint - already been investigated by the prison directly
- 1 complaint - consent form was not returned, so could not be progressed

NHS England monitors and seek assurance on patient experience within all commissioned health and justice healthcare services. Monitoring and reviewing complaints is one of the ways by which NHS England ensures that feedback from service users is used to drive quality improvement.
Providers are required to provide assurance that:

- service users are aware of how to raise complaints/concerns confidentially
- complaints information is readily available to service users and in accessible formats including how to escalate complaints/concerns externally to NHSEI and parliamentary ombudsman if service users are not satisfied with the outcome of internal investigation
- complaints/concerns are acknowledged and investigated in a timely manner.
- lessons are learned from complaints.

Complaints are reviewed and monitored via contact review meetings, quality schedule submissions, and quality assurance visits. Service users are also able to raise complaints directly with NHSEI complaints team. Where available, this information is shared at prison health and social care partnership board meetings. NHSEI review all concerns received and raised by other stakeholders.

- Ends -

Appendix 1: HJIPs data

Health and Justice Indicators of Performance

HMP Norwich

Note: the percentages shown in these tables are the percentage achieve of the eligible / relevant population

Area	Indicator Description	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Demographic	Population	656	657	664	689	686	665
	New Receptions	111	141	138	171	131	137
	New Transfers	3	7	8	18	24	15
	Discharges	136	119	104	127	97	112
	MH Population	84	73	75	77	79	80
	Dementia Population	3	3	3	2	1	1
	Depression Population	229	222	213	220	248	265
	Mental Health Caseload	102	110	107	125	127	123
	LD Population	15	12	13	12	11	10
	MH Remissions	0	2	3	0	0	2
	1st Reception screens	99%	99%	100%	100%	100%	100%
	2nd Reception screens	97%	100%	100%	100%	100%	100%
Non Cancer Screening	Abdominal Aortic Aneurysm (AAA) Screening Uptake	0%	0%	0%	0%	0%	0%
	Retinal Screening Uptake	0%	0%	0%	0%	57%	0%
	Chlamydia Screening Uptake	21%	16%	15%	58%	50%	33%
	NHS Physical Health Check Uptake			20%	77%	37%	70%
	Tuberculosis (TB) Screening Uptake	99%	99%	100%	100%	100%	100%
	Hepatitis B testing offered	100%	99%	100%	100%	100%	96%
	Hepatitis B HBsAg Uptake	11%	16%	21%	33%	22%	22%
	Hepatitis C testing offered	100%	100%	100%	100%	100%	100%
	Hepatitis C - HCV Ab	25%	24%	29%	31%	38%	27%
	HIV Testing - Uptake	25%	25%	29%	31%	38%	27%
Cancer Screening	Breast Cancer Screening (female estate only)						
	Cervical Cancer Screening (female estate only)						
	Bowel Cancer Screening	0%	0%	14%	0%	0%	0%
Medicines Management	In-Possession Medication (Arrivals)	99%	99%	100%	100%	100%	100%
	In-Possession Medication (Pre-existing population)	92%	86%	93%	94%	94%	97%
	Receipt of Medication	12%	16%	14%	19%	21%	19%
	Supply on Transfer	100%	100%	67%	50%	100%	88%
	Supply on Discharge	99%	94%	90%	92%	91%	93%
	Medicines Reconciliation	35%	34%	43%	48%	42%	38%
Mental health	Care Programme Approach (CPA) on Arrival	3%	3%	0%	2%	0%	0%

	Care Programme Approach (CPA) application in Prison	0%	0%	0%	0%	1%	3%
	Care Programme Approach (CPA) 6 Month Reviews	67%	100%		100%	100%	100%
	Care Programme Approach (CPA) Annual Health Check	0%					
Smoking	Smoking Prevalence at Reception	69%	63%	65%	65%	20%	36%
	Smoking Cessation Uptake	5%	2%	2%	3%	2%	3%
DART	5 Day Reviews	100%	94%	100%	100%	90%	100%
	13 Week Reviews	93%	91%	100%	67%	39%	5%
	Alcohol Screening	54%	55%	52%	47%	50%	42%

DART = Drug & alcohol related treatment

HMP Wayland

Area	Indicator Description	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Demographic	Population	955	951	964	952	936	959
	New Receptions	0	0	0			
	New Transfers	14	43	50	27	42	76
	Discharges	29	27	20	22	33	29
	MH Population	92	91	96	94	93	90
	Dementia Population	0	0	0	0	0	0
	Depression Population	324	330	338	335	332	331
	Mental Health Caseload	60	98	135	175	161	146
	LD Population	20	19	19	18	20	19
	MH Remissions	0	0	0	0	0	0
	1st Reception screens	100%	100%	100%	100%	100%	97%
	2nd Reception screens	100%	98%	100%	100%	100%	91%
Non Cancer Screening	Abdominal Aortic Aneurysm (AAA) Screening Uptake	0%	0%	0%	0%	0%	0%
	Retinal Screening Uptake	0%	0%	0%	0%	0%	0%
	Chlamydia Screening Uptake	0%	0%	25%	12%	9%	0%
	NHS Physical Health Check Uptake	0%	0%	22%	38%	25%	14%
	Tuberculosis (TB) Screening Uptake	93%	100%	100%	100%	100%	97%
	Hepatitis B testing offered	100%	86%	90%	100%	93%	100%
	Hepatitis B HBsAg Uptake	100%	74%	71%	100%	80%	86%
	Hepatitis C testing offered	93%	93%	96%	100%	97%	96%
	Hepatitis C - HCV Ab	86%	86%	81%	89%	87%	84%
	HIV Testing - Uptake	86%	88%	86%	89%	79%	80%
Cancer Screening	Breast Cancer Screening (female estate only)						
	Cervical Cancer Screening (female estate only)						
	Bowel Cancer Screening	8%	0%	9%	0%	0%	0%
Medicines Management	In-Possession Medication (Arrivals)	57%	100%	90%	96%	100%	92%
	In-Possession Medication (Pre-existing population)	93%	94%	94%	95%	95%	95%
	Receipt of Medication	0%	0%	0%	0%	27%	19%
	Supply on Transfer	63%	57%	73%	56%	80%	58%
	Supply on Discharge	59%	86%	60%	69%	68%	25%
	Medicines Reconciliation	93%	84%	60%	100%	100%	99%
Mental health	Care Programme Approach (CPA) on Arrival	0%	7%	0%	4%	2%	5%

	Care Programme Approach (CPA) application in Prison	0%	0%	0%	0%	0%	0%
	Care Programme Approach (CPA) 6 Month Reviews		100%	0%	100%	100%	
	Care Programme Approach (CPA) Annual Health Check						
Smoking	Smoking Prevalence at Reception	36%	35%	50%	22%	12%	28%
	Smoking Cessation Uptake	12%	7%	7%	8%	8%	8%
DART	5 Day Reviews						
	13 Week Reviews	100%	100%	100%	100%	100%	100%
	Alcohol Screening	57%	93%	82%	89%	79%	78%

HMP Bure

Area	Indicator Description	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Demographic	Population	612	605	597	581	580	586
	New Receptions	0	0	0			
	New Transfers	6	8	7	12	17	34
	Discharges	15	11	15	18	17	28
	MH Population	34	32	31	30	30	29
	Dementia Population	6	6	6	6	6	5
	Depression Population	175	169	166	159	160	113
	Mental Health Caseload	43	45	33	43	41	50
	LD Population	10	9	9	9	8	13
	MH Remissions	0	0	0	0	0	0
	1st Reception screens	100%	100%	100%	100%	100%	100%
	2nd Reception screens	100%	88%	100%	100%	100%	97%
Non Cancer Screening	Abdominal Aortic Aneurysm (AAA) Screening Upta	0%	0%	0%	73%	0%	8%
	Retinal Screening Uptake	0%	0%	0%	0%	67%	0%
	Chlamydia Screening Uptake	0%	0%	0%	0%	0%	0%
	NHS Physical Health Check Uptake	0%	0%	0%	45%	14%	74%
	Tuberculosis (TB) Screening Uptake	100%	100%	100%	100%	100%	100%
	Hepatitis B testing offered	100%	0%	60%	100%	73%	59%
	Hepatitis B HBsAg Uptake	0%	0%	0%	13%	0%	18%
	Hepatitis C testing offered	100%	50%	71%	100%	76%	53%
	Hepatitis C - HCV Ab	0%	0%	14%	50%	0%	13%
	HIV Testing - Uptake	0%	0%	0%	58%	0%	9%
Cancer Screening	Breast Cancer Screening (female estate only)						
	Cervical Cancer Screening (female estate only)						
	Bowel Cancer Screening	3%	0%	0%	0%	0%	0%
Medicines Management	In-Possession Medication (Arrivals)	100%	100%	100%	100%	100%	100%
	In-Possession Medication (Pre-existing population)	98%	100%	100%	100%	100%	100%
	Receipt of Medication	0%	0%	0%	0%	31%	11%
	Supply on Transfer	25%	75%	75%	29%	40%	62%
	Supply on Discharge	78%	64%	78%	72%	76%	70%
	Medicines Reconciliation	100%	88%	100%	100%	100%	97%
Mental health	Care Programme Approach (CPA) on Arrival	17%	0%	0%	0%	6%	0%

	Care Programme Approach (CPA) application in Pri	0%	0%	0%	0%	0%	0%
	Care Programme Approach (CPA) 6 Month Review	0%	0%	0%	0%	29%	33%
	Care Programme Approach (CPA) Annual Health Cl	0%			0%	0%	50%
Smoking	Smoking Prevalence at Reception	0%	38%	0%	42%	59%	53%
	Smoking Cessation Uptake	5%	5%	5%	4%	4%	5%
DART	5 Day Reviews						
	13 Week Reviews						
	Alcohol Screening	100%	100%	100%	100%	100%	100%

Extracts from the most recent annual reports of local prison Independent Monitoring Boards

1. **HMP Norwich Independent Monitoring Board report for the year 1 March 2019 – 28 February 2020**

The full report is available on the Independent Monitoring Board website IMB HMP Norwich 2019-20 report. The following extracts relate to health care only.

HMP Norwich
From IMB report 2019-20

8. **Healthcare (including mental health and social care)**

8.1 A new healthcare contract started in April 2019, commissioning several different health providers and splitting the previous cohesive provision overseen by VirginCare. Subject to paragraph 8.2 below, the Board considers that the healthcare service at the establishment is broadly comparable to that available in the community, within the obvious confines of necessary security controls. However, some GP and dentistry clinics have been cancelled at short notice – for example, on 12 April 2019, some evening reception sessions did not have GP cover. While waiting times two years ago for medical, dentistry and optician appointments were at least comparable to elsewhere in primary care, waiting times for dentistry under the new contract are now unsatisfactory. For example, on 20 August 2019, a prisoner on F wing reported that he had waited three months for an appointment for his painful cracked tooth and had resorted to putting in a Comp1 (the prison's complaint system); following the Board's complaint to the Patient Advice and Liaison Service (PALS), an emergency appointment was booked for him on 10 September 2019. The primary care and mental health nursing staff are to be commended for their unremitting conscientious care, which is displayed even in the face of abuse and threats.

8.2 It is unacceptable that Board members have been informed that, after many years of doing so, they are no longer to attend the informative contract meetings and we are not receiving any minutes. There were no elements of 'commercial confidentiality' ever expressed in such meetings, and individuals were not identified – the meeting's principal role being for the commissioner to analyse the performance of delivery. The information garnered then drove the Board's focus on areas of monitoring which otherwise would have been difficult to identify owing to medical confidentiality in individual cases. Losing the above insight has been compounded by the fact that healthcare complaints are no longer sent via the prison complaints system, thus impeding our ability to scrutinise patterns of complaint (see section 8.3). The above inevitably reduces transparency for monitoring and it is impossible to monitor healthcare provision evidentially, other than through individual incidents brought to our attention via Board applications or in the observation of areas such as abnormally lengthy queues at the medication dispensaries. As a result, the Board

currently feels unable to monitor healthcare provision at the prison effectively, and requests resolution on this matter from the Governor.

8.3 The current method of considering prisoners' healthcare complaints is a cause for concern. Following the earlier prison complaints system, all healthcare criticisms and enquiries were then managed through a PALS structure. This is no longer the case. Currently all complaints are answered by the head of healthcare. While he has introduced a new healthcare complaints form, this method does not offer an objective position and there is no external appraisal of grievance, nor can the Board offer an opinion on the quality or timeliness of responses to complaints.

8.4 Problems with sick leave, recruitment and retention continue, mirroring the situation with healthcare in the community, and there are staff shortages; for example, the substance misuse doctor was on sick leave throughout autumn 2019. The professional and committed permanent core of nursing staff is drained – they are under great pressure and much is demanded of them. The comprehensive reception screening process continues to triage needs carefully and effectively but is stretched. On 16 June 2019, there was only one general healthcare staff member on duty on the main site, with the pharmacy technician having to dispense medication. On 11 August 2019, the roll was delayed as there was only one nurse on B/C wings for controlled drugs. On 21 August 2019, the nursing staff was reported as below safe levels, with only one on the category C site and one on the main site. On the week of 25 August 2019, the permanent daytime nursing staff based in reception had to stay late every night as their relief was not on time, being over an hour late every evening, with no advice received as to whether or not anyone would be coming. On 28 August 2019, nurses were called from reception to an emergency on E wing and so initial health screenings had to wait; no holiday supply nursing was arranged and there were 50 secondary health screenings outstanding. On 10 September 2019, the doctor stated that no methadone could be prescribed to new receptions, as there was no 24-hour cover and no medication hatches on B wing. There was a skeleton staffing covering reception and the wings. These dedicated staff put their concerns to managers but on one occasion were just told to put in for overtime. The Board contacted the prison and also the regional commissioner of healthcare for prisons, as members were concerned for the welfare of nurses and their patients, and feared that these knowledgeable and capable nurses might leave, to the detriment of the prisoners, if this matter was not properly addressed. The prompt start of the dispensing of medication is vital to the smooth running of the core day, but this was not the case during the reporting year. Nurses reported that there were more prisoners on controlled drugs on the wings, with no more nurses to prepare and dispense them, causing an increased workload. On 1April 2019, pregabalin and gabapentin became class 3 controlled drugs, and tighter controls were in force, although healthcare policy was to reduce these potentially addictive medications. The dispensary was not starting at

7.15am, as scheduled, causing a knock-on effect for free-flow, activities and the timings of the rolls being submitted as correct. On 10 September 2019, the Board was told that an average of about 10 people daily were not getting to work owing to queues at the medication hatch, making them too late for free-flow. The Board has noted in recent months that the dispensary queues are now slightly better supervised on B/C wings, normally with an officer on the landing, but delays still occur, which have an impact on the efficient execution of the regime. Generally, officer supervision of the dispensing of medication and the queues is poor, which can result in bullying and aggressive and disruptive behaviour.

8.5 Last year, the Board said: 'Inpatient beds in the healthcare unit (HCC) are also allocated to prisoners with mental health issues who cannot be housed for safety reasons on normal location. The unit is regularly staffed by nurses who have little mental health training and many of the other prison staff have also not received appropriate training for these complex patients'. This situation continues. Ten of the 23 beds are allocated to the health provider for prisoners with physical health conditions, but the prerequisite peaceful environment of a healthcare unit is often disturbed by prisoners who are noisy and disruptive. On 1 April 2019, a prisoner was lying naked in the safer cell on constant watch. He would not wear clothes and was at serious risk of self-harm. He was awaiting transfer to a locked rehabilitation unit. He should not have been in HMP/YOI Norwich, as the prison was not equipped to manage his needs.

8.6 The appearance of the healthcare unit is outmoded, and the austere cells are purely functional and not conducive to physical or mental rehabilitation. However, the unit is kept well painted; any meaningful refurbishment would be costly. The shower facilities for disabled prisoners in the HCC have not worked for some years and there are no plans to replace them (see section 5.11). However, the general ethos of the unit is caring and Board members have observed patience and forbearance displayed by tolerant staff in the face of some unusual, sometimes provocative, and extreme behaviour.

8.7 Although the environment on L wing is outdated, the unit is kept clean and painted, and the standard of care continues to be of good quality and is compassionate and sensitive. A recent PPO report, when describing the healthcare provision, stated: 'good standard of care', 'equivalent to that ... in the community'. The programme of activities continues to be enhanced by 'forget me nots' providing cognitive stimulation, and a secure sense of community prevails in this unit. After a lengthy delay, a memorandum of understanding regarding social care has been signed and VirginCare appointed as the care provider, which ensures continuity of care, mainly to the older prisoners in L wing.

8.8 The day care centre on the main site is used for primary care on an appointment based system. The waiting rooms are bleak, uncomfortable

and crowded. Prisoners with appointments arrive on free-flow and should return to their allocated activities in order to be eligible for pay. Treatment rooms are clean and fairly well equipped. There are some reasonable wing-based treatment rooms. However, there are too many prisoners who do not attend their appointments, some of which could be attributed to the delays for appointments, particularly for dentistry clinics.

8.9 On 20 August 2019, the Board received an application regarding smoking cessation. A prisoner stated that he had been refused smoking cessation help as VirginCare was stating that prisoners could only choose to have smoking cessation at the beginning of their imprisonment, which proviso was not as stated in their contract. As there has been limited takeup of this support, there is capacity within the contract to provide smoking cessation to all who genuinely wish for help to stop smoking/vaping. Owing to some abuse of nicotine patches, lozenges will be used as the nicotine replacement therapy within the prison.

8.10 The mental health team has a new provider, but the diligent and reliable team members remain substantially the same, providing sound but, by necessity, triaged care to an increasing number of prisoners with mental health issues and complex needs. The team is fully integrated into the daily life of the prison, constantly seeing referrals. It is overstretched, operating on the basis of the most serious need while completing assessments, ACCT reviews, guidance plans for the management of prisoners with complex personality disorders, and so forth. The mental health team leader unfortunately has recently resigned, but he has been robust in his efforts to transfer prisoners with severe mental health illnesses to more appropriate environments. However, from May to October 2019, mainly because of the lack of available beds, only two of the seven transfers were within the 14-day guidelines of the Mental Health Act. On 18 October 2019, a member of the mental health team reported that there were insufficient radio handsets available, so no one on the team had one that day.

8.11 Within the integrated mental health and justice pathway, the mental wellbeing support team offers wellbeing/increased access to psychological therapies (IAPT) for mild-to-moderate mental health difficulties such as anxiety and depression. The team was fully staffed and very busy providing cognitive therapies to assist prisoners dealing with a myriad of issues; however, the team leader was leaving and no replacement had been recruited. The Board had some concerns when the team said, on 9 June 2019, that they were unable to see a prisoner because he was on the segregation unit, even though he was compliant and known to the team. MensCraft, a self-worth and motivational programme started in November 2019, together with other initiatives designed to lessen self-harm and improve mental wellbeing

Extracts from HMP Wayland Independent Monitoring Board report for the year June 2018 – May 2019, published in April 2020

The full report is available on the Independent Monitoring Board website IMB HMP Wayland 2018-19 report. The following extracts relate to health care only.

HMP Wayland
From IMB report 2018-19

8. Healthcare

Up until 1 April 2019, Wayland's healthcare was provided by Virgin Care, with the standards for prisoners generally equivalent to those in the community, although under greater stress: frequently dealing with drugs and violence, fuelled by new psychoactive substances (NPS) both in reaction to the drug and also the debt its availability encourages. For example, in September, 74 prisoners were treated by Wayland medical staff for being under the influence of drugs. Twenty-one self-harmed, and there were seven assaults and four overdoses requiring further treatment. In the same month, 37 ACCTs were opened, the reviews of which have to be attended by healthcare staff. Figures for January 2019 were very similar: 73 prisoners were treated on site for being under the influence of NPS, with 12 going to hospital, 29 had to be physically restrained, 19 self-harmed. Although there was only one overdose, there were 18 assaults, of which eight needed to be escorted to the local hospital. Fifteen ACCTs were opened. On the positive side, 84 prisoners agreed to stop smoking, of which 64% were successful. In October 2018, to make healthcare more accessible to prisoners, wing based care was introduced on E wing with a GP attending. There is a plan for this to extend to A and C wings.

In November it was announced that the local hospital would be working more closely with the three Norfolk prisons, so that procedures such as pre-operation assessments could be done by healthcare staff in the prisons, thus alleviating pressure on escort staff.

After 1 April 2019 the healthcare contract was taken over by Care UK. Since that time there has been a greater emphasis on mental health, in that there is now a seven-day service, with the psychiatrist coming in two or sometimes three times a week because of the continuing need. However, at the change-over of the contract there was no dentist in place, there was one GP short, and no nurse practitioner in post.

This under-supply of staff has increased the treatment and appointment waiting times in excess of that in the general community.

As noted there are now seven mental healthcare nurses, each with case load of 60 patients, with a wing-based system for treatment and assessment. In addition, there is a wellbeing service to which prisoners can be referred by the GP, the mental health team or self-refer. To encourage more prisoners to be tested for hepatitis B and C, there is a plan for the new drug services

provider, Phoenix Futures, to have peer mentors, who will also be working with prisoners with addictions.

The IMB understands that dentistry is a separate contract with Community Dental Health Service and is not managed by Care UK. It is to be regretted that since the change of healthcare provider, the IMB has been excluded from attending healthcare meetings, in contravention of our right to attend any meetings. Consequently, it has been difficult to monitor healthcare as closely as we should like and to get accurate healthcare statistics.

Extracts from HMP Bure Independent Monitoring Board report for the year 1 August 2019 – 31 July 2020

The full report is available on the Independent Monitoring Board website IMB HMP Bure 2019-20 report. The following extracts relate to health care only.

HMP Bure
From IMB report 2019-20

6. Health and wellbeing

6.1 Healthcare: general

Since our last report, good staffing levels have been maintained by Care UK, despite the isolation of the prison and the reluctance of potential candidates not wishing to work with men convicted of sexual offences.

6.2 Physical healthcare

The number of GP visits has increased, and there are currently six nurses and a pharmacist (shared with another prison), supporting five pharmacy technicians. A dentist attends two days a week but, because of the COVID-19 restrictions, the full range of procedures is not available. An optician attends one day every other week and will repair spectacles. Healthcare staff have been trained to do minor repairs to hearing aids, and video-calls are available, using a special camera, for advice on skin conditions. There has been a drop in the number of complaints sent directly to healthcare. However, the Board has raised concerns about the replies received by prisoners, which lack some necessary information. The healthcare manager has been made aware of this and has agreed to address the matter. Those who are currently shielding are seen twice a day for their physical and mental wellbeing. Since the start of the pandemic, the healthcare team has maintained low levels of staff absence, and witnessed a number of more serious incidents involving the intervention of the Air Ambulance Service. They have dealt with the situations in a professional manner, and the safer custody team has provided officer support to ensure the wellbeing of all healthcare staff.

6.3 Mental healthcare

The mental health team consists of three experienced full-time staff and a learning disability nurse. There has not been a significant increase in the workload during the COVID-19 situation but they have been unable to do face-to-face reviews, for the safety both of prisoners and staff. As the prison moved to a less restricted regime, the mental health team was able to speak with prisoners in the open air, until a dedicated COVID-19 safe room was prepared.

6.6 Drug rehabilitation Thirteen per cent of the population of Bure are monitored for drug-related issues. Members of the drug strategy recovery team have

continued their work although some were shielding during March and April. No programmes have been run since the outbreak of COVID-19 but staff have maintained one-to-one contact with prisoners and given the more vulnerable prisoners regular welfare checks.

Extracts from reports of unannounced inspections by HM Chief Inspector of Prisons & corresponding action plans

1. **HMP/YOI Norwich,** 21 October – 1 November 2019' and the action plan in response
2. **HMP Wayland,** 19 – 30 June 2017 and the action plan in response
3. **HMP Bure,** 27 March – 7 April 2017

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1. HMP/YOI Norwich 2019

The full report and action plan are available at HMP/YOI Norwich (justiceinspectorates.gov.uk). The following extracts relate to mental & physical health findings only.

HMP/YOI Norwich
From HM Inspectorate of Prisons report

Extracts from Summary

Safety

S13 There had been six self-inflicted deaths since the previous inspection. Managers had responded well to PPO recommendations following investigations. The rate of self-harm had shown an upward trend in the previous six months. A good range of useful data was collated and analysed, but it had not been used to develop an action plan to reduce self-harm. Although prisoners subject to assessment, care in custody and teamwork (ACCT) supervision for prisoners at risk of suicide or self-harm told us they felt staff cared for them well, reviews were not always meaningful. There were deficiencies in care planning and triggers (events that might cause a prisoner to self-harm) were not understood. The conversations recorded were mostly cursory. Quality assurance had been implemented but had not yet addressed these issues. There were not enough Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) in the main prison or in the LDU, and only 30% of prisoners in our survey said it was easy to see a Listener.

Respect

S22 Many aspects of health care were reasonable; however, we had some concerns about gaps in the GP provision and poor oversight of dental services. Staff recruitment was improving for most services and we observed conscientious and caring staff, but they were stretched across all services. There was a suitable range of primary care services, which had mostly acceptable waiting times. However, there were delays in offering some immunisations and vaccinations and uptake was low.

S23 The inpatient unit did not have clear admissions or discharge criteria. The mix of prisoners in the unit was not consistent with the needs of a therapeutic environment. L wing offered 24- hour nursing and social care packages for a mainly older group of prisoners with chronic health conditions. Care was of a high standard and prisoners we spoke to valued it. The palliative care pathway was well developed and had achieved external accreditation.

S24 Mental health services were reasonably good and a stepped care model (mental health services that address low level anxiety and depression through to severe and enduring needs) was offered, ranging from self-help through to complex case management. There was good access to psychiatrist support. With a small number of notable exceptions drug- or alcohol-dependent prisoners received prompt treatment and were monitored. There was a lack of psychosocial and mutual aid support for longer-term prisoners.

S25 The pharmacy provided a good service and improvements had been made since the previous inspection. However, officers' supervision of medication queues was inconsistent, which meant bullying and the diversion of medicines could take place.

S26 The dental provision did not meet the needs of the population – the waiting time for a routine appointment and urgent care was too long. Decontamination processes were inadequate.

Extracts from Section 1: Safety

Safeguarding

Expected outcomes: The prison provides a safe environment which reduces the risk of self-harm and suicide. Prisoners at risk of self-harm or suicide are identified and given appropriate care and support. All vulnerable adults are identified, protected from harm and neglect and receive effective care and support.

Suicide and self-harm prevention

1.37 There had been six self-inflicted deaths since the previous inspection. Managers had implemented key Prisons and Probation Ombudsman recommendations, which were kept under review under the establishment's wider action plan. The number of self-harm incidents had shown an upward trend in the previous six months. (See key concern and recommendation S48.)

1.38 The safer custody team met every month and collated a wide range of useful data that was analysed month by month. However, data were not used to identify causes of the high levels of self-harm or underpin an action

plan to reduce the number self-harm incidents. Investigations into serious acts of self-harm were not carried out promptly and lessons to be learned were not identified. All prisoners who were subject to assessment, care in custody and teamwork (ACCT) case management for prisoners at risk of suicide or self-harm had their work placements reviewed and, where appropriate, were allocated work to maximise their time out of cell, which was good.

1.39 Since February 2019, the prison had participated in a pilot programme to implement a new ACCT case management system. Forty prisoners were subject to ACCT case management during the inspection and, although prisoners told us they felt staff cared for them well, we found that the standard of documents was not good enough. Case managers were not consistent and reviews were not always meaningful. There were deficiencies in care planning, and triggers (events that might cause a prisoner to self-harm) were not understood. The conversations recorded remained mostly cursory. Quality assurance processes had been implemented but had not yet addressed these issues.

1.40 Prisoners with complex issues were discussed in the weekly SIM (see paragraph 1.13) and decisions to hold prisoners at risk in the segregation unit were now justified.

1.41 There were not enough Listeners in the main prison – there were none on the first night wing (see paragraph 1.4) and only one in the LDU. In our survey, only 30% of prisoners said it was easy to speak to a Listener compared with 45% at other similar prisons. Samaritans phones were available, but were not always working. The safer custody department carried out weekly checks on the phones, and replacements were obtained where necessary. (See key concern and recommendation S48.)

Extracts from Section 2: Health, well-being and social care

Expected outcomes: Patients are cared for by services that assess and meet their health, social care and substance use needs and promote continuity of care on release. The standard of provision is similar to that which patients could expect to receive elsewhere in the community.

2.42 The inspection of health services was jointly undertaken by the Care Quality Commission (CQC)14 and HM Inspectorate of Prisons under a memorandum of understanding agreement between the agencies. The Care Quality Commission issued ‘requirement to improve’ notices following the inspection (see Appendix III).

Strategy, clinical governance and partnerships

2.43 A new health contract had commenced in April 2019 and several health providers had been commissioned. Regular partnership board meetings and individual contract review meetings monitored services. A joint operational governance meeting had started to take place, but further work was needed to promote a more cohesive service. Overall, we found many aspects of health care reasonable, however we had some concerns about gaps in the GP provision and dental services.

2.44 A health and social care needs assessment completed in March 2019 was being used to develop the service. Clinical incidents were investigated thoroughly and there was effective oversight. Good progress was being made on implementing health-related Prisons and Probation Ombudsman recommendations.

2.45 Service provision had been affected by staff shortages, although recruitment was improving in most services and regular locum staff were covering some shifts. We observed conscientious, skilled and caring staff, but they were stretched across all services.

2.46 Mandatory training was well managed and professional development opportunities were available. Managerial and clinical supervision systems were in place, but some sessions had not taken place regularly owing to pressure on the service and staff sickness. However, this had started to improve.

2.47 Health services were split across the prison site. There were reasonable wing-based treatment rooms and a modern primary care centre on the main site, although waiting rooms were stark and needed attention. Managers regularly carried out infection prevention and control (IPC) audits, including of handwashing and the management of clinical waste. Maintenance work was required in some of the treatment rooms, which the prison was due to carry out. An inpatient unit, a social and palliative care unit and other clinical space were available in the LDU. They were generally clean.

2.48 Clinical audits included monthly sampling of clinical records. All services apart from Phoenix Futures (the psychosocial substance use support provider) used one electronic clinical information system SystmOne, but this was due to be resolved. There was an extensive range of policy and procedural guidance for staff to follow.

2.49 Prisoners could use a confidential complaints system to make a complaint. Sampled responses were timely, polite and addressed the issues raised. Compliments were also recorded. Prisoners could meet with the health care manager to discuss concerns and until very recently the Patient Advice and Liaison Service officer routinely visited wings and held clinics to resolve complaints. The prison was recruiting to fill this post. All services sought

patient feedback through surveys, but there were no regular patient forums to inform service provision.

2.50 Health care staff had received life support training and responded to medical emergencies throughout the 24-hour period. Emergency equipment was strategically placed across the prison in offices so that officers could also access the automated external defibrillators. The equipment was checked regularly, but we came across a few items that needed to be replaced, which demonstrated that checking needed to be more thorough. We also found too many oxygen cylinders stored inappropriately in a wing office on the floor next to heating pipes and in reception near a radiator, which was potentially hazardous. This was rectified as soon as we highlighted it.

2.51 Approximately 29% of prison staff were trained in emergency responses. Not all prison staff understood the coding system for calling for assistance in medical emergencies and, in some cases, staff did not call an emergency ambulance until the health team had arrived and verified one was required, which posed a significant risk and needed to be addressed.

Promoting health and well-being

2.54 Health promotion did not have a particularly high profile in the establishment. There was no calendar of events or prisoner fair, but posters were displayed in some areas, and prisoners' in-cell TV was used to inform them about health services and initiatives. Health promotion leaflets were available and could be translated. Telephone interpreting had been used for some health consultations, but staff said other prisoners had occasionally been used as interpreters, which was inappropriate.

2.55 An older patient lead staff member, based in the LDU, undertook promotional work across the prison, including coordinating bowel cancer and abdominal aortic aneurysm screening. Smoking cessation support was available, but take-up was low as most prisoners preferred vaping. Prisoners could access specialist internal and external sexual health services and barrier protection was available during their sentence and on release.

2.56 Uptake of NHS health checks, immunisations and vaccinations was low and some clinics had been cancelled because of staff shortages. However, clinics were now being held more regularly. There were no health trainers or peer workers.

Primary care and inpatient services

2.58 A registered nurse carried out a comprehensive health screening for all new arrivals, and also had to respond to emergencies. This meant that

screenings were occasionally disrupted leading to delays in completing the process, which was inappropriate and needed to be reviewed.

2.59 Most secondary health screenings occurred within seven days of their first screening as outlined in established guidance and staff followed up on the reasons for non-attendance outside this timeframe and rebooked appointments.

2.60 There was a suitable range of primary health care services, including optician and podiatrist provision, with mostly reasonable waiting times. Work was in progress to reduce the high rate of non-attendance at some clinics, which extended waiting times and wasted valuable clinical time. It was decreasing, but it was still too high in some areas, including for the dentist and nurse-led clinics.

2.61 There had been gaps in GP cover for routine appointments and evening reception sessions, which had meant a few clinics were cancelled and a small number of prisoners did not receive the necessary opiate detoxification medication on their first night, which was potentially dangerous. (See key concern and recommendation S45 and paragraphs 1.5 and 2.85.) A nurse saw prisoners in the segregation unit every day and a GP saw them three times a week.

2.62 There was a range of nurse-led clinics and patients with long-term conditions received regular reviews. Although spirometry testing was unavailable, staff training to carrying out the test had been booked. Health staff liaised with the GP and external specialists to ensure a coordinated approach. Care was evidence-based and patient-centred.

2.63 There was an effective process for monitoring external hospital referrals. The reasons for any appointment rescheduling was recorded and there was clinical oversight, but too many appointments were cancelled for a variety of reasons, including a lack of officer escorts.

2.64 The inpatient unit did not have clear admissions or discharge criteria. Out of the 23 beds available only 10 were allocated to the health department and while the care they received was generally good, the mix of prisoners in the unit (for example, including those from the segregation unit or vulnerable prisoners) did not promote a therapeutic environment and the overall function of the unit needed to be reviewed.

2.65 On release, patients received a GP discharge letter, detailing the care they received and any ongoing medications if required. They received information on how to access health services in the community if they were not registered with a GP.

Mental health care

2.72 Mental health services were reasonably good and offered a stepped care approach (mental health services that address low level anxiety and depression through to severe and enduring needs) to patients needing primary and secondary care, ranging from self-help through to complex case management. They were available seven days a week.

2.73 Urgent referrals were seen promptly, but the team did not always meet its target of seeing routine referrals within seven days. This was mainly because it was responding to the large number of assessment, care in custody and teamwork (ACCT) case management reviews for prisoners at risk of suicide or self-harm. Members of the team attended ACCT reviews for patients on their caseload as well as first reviews – sometimes two mental health nurses were undertaking this work.

2.74 There was good access to a psychiatrist, who was on site for four sessions a week. Staff held regular multidisciplinary team meetings to discuss the management of caseloads and complex patients. Competent and skilled practitioners delivered a range of evidence-based interventions for patients with learning disabilities and neurological, mental and personality disorders. There had been an average of 130 referrals per month since April 2019.

2.75 There was a well-being and Improving Access to Psychological Therapies (IAPT) team, which provided a good range of interventions, such as cognitive therapies to help prisoners cope with anxiety, depression, sleep difficulties, low self-esteem and poor mental health associated with long-term conditions. However, no bereavement or counselling services were available for patients in the prison. A psychologist was being recruited.

2.76 Physical health checks, including regular blood tests and prescribing reviews, were completed for patients on mental health medication. Clinical records were of a good standard and assessments and risk assessments were completed. Care plans showed patients were involved and objectives were regularly reviewed.

2.77 Patients with severe and enduring mental illness were supported through the care programme approach (CPA) and had regular reviews. The clinical lead staff member was developing CPA programme templates to strengthen the multidisciplinary approach. Staff supported 11 patients in the previous six months under the CPA, which provided prisoners who were released with a supportive pathway.

2.78 The team developed management guidance plans for patients with complex personality disorders, which prompted a multidisciplinary approach across the prison and ensured key staff understood how to communicate consistently and support the patient.

2.79 In the previous six months, seven patients had been transferred under the Mental Health Act, only two within the 14-day guideline. This was due to external factors and a lack of available mental health beds.

Good practice

2.80 *The provision of mental health management guidance plans for prisoners with complex personality disorders promoted a consistent approach between mental health staff and prison staff, ensuring that patients received appropriate support.*

Substance use treatment

2.81 The prison was in the process of implementing a new drug and alcohol strategy, but it did not have an action plan or needs analysis to inform future service developments. The clinical and psychosocial substance use teams experienced staffing problems, which affected outcomes for prisoners.

2.82 All new arrivals were seen individually and provided with harm reduction information, and 275 prisoners (40% of the population) were involved with drug and alcohol practitioners. The team's presence in the main units enhanced accessibility, but the high 'churn' of prisoners, meant initial assessments, clinical reviews, and pre-release work were prioritised over continuing support.

2.83 Joint work between staff providing the psychosocial service and those offering the clinical service was promoted by co-location in the stabilisation unit, although practitioners did not yet have access to SystmOne patient records, and there were no formal meetings for shared care planning.

2.84 We saw evidence of good quality one-to-one work. There were brief interventions for the short-term population but insufficient programmes for the longer-term population. Self-help support was limited and only prisoners in the enhanced level unit could access Alcoholics Anonymous meetings, and peer supporters felt under-used.

2.85 The clinical management of most prisoners with drug and alcohol problems was safe, but inconsistencies created risks. We found prisoners who were not receiving first night treatment for opiate dependency and several prisoners with opiate and alcohol dependencies who were not in the stabilisation or inpatient unit, which caused inconsistencies in night time observations. (See key concern and recommendation S45 and paragraph 1.5.)

2.86 One hundred and four prisoners were prescribed opiate substitutes in the main prison and in the LDU, and 78 had completed alcohol detoxification in the previous six months. Treatment was flexible and reviewed regularly, but

reviews were often conducted on the wings where there was little privacy. Officers did not supervise controlled drug administration queues in the stabilisation unit, which could have led to the diversion of medication and a lack of safety for clinical staff. (See key concern and recommendation S46.)

2.87 Joint working with the mental health service was ad hoc, and a dual diagnosis pathway for patients with mental health and substance-related problems had not been developed.

2.88 Prisoners were consistently provided with harm reduction information pre-release, and given naloxone training and supplies to treat an opiate overdose in the community. Release plans were detailed, and there were good internal and external links to ensure treatment continuation on release. 15 In the previous report substance use treatment was included within safety, while reintegration planning for drugs and alcohol came under rehabilitation and release planning (previously resettlement).

Medicines optimisation and pharmacy services

2.91 Medicines were dispensed from the in-house dispensary and were individually labelled for patients. Stock check arrangements were appropriately recorded and medicines were stored in the main pharmacy unit and wing treatment rooms. The pharmacy service operated on weekdays only and emergency stock was available in cupboards in the reception and on the wings for use at the weekend or in the evenings if required. The use of the emergency stock was carefully monitored, there were regular checks and the administration rooms were appropriately maintained. Prisoners were encouraged to order their own medication where possible.

2.92 Medicines were administered by trained pharmacy technicians and nurses every day, but officers were not routinely present during administration and the risk of bullying and diversion remained. (See key concern and recommendation S46.) Each wing had a slightly different administration regimen – two wings provided medication four times a day, others administered medicines twice a day and one issued all medicines in possession. The inpossession policy took account of the patient and the medication. Information was recorded on SystmOne and a prisoner's in-possession status was visible when prescribing took place and was reviewed when necessary.

2.93 Patients could receive paracetamol or ibuprofen, along with several other over-the-counter medicines from health care staff and there was a policy to cover it. There were patient group directions (which authorise appropriate health care professionals to supply and administer prescription-only medicine) to assist in the administration of vaccines.

2.94 The pharmacy provided a good service and improvements had been made since the previous inspection. Three of the pharmacists were prescribers and had undertaken additional training. They provided a pharmacy clinic on two days a week. The pharmacist proactively reviewed prescribing information every month to identify any trends and monitor the use of higher risk medicines. They generated a monthly report to ensure that those receiving these medicines were identified and that the appropriate bloods tests were carried out to ensure that the medicines were used safely. The pharmacy team identified medicines that might have been overused or abused. There were programmes in place to reduce the prescribing of abusable medication and the pharmacy had started a campaign to raise awareness of the issues associated with pregabalin (an anti-convulsant). There was a prescribing formulary (a list of medications used to inform prescribing) and any decision to prescribe medication outside its parameters required robust justification.

Dental services and oral health

2.95 A full range of NHS dental treatments was available, including dental therapy to promote oral health. One treatment clinic a week was provided, alternating between the main site and the LDU. This meant that any urgent referrals were not seen for over two weeks and there was a nine-week waiting time for a routine appointment, which did not meet the demands of the population. The primary health care team offered triage and pain relief as required. There was still a large non-attendance rate, which managers were trying to reduce.

2.96 There was a dental suite on each site and both were well equipped. However, managers did not have a copy of some equipment service logs and could not demonstrate that the equipment was safe to use. IPC audits were conducted, but there was some dust in the clinic rooms.

2.97 Some governance arrangements had not been implemented in full and assurance systems were poor. Some assurance tests, needed to check if the decontamination process was effective, were not carried out and decontamination audits had not been completed, along with other necessary audits. This meant that decontamination processes were compromised. (See key concern and recommendation S51.)

Extracts from Section 5: Summary of Recommendations and Good Practice
And
Corresponding extracts from the action plan submitted to HM Inspectorate of Prisons in May 2020

Key concerns and recommendations

HMP/YOI Norwich
From HM Inspectorate of Prisons report

S48 **Key concern**: There had been six self-inflicted deaths at Norwich since the previous inspection and self-harm incidents were on an upward trend. ACCT documents were weak and there were too few Listeners. There was no strategic approach to reducing levels of self-harm.

Recommendation: Effective, well-coordinated action should be taken and sustained in order to reduce levels of self-harm.

Action:

Effective action will be taken to reduce levels of Self-Harm by;

- Appointing a senior manager, solely dedicated to the reduction of suicide and self-harm.
- Introducing a new local suicide and self-harm reduction policy, which will be underpinned by actions to deliver reduced self-harm in the prison.
- Improving the availability of and access to Listeners within the establishment.
- The Safety Team CM will undertake robust management checks of the quality of interactions between Residential Prison Officers and prisoners, as documented in the observation section of the ACCT form.

Action by: Governor;
Target date: September 2020

The above actions and reviews of previous incidents will be monitored and coordinated through the monthly Safety Meeting, to ensure that improvements are sustained.
Action by: Governor;
Target date October 2020:

S51 **Key concern:** Prisoners waited too long for urgent and routine dental appointments. Clinical governance and assurance procedures were poor. Some equipment service logs were unavailable, which meant staff were unable to demonstrate that equipment was safe to use. Some essential clinical audits, including those for decontamination and some testing procedures for decontamination equipment were not being undertaken, which compromised the integrity of decontamination processes.

Recommendation: Managers should ensure prisoners receive prompt, safe and effective dental care.

Action:

The Local Healthcare Commissioner reports that the waiting list has been reviewed and additional sessions have been put place to ensure prompt, safe and effective dental care.

Action by: NHS England;
Completed.

The Deputy Governor will hold monthly meetings with the dental provider to ensure waiting times remain appropriate.
Action by: Governor;
Ongoing.

All equipment has been serviced and maintenance contracts are now in place. All staff have been retrained in relation to decontamination processes and competencies will be checked annually. Clinical audits have been established and will be reported to the quarterly NHS England contract review meeting.
Action by: NHS England;
Completed and quarterly.

General recommendations

2.52 Oxygen should be stored safely and emergency resuscitation equipment should be checked more robustly.

Action:
The Health and Safety Advisor will examine current arrangements and recommend improvement action to Virgincare, supported as necessary by Government Facilities Services Limited (GFSL).
Action by: Head of Virgin Care;
Target date: September 2020.

2.53 All custody staff should understand agreed emergency codes to ensure medical emergencies receive a prompt and appropriate response.

Action:
In accordance with PSI 03/2013, understanding of agreed emergency codes will be improved by;

- Introducing a system of management checks and observations by the head of Suicide and Self Harm, including checks on comprehension of emergency codes through the Wing adoption process.
- Publication of a Governor's Order, reinforcing staff's need to understand emergency codes and advising of new checking systems.
- Every member of staff will be issued with an aide memoire to prompt their proper response.
- The Safety Team will deliver regular briefings to all groups of staff and as part of the induction of new staff.

Action by: Governor
Target date: August 2020

2.57 The NHS health check, immunisations and vaccinations should be available to those eligible in line with national programmes and implementation should be timely to promote prisoners' health.

Action:
The Healthcare provider is moving to a wing-based model of service provision and a 'one stop shop', which offers better access to screening, vaccination and immunisation programmes.
Action by: NHS England
Target date: November 2020

2.66 Prisoners should have regular access to a GP in line with the contract and receive appropriate, timely care.

Action:
Another General Practitioner (GP) provider is now in place, providing regular GP surgeries. Remote access to a GP is now also available.
Action by: NHS England
Completed

2.89 Drug and alcohol support for longer-term prisoners should be enhanced, include regular self-help support and be informed by a detailed population needs assessment.

Action:
Phoenix Futures will continue to ensure that peer support and peer mentors are in place. This work is ongoing and requires regular refreshing due to the high prisoner turnover and complex location. They will continue to work towards recruiting up to 6 individuals. This is monitored through the National Health Service England (NHSE) quarterly contract review.

Phoenix futures will roll out 'Smart recovery groups' to offer long term, peer and recovery support to prisoners across the site. This entails peer-led fellowship meetings, coordinated by Phoenix futures.

Action by: Phoenix Futures
Target date: August 2020

A Health and Social Care Needs Analysis (HSCNA) was undertaken on behalf of NHSE in early 2019 and will be kept up to date.
Action by: NHS England
Completed

2.90 A clear pathway to coordinate the care of patients with mental health and substance use problems should be developed.

HMP/YOI Norwich
From HM Inspectorate of Prisons report

Action by: NHS England
Target date: September 2020

Health related recommendations from the previous inspection that had not been implemented at the time of the 2019 inspection

Discipline officers should be available during medicines administration times to minimise potential bullying and diversion of supplies. (2.62)
Not achieved

The transfer of prisoners to hospital should occur within Department of Health transfer target timescales. (2.76)
Not achieved

2. HMP Wayland, 2017

HMP Wayland
From HM Inspectorate of Prisons report

The full report and action plan are available at HMP Wayland (justiceinspectorates.gov.uk). The following extracts relate to mental & physical health findings only and from the action plan in response to recommendations.

Extracts from Summary

Safety

S9 In the previous six months, 110 prisoners had self-harmed, which was far more than we see elsewhere. There had been five self-inflicted deaths since the previous inspection. Reasonable progress had been made to implement the Prisons and Probation Ombudsman's recommendations following deaths in custody.

S10 The suicide and self-harm policy was underpinned by a robust action plan and annual safety survey. Safer prisons and safeguarding meetings were well attended by all relevant disciplines and were productive. Assessment, care in custody and teamwork (ACCT) case management documentation for prisoners at risk of suicide or self-harm was reasonable but flaws remained: some triggers were incorrectly recorded, actions on care maps were not completed and some documents were closed too quickly. Access to trained peer supporters (Listeners) was adequate but the rooms provided for that support (Listener suites) were in very poor condition.

S19 The prison's interim drug and alcohol strategy was not informed by a detailed needs analysis. Clinical and psychosocial services collaborated well but links with primary care prescribers required improvement. The Rehabilitation of Addicted Prisoners trust (RAPt) offered a wide range of psychosocial interventions. Resources in the RAPt team were stretched, which limited opportunities for service development. Clinical management was safe and prescribing regimes flexible, with two-thirds of prisoners reducing their dosage or completing treatment.

Respect

S34 Partnership working between health services staff and the wider prison was improving but there were concerns about ineffective communication with key stakeholders. The management of long-term conditions was poor. Very few patients had current care plans and reviews were not routinely undertaken. There were no nurse-led clinics for long-term conditions as staff were not appropriately trained.

S35 A good Patient Advice and Liaison Service was provided, which promoted patient engagement and managed complaints, but was not well advertised

and was underused. Medication administration was not always confidential, and medication queues were not supervised by prison officers. Dental services had improved considerably and waiting times were acceptable.

S36 Arrangements for prisoners reporting sick were inadequate as they had to apply via their wing officer, causing delay and prejudicing confidentiality. Routine appointments were accessed via application but many prisoners told us that they missed appointments as they did not receive advance notification. Non-attendance rates were too high.

S37 Primary and secondary mental health services were provided by a well-resourced team. Patients we spoke to were very satisfied with their care. A well-being service was separately commissioned to provide care for prisoners experiencing low-level needs. There was a high level of need, and demand exceeded provision. Prisoners waited up to two months for an initial appointment.

Resettlement

S64 Health discharge planning was timely and appropriate for prisoners with either physical or mental health needs. Prisoners on medication were given a two-week supply on a risk assessed basis, and a letter for their GP. There were appropriate arrangements for prisoners requiring palliative care. For those with substance misuse issues, there was evidence of detailed release plans, relapse prevention work, the provision of harm reduction information and links with community service providers to facilitate post-release support.

Extracts from Section 1: Safety

Suicide and self-harm prevention

Expected outcomes: The prison provides a safe and secure environment which reduces the risk of self-harm and suicide. Prisoners are identified at an early stage and given the necessary support. All staff are aware of and alert to vulnerability issues, are appropriately trained and have access to proper equipment and support.

1.12 The level of self-harm was high. In the previous six months, 110 prisoners had committed a total of 216 acts of self-harm, which was far more than we see elsewhere, and than at the time of the previous inspection. In this period, the constant watch cells had been used on 11 occasions, by a total of seven prisoners.

1.13 Since the previous inspection, there had been eight deaths: five self-inflicted, two from natural causes and one of unknown cause. Reasonable progress had been made to implement the Prisons and Probation Ombudsman’s recommendations following deaths in custody. For example,

staff were aware of emergency response codes and checked prisoners' well-being when unlocking cells in the morning.

1.14 The strategic management of self-harm and suicide was good. The suicide and self-harm policy was supported by a robust action plan and annual safety survey. Monthly safer prisons and safeguarding meetings were well attended by representatives from relevant departments and were productive. We attended one such meeting where staff displayed great knowledge of, and care for, more complex prisoners. Mental health support for prisoners in crisis was particularly good.

1.15 In the previous six months, assessment, care in custody and teamwork (ACCT) case management procedures had been used on 204 occasions, far more than at the time of the previous inspection. ACCT documentation was reasonably good but some flaws remained, for example, triggers were incorrectly recorded and actions on care maps were not completed. Not all staff were up to date with ACCT training. Prisoners in crisis told us that they were being supported by staff, and the case reviews we attended were good. Access to the enthusiastic Listeners (peer supporters trained by the Samaritans) was adequate but the Listener suite was in a poor state.

Substance misuse

Expected outcomes: Prisoners with drug and/or alcohol problems are identified at reception and receive effective treatment and support throughout their stay in custody.

1.43 A sharp focus on NPS had left some gaps in the prison's interim drug and alcohol strategy, including the lack of a detailed needs analysis. The action plan was strong on supply reduction but did not include sufficient focus on reducing demand. Drug strategy meetings lacked strategic focus and were not consistently attended by representatives of relevant departments, although a new drug strategy lead had begun to address these issues (see main recommendation S70).

1.44 The clinical substance misuse service was provided by Virgin Care, and psychosocial support by the Rehabilitation of Addicted Prisoners trust (RAPt). An experienced RAPt team saw HMP Wayland new prisoners within five days of arrival but their resources were stretched. Due to the high use of NPS among the prison population (see also section on security), referrals to the service had almost doubled in the previous year and brief interventions had risen by a third. Currently, RAPt supported 220 prisoners through one-to-one work and a range of drug awareness and relapse prevention workshops. The team had not been able to develop work with families.

1.45 RAPt's abstinence-based substance misuse dependency programme, which ran on G wing, was due to be replaced by the shorter and less

intense Bridge programme. Prisoners on this unit were concerned about the lack of other drug-free wings to support their recovery following programme completion. While Alcoholics Anonymous self-help groups met weekly and could be accessed by all prisoners, regardless of location, Narcotics Anonymous meetings were restricted to G wing prisoners, and currently only one peer supporter was available for the whole prison.

1.46 Prisoners requiring opiate substitute treatment (OST) were managed safely and there was sufficient specialist prescribing input to review treatment regimes regularly. An average of 62 prisoners received methadone or buprenorphine, with two-thirds reducing their dosage or completing treatment. Reduction regimes were flexible and 13-week reviews were conducted jointly with substance misuse nurses and RAPt workers. However, there was insufficient joint working with primary care GPs to manage the prescription of pain management (see also paragraph 2.67).

1.47 OST administration took place on D wing, the drug treatment unit and the location of the substance misuse teams. Consistent officer cover ensured appropriate supervision of methadone and buprenorphine.

1.48 The clinical substance misuse service linked in well with mental health teams, to provide care for patients with drug and mental health-related problems.

Extracts from Section 2: Respect

Health services

Expected outcomes: Patients are cared for by services that assess and meet their health, social care and substance use needs and promote continuity of care on release. The standard of provision is similar to that which patients could expect to receive elsewhere in the community.

2.46 The inspection of health services was jointly undertaken by the Care Quality Commission (CQC) and HM Inspectorate of Prisons under a memorandum of understanding agreement between the agencies. Areas have been identified that require improvement with a subsequent notice issued by the CQC, which has been detailed within Appendix III of this report.

Governance arrangements

2.47 The Care Quality Commission issued ‘requirement to improve’ notices following the inspection (see Appendix III).

2.48 Health services, provided by Virgin Care and commissioned by NHS England East, did not provide a 24-hour service. A health needs assessment completed in 2016 had identified some service gaps, and some

of these remained, most notably in the area of long-term condition management (see below).

2.49 Partnership working between health services staff and the wider prison had improved, but unsatisfactory information sharing and communication between health services professionals and wider stakeholders affected the management of care. Information sharing agreements had been developed and teams were working to resolve concerns.

2.50 Governance arrangements were adequate. There were monthly contract review meetings, a quarterly partnership board, which was chaired by the commissioner, and regular quality visits. A range of policies had been published but it was not clear whether staff had read them.

2.51 A total of 31 incidents had been reported in 2017, many of which concerned the management of medication, and all of which had been dealt with appropriately.

2.52 Following the eight deaths in custody since the previous inspection (see also paragraph 1.13), a health care action plan had been put in place and the majority of recommendations had been satisfactorily implemented.

2.53 The health care leadership team had successfully reduced the use of agency staff and stabilised the service with permanent staff. The final two vacancies in the team had been filled but there were delays in obtaining security clearance for them to start work.

2.54 Staff had regular performance appraisals though not all, except for the mental health team, engaged in regular clinical supervision.

2.55 Clinical rooms met infection prevention and control standards. Waiting areas were basic, with little health promotion information available. The location of a prison officer in the health care centre was a recent initiative that had had a positive impact on the environment.

2.56 Emergency care equipment was appropriate and routinely checked. Out-of-hours emergency responses were good, and senior prison staff were adequately trained. However, the health care treatment received out of hours was not documented appropriately on SystmOne (the electronic clinical record). This meant that ongoing treatment and advice were not always up to date and seamless.

2.57 Some prisoners submitted health care complaints through the main prison complaints procedure, and some through the Virgin Care system, which was equally confidential, with timely responses. The Virgin Care process was managed by a customer experience officer, and was linked into the Patient Advice and Liaison Service (PALS); this promoted patient

engagement, and complaints were managed through a weekly complaints clinic, where issues could be resolved face to face. However, PALS was not well advertised and was underused. Complaints received through the prison system were managed by the deputy head of health care and this was not well linked into PALS. Complaints submitted, through either process, were analysed for themes and trends but not aggregated to give a reliable overview of all complaints.

2.58 There were well-attended screening and treatment clinics for blood-borne viruses and sexually transmitted infections. Smoking cessation treatment was available but access to community screening programmes, such as for bowel cancer, was limited. Condoms were available but not well advertised.

2.59 There was no overall strategic health promotion plan but the PALS officer had linked with Wayout TV (see paragraph 2.5) to create promotional videos. Prisoner health care representatives promoted attendance at monthly forums. A patient forum for prisoners with disabilities had also recently held its first meeting, which was a promising initiative.

Delivery of care (physical health)

2.64 New arrivals had an initial health care assessment which identified immediate issues, and appropriate referrals were made. A secondary, more in-depth health screen was undertaken the following day. A health care leaflet was issued to prisoners in reception but it was out of date and contained incorrect information. We were assured that a new one had been developed but was not yet available to prisoners.

2.65 Waiting times for primary care clinics were comparable with those in the community. However, in our survey, only 42% of prisoners said that it was easy to see a nurse, which was worse than at similar prisons (49%).

2.66 Arrangements for prisoners reporting sick were inadequate as they had to apply via their wing officer and told us that they felt uncomfortable involving non-clinical staff. Officers made appointments for prisoners at the triage clinic, to be seen on the same day. Routine appointments were accessed via application but many prisoners told us that they missed appointments as they did not receive advance notification. There was a 15% non-attendance rate across health care, which was too high.

2.67 A fortnightly GP-led analgesia review clinic was held, with the aim of reducing the number of prisoners reliant on opiate-based pain medication. While this was a good initiative, there was insufficient communication between the GP and the clinical substance misuse team when reviewing medication for their patients.

2.68 Patients with lifelong conditions were poorly managed. There were no nurse-led clinics for them as staff were not appropriately trained, and the GP service was not resourced to provide effective monitoring or oversight. While prisoners with diabetes received regular podiatry and retinal screening reviews, we noted a patient who had arrived at the prison with a pre-existing long-term condition and had not been seen by health services staff for five months. The electronic clinical records we reviewed were appropriate but too many patients with lifelong conditions did not have care plans, and reviews were not undertaken routinely.

2.69 Outside hospital referrals were generally well managed and the four daily external escorts provided by the prison usually met demand. Since January 2017, only 6% of appointments had been cancelled owing to a lack of escorting staff.

Pharmacy

2.72 Individually labelled medicines were dispensed by Virgin Care from HMP Norwich. Deliveries were received every day, although it could take up to three days to receive newly prescribed medicines. The pharmacy required one week to process repeat in-possession requests but there was no access to FP10 prescriptions, to get medicines from a local chemist if needed more quickly. The pharmacy team recognised the delays in obtaining medicines and had set up patient packs for commonly required items so that the health services staff could access them quickly.

2.73 Medicines were stored safely and securely, and administered from six locations across the prison, but only three locations had the facilities to administer controlled drugs. Medicines were administered twice a day, at 8am and 4pm, but an extra dose could be administered at noon if deemed clinically necessary. Night treatments were given in-possession at 4pm.

2.74 Some medication queues we observed were disorderly and unsupervised. While interactions with patients were professional, they were not always confidential. Eighty-one per cent of medication was supplied in-possession but not all patients had lockable storage. Risk assessments were in place for many prisoners but reviews were not always timely. The inpossession policy was nine months out of date but we were told that the service was waiting for the publication of national guidance which would inform the review. Prisoners could receive treatment for minor ailments through the use of general sale list medicines.

2.75 Prescriptions, administrations and the issuing of in-possession medications were recorded electronically in four of the six locations from which drugs were administered but the other two locations used paper records. Contingency arrangements had been established in the event of a system

failure. Medicines administered as patches were not recorded appropriately but this had been identified and a recording template was being developed.

2.76 Medicines were appropriately continued when prisoners arrived from other prisons. Patients were referred to the health care department after three days of refused medication; a list of critical medicines requiring more urgent attention was in development. Emergency medicines were readily available and checked regularly.

2.77 Prisoners could request a consultation with a member of the pharmacy team at a weekly clinic, where issues with medications could be resolved. Medicine errors were reported and reviewed at the quarterly medicines management group meeting and we saw some appropriate learning and actions being put into place following incidents.

Dentistry

2.82 The dental service was subcontracted by Virgin Care to John G. Plummer & Associates and had improved considerably since the previous inspection. Patients had timely access to the service, and treatments were undertaken efficiently, with oral health advice given to those seen by the dentist. Dental emergencies were managed appropriately and the dental service manager operated the waiting list effectively. Governance and maintenance records were all managed appropriately. Patients were seen within one week for an initial routine review before being booked for treatment, for which there was a current waiting time of six weeks.

Delivery of care (mental health)

2.83 In our survey, 38% of prisoners said that they had an emotional well-being or mental health problem, which was in line with the percentage at similar prisons but more than at the time of the previous inspection (25%).

2.84 Services were provided by a fully integrated mental health team, who worked with a stepped care model. The team comprised a psychiatrist (who visited one day a week), four mental health nurses, two social workers and two support workers.

2.85 Counselling services were provided by the chaplaincy. Improving access to psychological therapies (IAPT) services were provided by a separately commissioned well-being service to provide care for prisoners experiencing low-level needs, delivered by Norfolk and Suffolk NHS Foundation Trust. The service provided a psychological well-being practitioner and cognitive behavioural therapist for two days a week, which was not sufficient to meet demand. At the time of the inspection, there was a two-month wait for an initial assessment but there were plans to increase provision in the coming months.

2.86 At the time of the inspection, the mental health team had a caseload of 129, with all members caring for patients with complex primary and secondary care needs. There were 16 patients under the care programme approach and 29 with secondary care needs. There were good links with the GP service, which provided support for patients with more complex primary mental health needs.

2.87 Referrals were made via the reception assessment, wing staff and GPs. Patients were seen within two working days, and urgent referrals were seen on the same day by the duty mental health nurse. The team did not attend all ACCT reviews but were present at those for patients with mental health issues.

2.88 Mental health services were well regarded across the prison, and some of the patients we spoke to were very satisfied with their care. The team worked effectively with segregation unit staff.

2.89 The team met weekly to discuss new referrals and patients of concern. They also contributed to other health care and prison-wide meetings where complex cases and potentially vulnerable prisoners were discussed. Links had recently been established between the mental health team and the psychologically informed planned environment (PIPE) and personality disorder (PDU) units on Wensum unit (see also paragraph 4.48), in order to support patients with any emerging mental health issues.

2.90 The team provided mental health awareness training to prison staff, three times a year. In the last three years, 94 people had been trained.

2.91 Three prisoners had been transferred to hospital under the Mental Health Act in the previous six months, all of whom had waited longer than two weeks.

Extracts from Section 4: Resettlement

Healthcare

4.34 Health discharge planning was timely and appropriate for prisoners with either physical or mental health needs. Prisoners on medication were given a two-week supply on a risk assessed basis, and a letter for their GP. If needed, they were also given information on registering with a dentist. Those with complex mental health needs were well managed on discharge. Good links were made with community services, even when patients were discharged outside the local area. There were appropriate arrangements for prisoners requiring palliative care.

Drugs and alcohol

4.35 Clinical and psychosocial substance misuse teams worked jointly to facilitate treatment continuation on release, although many prisoners were transferred to resettlement prisons for local release. Prisoners were given harm reduction and overdose prevention information but naloxone training to treat opiate overdose in the community was not yet available.

4.36 The Rehabilitation of Addicted Prisoners trust (RAPt) team had established appropriate links with community drug and alcohol services; release plans were of good quality and prisoners could attend relapse prevention workshops. Recovery workers had managed to arrange several residential rehabilitation placements for prisoners following release.

Good practice

4.49 *The personality disorder (PDU) and psychologically informed planned environment (PIPE) units, both located on Wensum unit, were excellent initiatives. In particular, they gave training and support to uniformed staff who were fully engaged in the therapeutic process, and had a positive impact within the prison as a whole.*

Extracts from Section 5: Summary of Recommendations and Good Practice
And from the action plan in response to recommendations

Recommendations to the Governor

Self harm and suicide

5.8 Assessment, care in custody and teamwork (ACCT) documentation should be completed properly. Triggers should record possible future events that might cause self-harm, while actions in care plans should be relevant and signed off when completed. (1.16)

Action:
Guidance will be issued to all case managers in relation to Care Plans and potential triggers for those at risk of self-harm. A new Quality Assurance process will be adopted, led by the Violence Reduction team, which will address areas of noncompliance and report back on the quality of ACCT documentation to the Senior Management Team (SMT).

Action by:
Head of Safer Prisons and Equality

Target date:
January 2018

5.9 All staff should have up-to-date training on safer custody and ACCT procedures. (1.17, repeated recommendation, 1.30)

Action:
All staff working with offenders will receive Suicide and Selfharm (SASH) training. This will not be fully agreed due to the training not being required for staff who do not work with offenders.

Action by:
Head of Safer Prisons and Equality

Target date:
June 2018

Substance misuse

5.15 The Rehabilitation of Addicted Prisoners trust (RAPt) service should be sufficiently resourced to develop initiatives such as peer support and work with families, and postprogramme support for prisoners in recovery should be increased, in partnership with the prison. (1.49)

Action:
A review of existing resources and work commitments within the Drug Rehabilitation Unit and psychosocial services provision will take place, examining both prison staffing and that of the organisation selected following the current NHS tender for providing psychosocial services. The potential to fund peer support, work with families and post-programme support and provide training on overdose management (including naloxone) will be explored. This recommendation cannot be fully agreed as this work may not be able to be delivered without additional resources. Designated accommodation will be found within HMP Wayland to establish a community for programme graduates and act as a throughcare unit where the review establishes the need for this Psychosocial support.

Action by:
Head of Reducing Reoffending

Target date:
June 2018

Health services

5.28 All clinical staff should be in date with basic life support training. (2.60)

Action:
All clinical staff are currently in date for Basic Life Support (BLS) and Advance Life Support training. A training programme is planned in 2018 to ensure all clinical staff are up to date and compliant with basic life support training.

Action by:
Head of Healthcare

Target date:
June 2018

5.29 When prisoners receive out-of-hours care, their medical record should be updated immediately, to ensure that ongoing treatment and advice are acted on. (2.61)

Action:
The system for documenting out of hours emergency care on SystmOne will be reviewed to ensure treatment and advice are updated as soon as is practicably possible following attendance. However, the Health Care provider has not been commissioned by NHS England to provide out of hours cover.

Out of Hours care cover duties are assumed by the East England Ambulance Trust and local hospitals. The timing and method of recording treatment is beyond the control of the prison when it is provided by these external stakeholders, so this recommendation can only be partly agreed on this basis.

Action by:
Head of Healthcare

Target date:
March 2018

5.30 A single health care complaints system should be in operation, and it should be well advertised. (2.62)

Action:
A single system of raising healthcare complaints and the appeals process will be introduced across all Norfolk prisons Linked to PALS. This system will be actively promoted and advertised.

Action by:
Health Care Manager

Target date:
April 2018

5.31 There should be regular systematic health promotion campaigns. (2.63)

Action:

A calendar of planned health promotion campaigns will be published and delivered, information leaflets will be regularly restocked and updated.

Action by:
Health Care Manager

Target date:
April 2018

5.32 Prisoners should not have to rely on prison officers in order to access health care triage services (2.70).

Action:
Arrangements for prisoners to report sick and access Triage services will be reviewed. Non-clinical staff will be removed from the process. The Triage Protocol has been amended to include that all patients requesting to see Healthcare must be seen in a timely way without the need to disclose any medical in confidence information to non-clinical staff. An audit will be run for further assurance that patients are able to access triage in context of those that report sick during the day (after triage).

Action by:
Health Care Manager

Target date:
January 2018

5.33 Prisoners with long-term conditions should receive regular reviews and have evidence-based care plans developed and delivered by competent health professionals (2.71).

Action:
A separate Action Plan to address these particular concerns will be produced for the Care Quality Commission. Management attention will be given to fulfilling the resultant action plan commitments which will have CQC oversight. Nurse led Long Term Conditions (LTC) clinics have started since the Inspection. LTC pathways following National Institute Care Excellence (NICE) Guidelines have been embedded in practice. There is an escalation process to Nurse Practitioner and GP when required. Additional training is being organised to up skill nurses in management of Long Term Conditions.

Action by:
Health Care Manager

Target date:
January 2018

5.34 Medication administration should be fully supervised by prison staff, to ensure confidentiality and prevent diversion. (2.78)

Action:
Prison Officer staffing levels will be increased across Residential Units at key times of the day when additional supervision is deemed most necessary, particularly when medication is being dispensed. New Work Profiles will be introduced to properly resource the need for an Officer to be present within the Health Care Centre whenever clinics are being run.

Action by:
Deputy Governor

Target date:
March 2018

5.35 All prisoners should have the facility to lock away in-possession medication. (2.79)

Action:
A business case for the procurement and installation of digital safes in all cells will be produced. **This recommendation cannot be agreed** as it will not be possible to provide safes for all cells without additional funding.

Action by:
Estates Service Delivery Manager

5.36 In-possession reviews should be completed in line with a policy that is up to date. (2.80)

Action:
The In possession policy will be reviewed in conjunction with the new National In-Possession Template and strategic plan for implementation will be written. New templates went live on 20 December 2017.

Action by:
Pharmacy Manager / Head of Healthcare

Target date:
January 2018

5.37 For medicines that are deemed critical, follow-up should take place for missed or refused doses sooner than 72 hours. (2.81) 5.38 The transfer of patients to hospital under the Mental Health Act should occur within agreed Department of Health timescales. (2.92)

Action:

The arrangements for following up on missed or refused doses of high risk medicines will be reviewed and revised arrangements shared with dispensing staff. A list of critical medication will be agreed and monitored through pharmacy technicians to ensure a same day or next day review of those patients.

Action by:
Head of Healthcare / Pharmacy Manager

Target date:
February 2018

Reintegration planning

5.66 Prisoners with substance misuse needs should be able to have training on overdose management, including the use of naloxone, before their release. (4.37)

Action:
A review of existing resources and work commitments within the Drug Rehabilitation Unit and psychosocial services provision will take place, examining both Prison staffing and that of the organisation selected following the current NHS tender for providing psychosocial services. The potential to fund peer support, work with families and post-programme support and provide training on overdose management (including naloxone) will be explored. Designated accommodation will be found within HMP Wayland to establish a community for programme graduates.

Action by:
Head of Reducing Offending

Target date:
June 2018

Health related recommendations from the previous inspection that had not been implemented at the time of the 2017 inspection

All staff should have up-to-date training on safer custody and ACCT procedures. (1.30)
Not achieved (recommendation repeated, 1.17)

The medicines and therapeutics committee should ensure that all medication policies and procedures, including the in-possession policy, are reviewed and followed. (2.81)
Not achieved

3. HMP Bure, 2017

The full report is available at HMP Bure (justiceinspectorates.gov.uk). The following extracts relate to mental and physical health findings only.

HMP Bure
From HM Inspectorate of Prisons report

Extracts from Summary

Safety

S6 There had been no self-inflicted deaths at the prison since its opening in 2009. The number of self-harm incidents was low, had decreased since the previous inspection and was much lower than we see at prisons with the same function. However, the management of the small number of prisoners with complex needs who required significant ongoing support was not sufficiently well developed or innovative. Assessment, care in custody and teamwork (ACCT) case management for prisoners at risk of suicide or self-harm was poor for this group. Some risk assessments were flawed; care maps did not identify clear goals to address the issues; and support for some ended too soon.

S15 There was a clear drug strategy, and Rehabilitation of Addicted Prisoners trust (RAPt) worked well in partnership with other stakeholders to deliver a number of priorities. A wide range of psychosocial interventions was delivered, including individual and group-based sessions. Peer support was utilised effectively in a number of recovery-focused activities. There was little demand for clinical management of substance misuse and the arrangements in place were sound.

Respect

S24 Since the previous inspection, residential unit 7 had been added. This accommodated some prisoners with disabilities or mobility issues, and provided additional support, such as in-cell showers and two adapted cells. Older prisoners and those with disabilities could access a well-developed programme of recreational activities, including a creative range of sessions in the gym. Care and support for transgender prisoners was good.

S28 Competent health care practitioners delivered effective clinical care. Prisoners spoke positively about the support they received, and rated all aspects of health services provision in our survey more positively than those at other category C prisons. Clinical governance arrangements were effective and there were good relationships across the prison. A range of appropriate primary care services were provided and waiting lists for clinics were short. Overall, the management of medicines was adequate and appropriate use was made of inpossession arrangements, but supervision of administration by officers on residential unit 7 was inadequate. Dentistry

services were very good, with short waiting times. Mental health services were reasonably good, with an appropriate range of interventions provided. Social care provision was appropriate to meet needs.

Resettlement

S49 Prisoners' health needs were checked before discharge and they were offered appropriate support. For those with complex care needs, there was good joint working between the health care worker and the offender management unit, to ensure appropriate onward care and support. The mental health team linked with local community teams to support discharge planning, including for those prisoners with severe and enduring mental health needs. A 'through-the-gate' support service was available from the Rehabilitation of Addicted Prisoners trust (RAPt) team and good substance misuse aftercare arrangements were available following release.

Extracts from Section 1: Safety

Suicide and self-harm prevention

Expected outcomes: The prison provides a safe and secure environment which reduces the risk of self-harm and suicide. Prisoners are identified at an early stage and given the necessary support. All staff are aware of and alert to vulnerability issues, are appropriately trained and have access to proper equipment and support.

1.19 There had been no self-inflicted deaths at the prison since its opening in 2009. There had been 42 self-harm incidents in the previous six months, which was far lower than we see at prisons with the same function and than at the time of the previous inspection.

1.20 Assessment, care in custody and teamwork (ACCT) case management was reasonable for most prisoners. However, for a small number of prisoners with complex needs and requiring significant ongoing support, it was poor. These prisoners were subject to repeated periods of ACCT monitoring, and one had made a serious attempt to take his own life two weeks before the inspection. The management of these prisoners was not sufficiently well developed or innovative. Although there was some monthly data analysis, the safer custody team had not identified the particular difficulties faced by the local population and did not have their own action plan to improve outcomes for this small but troubled group of prisoners (see main recommendation S52).

1.21 Although ACCT case reviews were usually multidisciplinary and there was good attendance by mental health staff, some risk assessments were flawed, even after prisoners gave clear signs of imminent risk, such as

making ligatures. Care maps did not address all of the prisoner's issues, and in some cases were left blank if the prisoner refused to engage. Support for some individuals was ended too soon, only for the ACCT document to be quickly reopened (see main recommendation S52).

1.22 The only constant supervision cell available was located on the segregation unit. Although the unit was quiet during the inspection, it was sometimes used to segregate prisoners from nearby HMP Norwich. We were not confident that removing a man from the mainstream residential units and placing him on a segregation unit was the best way of supporting him during periods of personal crisis.

1.23 There was a large group of enthusiastic and well-supported Listeners, who provided an impressive service. However, there were no dedicated Listeners suites, so callouts had to take place in cells. The prison had two 'time out' rooms but they were not used for this purpose.

Substance misuse

Expected outcomes: Prisoners with drug and/or alcohol problems are identified at reception and receive effective treatment and support throughout their stay in custody.

1.52 A clear whole-prison drug strategy had been established which informed practice and facilitated effective partnership working. An action plan to deliver the goals of the strategy was being implemented and was subject to routine monitoring.

1.53 The needs of prisoners were assessed on arrival at the establishment, and individuals with substance misuse problems were referred to the Rehabilitation of Addicted Prisoners trust (RAPt) for a detailed assessment and, where appropriate, ongoing support from a small team of experienced and skilled practitioners.

1.54 An appropriate range of psychosocial interventions was provided through individual and group-based sessions. The service was well promoted and information about the available support and harm reduction practices was clear. Prisoners could self-refer or be referred from a range of other areas, including following an adjudication or positive MDT result. They were assessed promptly and could access evidence-based programmes dealing with the misuse of alcohol and other substances. Peer workers were utilised effectively in a number of recovery-focused activities. However, this group was small and they were unable to access all residential areas, although there were plans to increase capacity.

1.55 The main focus of the support available was on alcohol use linked to offending behaviour, and there were additional group sessions facilitated by Alcoholics Anonymous. Care plans were of high quality and we found evidence of detailed one-toone work, voluntary testing compacts,

appropriate coordination of care and effective information sharing with other stakeholders.

1.56 Clinical substance misuse services were provided by Virgin Care Services Limited ('Virgin Care'), with access to a specialist GP when required. The arrangements in place were sound but demand was extremely low, with only one prisoner requiring opiate substitute treatment during the inspection.

1.57 There was good joint working with the 'well-being service' (see paragraph 2.70), but collaboration with Virgin Care for those with more complex mental health needs was underdeveloped.

Extracts from Section 2: Health services

Expected outcomes: Patients are cared for by services that assess and meet their health, social care and substance use needs and promote continuity of care on release. The standard of provision is similar to that which patients could expect to receive elsewhere in the community.

2.39 The inspection of health services was jointly undertaken by the Care Quality Commission (CQC) and HM Inspectorate of Prisons under a memorandum of understanding agreement between the agencies. The Care Quality Commission found no breaches or concerns about regulations during the inspection.

Governance arrangements

2.40 Health services were provided by Virgin Care Services Limited ('Virgin Care'), with some specialist sub-contracted input established for GP, dentistry and mental health well-being support. Governance arrangements were sound and relationships between stakeholders effective. A partnership board had been established and health services staff contributed appropriately to several important prison processes. A health needs assessment had been undertaken and this had helped to shape service delivery.

2.41 Clinical governance arrangements were impressive. Quality assurance and audit systems were robust, with thorough reporting systems and effective learning demonstrated from serious untoward incidents. Patient representatives contributed to improving services, with additional feedback received via patient questionnaires.

2.42 A health care manager had only recently taken up post, but continuity and accountability arrangements were well established. At the time of the inspection, there were a few staff vacancies but workforce plans were clear and enabled the appropriate delivery of care. Essential training, supervision

and access to service-led professional development ensured a balanced skills mix within the workforce and appropriate access to specialist skills.

2.43 There were systems to prevent communicable disease and deal with outbreaks. Information governance arrangements, including training for staff, were appropriate.

2.44 The health centre was clean and clinical rooms were fit for purpose and complied with infection prevention standards. Access to the health centre was facilitated by free-flow movements, and a lift enabled ready access to all facilities.

2.45 The arrangements to respond to medical crises were good. The emergency services sometimes took a while to arrive on site if called, but this was commensurate with local demographics and no concerns had been reported. Equipment, including resuscitation kits, was checked and maintained regularly, and health services staff received intermediate-level resuscitation training. Automated external defibrillators were in place on all residential units, and rotas were arranged to ensure that first-aid-trained prison staff were consistently on duty.

2.46 Information provided for prisoners about health care was adequate but out of date. Complaints about health care were managed well; investigations were thorough, and patients were often seen face to face to discuss the response and ensure that the outcome had been clearly understood and accepted. Responses were timely, dealt directly with the concern and were respectful in tone. Complaints were analysed and trends were identified to improve the service and help to raise standards of care.

2.47 There was a systematic approach to disease prevention, with prisoners' needs addressed individually through a number of clinics established to facilitate vaccination programmes and age-appropriate screening. Support for the prison smoke-free initiative had triggered a comprehensive approach to smoking cessation support. Barrier protection was available on request but this was not well advertised. We saw evidence of a developing approach to health promotion, including the use of technology, through a dedicated television channel but the delivery plan was not sufficiently strategic to ensure a more coherent population-based approach.

Delivery of care (physical health)

2.48 Health screening on reception was well managed, with risk identified early, ensuring prompt access to specialist follow-up if required and appropriate arrangements to access professional telephone interpreting services when needed. Health care practitioners, including the GP, had appropriate contact with all prisoners on the segregation unit.

2.49 Prisoners we spoke to were very positive about the quality of the health services provided, and this was reflected in our survey, with 61% of respondents rating the overall quality of services as good or very good, against the 42% comparator.

2.50 An appropriate range of primary care services, including physiotherapy, was provided and waiting times were short. Routine GP appointments were available within two days, and 'on the day' urgent appointments were facilitated based on clinical need. Out-of-hours GP cover was provided to the same level as in the community.

2.51 The non-attendance rate for most clinics was low, and information on those who did not attend was obtained and analysed, with action taken to decrease this rate even further.

2.52 Long-term conditions and complex health needs were overseen by the GP, who liaised with health services staff to ensure a coordinated approach. There were plans for this to be changed to nurse-led long-term condition clinics, to provide a more systematic approach.

2.53 Clinical records were held on SystmOne (the electronic clinical record) and those we sampled were good, with appropriate use of care plans and templates based on national clinical guidance.

2.54 Patients had good access to secondary care services. External hospital appointments were well managed, with good support from the prison, which ensured that security measures on escorts were proportionate and based on individual risk.

Pharmacy

2.55 Individually labelled medicines were dispensed by Virgin Care from HMP Norwich. Deliveries were received every day but we were told that it could take three days to receive routine medicines, and one prisoner we observed waited five days for newly prescribed analgesia, even though there was a system for obtaining urgent medicines from a local pharmacy.

2.56 Prisoners could receive treatment for minor ailments through the use of general sale list medicines, when endorsed by nursing staff, although there was no provision for some minor conditions such as coughs or sore throats.

2.57 Medicines were stored and administered in two locations, the pharmacy and residential unit 7. We observed medicines, including controlled drugs, being transported during prisoner movement, which was unacceptable, but this was immediately stopped when we brought this to the attention of the new head of health care. The refrigerator in the main pharmacy had often exceeded the maximum recommended temperature, with no evidence of

action being taken, although the refrigerator was replaced immediately when we highlighted this issue.

2.58 Eighty-seven per cent of medications were supplied as in-possession, and we observed appropriate risk assessments. Medicines were reconciled appropriately, ensuring that these were continued appropriately once prisoners arrived at the establishment.

2.59 For most prisoners, medicines were administered three times a day, from the main health centre. The medicine queue was well supervised and patients were provided with privacy and respect. Other time slots were available for collecting in-possession medicines. A few patients received medication from the unit 7 treatment room but the supervision of administration by officers there was inadequate.

2.60 All prescriptions, administrations and issuing of in-possession medications were recorded electronically, with robust contingency arrangements established in the event of system failure. Records showed that medicines administered as patches were not used in line with the manufacturer's recommendations. Prisoners could request an appointment with the pharmacy team for medicines advice but patient information leaflets were not provided routinely to prisoners receiving supervised medicines. Prisoners were offered an eight-week programme for smoking cessation on arrival at the establishment and could access nicotine replacement products from the prison shop after this time if required.

2.61 Every prisoner had an annual medicine review and the pharmacy team assisted with the monitoring of high-risk medicines. Emergency medicines were readily available and checked regularly. Drug alerts and recalls were actioned appropriately. Medication errors were reported and reviewed at the medicines management group meeting. The clinical audit programme was supported by pharmacy staff, who also provided medicines management training for all health services staff.

Dentistry

2.65 Dental services were provided by John G Plummer & Associates and were good, offering a range of treatments equivalent to that in the wider community. Dental cover was well organised and responsive to prisoners' needs. The waiting time for routine appointments was appropriate, at four weeks, and emergency provision was effective, with urgent referrals seen promptly. A dental nurse provided comprehensive oral health promotion and advice.

2.66 All care and treatment were carried out safely and to the required standards. The dental suite was modern, clean, spacious and properly maintained in accordance with current legislation. There was a separate

decontamination room, and current infection control standards were met. There were safe arrangements for disposing of waste materials.

Delivery of care (mental health)

2.67 Virgin Care delivered mental health services using a stepped-care approach, ranging from facilitating self-help through to supporting prisoners with complex needs. Only the GP received referrals and acted as a gatekeeper to the service.

2.68 Referrals were screened at a weekly team meeting and allocated to practitioner caseloads. Routine assessments were undertaken within two days. The core team consisted of a nurse manager, two registered nurses and a health care assistant. They operated five days a week, with input one day each week provided, respectively, by a clinical psychologist and psychiatrist.

2.69 The team saw all prisoners placed on an ACCT but, other than that, dealt only with acute concerns presented by prisoners already engaged with the service. At the time of the inspection, the team was supporting 56 prisoners. Of these, 12 had been identified as requiring support under the care programme approach, which was used appropriately to identify the support required for those with severe and enduring mental health needs.

2.70 Complementing provision, Norfolk and Suffolk NHS Foundation Trust delivered individual and group talking therapies through a standalone 'well-being service', which accepted referrals directly from prisoners. This service offered a wide range of time limited interventions designed to alleviate mild- to moderate-level problems for around 85 prisoners, and there were plans to increase capacity in this area.

2.71 The small Virgin Care team undertook reception mental health screening but had limited scope to undertake development work, such as mental health promotion. We judged the care provided as appropriate to the prison population, although there was some overlap between the provision of the well-being service and that of the Virgin Care team. In addition, there was no opportunity to review prisoners jointly when care overlapped or in cases where shared care arrangements (for example, with the GP, the well-being service and the Rehabilitation of Addicted Prisoners trust (RAPt) team) might have been more appropriate, which could have had a detrimental impact on prisoners' outcomes.

2.72 No prisoners had needed assessment for treatment in hospital under the Mental Health Act in the previous 12 months. A programme of mental health awareness training for prison staff was due to restart in May 2017 after a recent hiatus, and a number of staff had already attended previous training.

HMP Bure
From HM Inspectorate of Prisons report

Extracts from Section 4: Resettlement

Healthcare

4.39 Patients received good pre-release assessments from a nurse, to support them to register with community health services on release. Patients with a known release date were offered an appointment at the discharge clinic and issued with a supply of take home medication if required. For those with complex care needs, there was good joint working between the health care worker and the OMU, to ensure appropriate onward care and support.

4.40 Links were established with local community mental health teams and other partners, to support discharge planning for prisoners with ongoing mental health needs. However, arranging external input into care programme approach discharge planning, to support prisoners with ongoing severe and enduring difficulties, was often delayed until the final few weeks of their sentence owing to uncertainty about resettlement plans.

Drugs and alcohol

4.41 A 'through-the-gate' support service was available from the Rehabilitation of Addicted Prisoners trust (RAPt) team for the very few prisoners who required ongoing support with substance use issues. The team arranged pre-discharge support and linked into community teams, to ensure that good substance misuse aftercare arrangements were available following release.

Extracts from Section 5: Summary of Recommendations and Good Practice

Main recommendations to the Governor

5.1 The quality of assessment, care in custody and teamwork (ACCT) case management should be improved, including better and more accurate risk assessments, comprehensive care maps with clear goals, and support that continues until evidence shows that the prisoner's personal crisis has been fully managed and reduced. (S52)

Recommendations to the Governor

Self harm and suicide

5.8 The constant supervision cell should not be located on the segregation unit. (1.24)

5.9 Listeners should have dedicated rooms to accommodate callouts. (1.25)

Health services

HMP Bure
From HM Inspectorate of Prisons report

5.17 Newly initiated medicines should be ordered and supplied in a timely manner, to ensure that treatment begins promptly. (2.62)

5.18 Medicines requiring cold storage that are found to be kept outside the recommended range should be managed appropriately. (2.63)

5.19 The application of transdermal patches should be in line with manufacturer's instructions. (2.64)

5.20 Referrals from any health professional should be considered and assessed directly by the mental health team. (2.73)

5.21 All mental health caseloads, particularly those involving overlapping or shared care, should be reviewed regularly in a multidisciplinary and multiagency clinical forum. (2.74)

Health related recommendations from the previous inspection that had not been implemented at the time of the 2017 inspection

The standard of entries in assessment, care in custody and teamwork documentation should be of a consistently high quality. (1.29)
Not achieved

Health recommendations from Health and Social Care Needs Assessment for HMP Norwich – March 2019

Mental health	-	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.
	-	There should be a clear ADHD (attention deficit hyperactivity disorder) pathway in 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.
Learning disabilities	-	Identifying learning disabilities in both[1] 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.
	-	A distinct learning disability lead role should be created, with responsibility for promoting the management of those with learning disabilities across the prison.
Substance misuse	-	To investigate the low treatment commencement rate of those transferred to Norfolk. *(Refers to a low treatment commencement rate for transfers from HMP Norwich to the community)*
Primary care	-	There should be an offering of spirometry in the prison.
Pharmacy	-	Pharmacy-led clinics should be explored, particularly medicine use review clinics.
Clinics – dentist	-	The new provider should ensure that there are appropriate processes in place for the servicing and replacing of dental equipment.

[1] 'Both' refers to HMP Norwich and the comparator prison in the report, HMP Peterborough

Information from Healthwatch Norfolk's report on 'Diabetes Care in East of England Prisons', March 2020

Healthwatch Norfolk's study was conducted through focus group meetings with prisoners with type 1 and type 2 diabetes at two prisons, HMP Bure and HMP Littlehey, and a survey of staff by questionnaire.

In relation to HMP Bure the findings from resident focus groups were (in summary):-

- Possible inconsistencies in how residents are informed of their medication and prescriptions
- Difficulties in self-checking blood levels
- Residents have to use their own funds to access healthier options via the canteen
- Residents do not get sweeteners as standard instead of sugar sticks so have to buy their own
- Participants felt the menus do not have healthier options for residents with diabetes
- Participants felt they don't know enough about the ingredients of the prison menu
- Participants were not aware of how best to monitor their diabetes if they are unwell
- Inconsistent awareness as to eligibility for foot and eye screening
- Some difficulty in accessing foot care
- Peer-led support groups and external training sessions would be welcomed by residents with diabetes
- Participants felt the most important things to improve diabetes management is food (variety, quality and knowledge of nutritional values), and access to a gym
- Self-management was recognised as important but not always actioned by participants

The findings from the staff survey (combined across HMP Bure and HMP Littlehey) were:-

- 93% of all respondents are not aware of any education programmes for staff around managing residents with diabetes
- 78% of all respondents answered 'no' or 'not sure' when asked whether they feel they have enough training to deliver care to residents with diabetes
- 63% of non-medical staff answered 'no' or 'not sure' when asked whether they know what to do if a resident was unwell because of their diabetes
- Respondents highlighted that they would contact the healthcare team if a resident with diabetes became unwell, however healthcare are not available during the night
- Respondents felt that lack of staff knowledge, and diet are the two biggest risk to residents with diabetes

- Respondents felt that staff training, resident diets, and staffing levels / availability are the three biggest priorities for supporting residents with diabetes

Healthwatch recommended:-

1. Produce written documentation to inform residents with diabetes of what to do in the event of a ‘sick day’. This should contain information on how best to manage and monitor their symptoms if they cannot eat or drink as they would normally.

2. Kitchen staff should produce guides with basic nutritional information, particularly focussing on calories, carbohydrate levels and sugar levels, for each meal on the menu. This should be clearly displayed on the menus that residents can access.

3. Establish a self-help group to allow residents with diabetes to meet, supervised by healthcare staff, to share information and ideas on managing diabetes. This could be in conjunction with kitchen staff, too, to work to ensure there is always a friendly option for residents with diabetes.

4. Provide sweeteners as a substitute to sugar packets free of charge for all residents with diabetes.

5. Develop provisions for emergency boxes to allow residents with diabetes to access food during out of hours, without having to rely on buying items themselves through the canteen.

6. Ensure that the canteen includes sugar free options, particularly for drinks.

7. Ensure that all prison officers receive basic training on diabetes awareness and clear guidance on what to do if a resident with diabetes falls ill when the healthcare team is not available.

Norfolk Health Overview and Scrutiny Committee

ACTION REQUIRED

Members are asked to consider the current forward work programme:-

- whether there are topics to be added or deleted, postponed or brought forward;
- to agree the agenda items, briefing items and dates below.

Proposed Forward Work Programme 2021

Meeting dates	*Main agenda items*	*Administrative business*
18 Mar 2021	The Queen Elizabeth Hospital NHS Foundation Trust – progress report Local actions to address health and care workforce shortages – progress update since July 2019 Access to local NHS services for patients with sensory impairments (follow-up to NHOSC 26/11/20)	*CCG unlikely to be able to attend re wide-ranging Accessible Information Standard implementation, therefore focus on NHSE&I response to recommendations re BSL service for Deaf patients.*

NOTE: These items are provisional only. The OSC reserves the right to reschedule this draft timetable.

NOTE: Norfolk County Council election will be held on 6 May 2021

Provisional dates for later reports to the Committee 2021 (main agenda items)

10 June 2021 - Ambulance Service (follow-up to NHOSC 8/10/20)

i. An update on what has been done to address the CQC concerns about EEAST (i.e. in the September 2020 CQC report, including safeguarding of patients and staff). To include an explanation of the concerns in relation to Norfolk and Waveney, why the concerns persisted for so long, what EEAST has learned from the situation and its changes to policies and practices.

ii. A progress report on the measures being put in place to improve the emergency response to patients with mental health requirements, including data on the effect of those measures and an explanation of why the past concerns about the service for patients with mental health emergencies have persisted for so long and what has been learned.

Vulnerable adults primary care service Norwich (replacing City Reach) – progress report

Children's neurodevelopmental disorders (i.e. autism and other conditions) – waiting times for diagnosis

15 July 2021 - Cancer Services (follow-up to NHOSC 8/10/20)

i. The impact of Covid 19 on backlogs and waiting times within screening, diagnosis and treatment services
ii. The impact on cancer patient outcomes in Norfolk and Waveney
iii. Measures to encourage people to come forward for screening, particularly those who are vulnerable and need support
iv. Effectiveness of the measures to encourage people to come forward for screening.

Provisional dates for items in the NHOSC Briefing 2020-21

Date TBC - Primary care developments in King's Lynn (progress on relocation of St James' Medical Practice and on business case for a second new surgery in the town. Follow-on from NHOSC 26/11/20)

Date TBC - Update on progress with delivery of annual physical health checks for people with learning disabilities (age 14 and over)

July 2021 - Merger of Norfolk and Waveney CCGs – progress briefing

- How the new CCG has maintained local focus one year on from merger
- Extent to which various healthcare statistics etc are still available on a district or locality basis to enable understanding of local issues.

July 2021 - ME / CFS service – steps taken by the CCG and service provider to comply with new NICE Guidance
Depending on publication of new NICE Guidance. Expected publication date 21 April 2021.

Nov 2021 - Annual update on childhood immunisation take-up rates (follow-up from NHOSC 8/10/20 meeting)

NHOSC Committee Members have a formal link with the following local healthcare commissioners and providers:-

Norfolk and Waveney CCG	-	Chairman of NHOSC – Penny Carpenter (substitute Vice Chairman of NHOSC – Dr Nigel Legg)
Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust	-	Sheila Young (substitute Michael Chenery of Horsbrugh)
Norfolk and Suffolk NHS Foundation Trust (mental health trust)	-	David Harrison (substitute Michael Chenery of Horsbrugh)
Norfolk and Norwich University Hospitals NHS Foundation Trust	-	Dr Nigel Legg (substitute David Harrison)
James Paget University Hospitals NHS Foundation Trust	-	Emma Flaxman-Taylor
Norfolk Community Health and Care NHS Trust	-	Emma Spagnola

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Norfolk Health Overview and Scrutiny Committee 4 February 2021

Glossary of Terms and Abbreviations

ACCT	Assessment, Care in Custody and Teamwork - the care planning process for prisoners identified as being at risk of suicide or self-harm
A&E	Accident and emergency
CCG	Clinical Commissioning Group
CDS	Community Dental Services – an employee owned social enterprise community interest company providing clinical dental and Oral Health Promotion services
CHD	Chronic Heart Disease
CIC	Community Interest Company
CM	Custodial Manager
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach – a package that may be used to plan mental health care
CQC	Care Quality Commission – the independent regulator of health and social care in England. Its purpose is to make sure health and social care services provide people with safe, effective, high quality care and encourage care services to improve.
DART	Drug and alcohol related treatment
DDA	Disability Discrimination Act 1995
FP10	FP10 prescriptions are purchased by NHS organisations and are distributed free of charge to medical and non medical prescribers, NHS dentists and other organisations as required
GFSM	Government Facilities Services Limited
GP	General Practitioner
HCC	Healthcare centre
HMP	Her Majesty's Prison
HMIP	Her Majesty's Inspectorate of Prisons
HSCNA	Health and Social Care Needs Analysis
IAPT	Improving Access to Psychological Therapies
IMB	Independent Monitoring Board (prison monitoring)
IPC	Infection prevention & control
IQ	Intelligence quotient
LD	Learning Difficulties / Disability
LDU	Local Discharge Unit
N-DAP	Norfolk Drug and Alcohol Partnership
NHOSC	Norfolk Health Overview and Scrutiny Committee
NHSE&I EoE	NHS England and NHS Improvement, East of England. One of seven regional teams that support the commissioning

	services and directly commission some primary care services and specialised services. Formerly two separate organisations, NHS E and NHS I merged in April 2019 with the NHS England Chief Executive taking the helm for both organisations. NHS Improvement, which itself was created in 2015 by the merger of two former organisations, Monitor and the Trust Development Authority, was formerly the regulator of NHS Foundation Trust, other NHS Trusts and independent providers that provided NHS funded care.
NOMS	National Offender Management Service
NPS	New psychoactive substances
OMU	Offender Management Unit
OST	Opiate substitute treatment
PALS	Patient Advice and Liaison Service
PDU	Personality Disorder Unit
PIPE	Psychologically informed planned environment
PPO	The Prisons and Probation Ombudsman - carries out independent investigations into complaints and deaths in custody
PSI	Prison Service Instruction
QOF	Quality Outcomes Framework – the annual reward and incentive programme for GP practices. It rewards practices for provision of quality care and helps standardise improvement in the delivery of primary medical services
RAPt	Rehabilitation of Addicted Prisoners Trust
Spirometry	A pulmonary function test that measures how much air a person breathes out and how quickly, indicating how well the lungs are working
SSV	Short scrutiny visits – replacing the usual cycle of HM Inspectorate of Prisons' prison inspections during the Covid 19 pandemic
SystmOne	A clinical system for a one patient, one record model of healthcare
YOI	Young Offender Institution