HMP BURE

HEALTH & SOCIAL CARE NEEDS ASSESSMENT

SEPTEMBER 2019

Version 1.6

UNSUPPRESSED VERSION

S Squared Analytics

INTRODUCTION

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY OVERVIEW

INTRODUCTION

HMP Bure and HMP Littlehey are category C training prisons holding convicted sex offenders. HMP Littlehey holds over 1200 prisoners, while HMP Bure holds approximately 650 prisoners. Both prisons were characterised by having stable, predominantly older populations, with high average lengths of stay. Average length of stay in HMP Bure was 535 days, with the average in HMP Littlehey being 611 days. 16% of the population in HMP Littlehey have been in the prison for more than 3 years compared to 11% in HMP Bure.

DEMOGRAPHICS

A key finding when looking at the demographics is the increase in patients over the age of 70 in both prisons. Since the last health needs assessment in 2016, the over 70 population has increased by 22% in HMP Bure and 39% in HMP Littlehey. The ethnicity of the populations in the two prisons has remained similar to the previous needs assessment in 2016.

Both prisons have a high proportion of prisoners over the age of 50 (HMP Bure – 46%; HMP Littlehey – 47%) which creates a number of specialised health and social care needs. These can be characterised by:

- A high prevalence of long-term conditions and chronic illnesses (supplementary to this is a greater demand for hospital appointments and end of life care)[1]
- Mobility issues[2]
- Sensory impairment[3]
- Greater prescribing needs[4]
- Higher mental health issues, particularly depression[5]

HEALTHCARE PROVISION

In HMP Bure, healthcare is provided by Care UK, who took over provision in April 2019. Care UK had undertaken a lot of work on recruitment. A number of staff had left the service in the previous 12 months, however the primary care team had 5 permanent nursing staff. In HMP Littlehey, healthcare is provided by Northamptonshire Healthcare NHS Foundation Trust. The healthcare team is comparatively stable, and is made up of a number of experienced staff members.

SUBSTANCE MISUSE

Analysis of the available data indicates that substance misuse needs in the two prisons is low. There are low rates of positive drug tests, low numbers of drug finds, and a small number of patients in receipt of opiate replacement therapy. There was a small amount of reported NPS usage. Illicit drug use in both prisons appeared to centre

[1] Public Health England, 'Health and social care needs assessments of the older prison population: a guidance document', November 2017, p.8; House of Commons Justice Committee, 'Older Prisoners: Fifth Report of Session 2013-14', July 2013, p.10.
[2] 'Health and social care needs assessments of the older prison population', p.8; 'Older Prisoners: Fifth Report of Session 2013-14', p.10.
[3] 'Health and social care needs assessments of the older prison population', p.8; 'Older Prisoners: Fifth Report of Session 2013-14', p.10.
[4] HM Inspectorate of Prisons, 'Older prisoners in England and Wales: a follow-up to the 2004 thematic review by HM Chief Inspector of Prisons', June 2008, p. 29.
[5] 'Older Prisoners: Fifth Report of Session', p.11.

around the misuse of prescribed medication. The psychosocial services in both prisons is provided by Phoenix Futures and they offer a range of group work appropriate to the population.

MENTAL HEALTH

The mental health provision in the two prisons are slightly different. In HMP Bure, mental health provision is delivered by an integrated primary and secondary mental health team, with IAPT provision delivered by Norfolk and Suffolk NHS Trust.

In HMP Littlehey, there is a Mental Health In-reach Team, which provides primary and secondary mental health care. The team also includes a psychologist and assistant psychologist who deliver talking therapies in conjunction with mental health practitioners from the In-reach Team.

The teams in both prisons were both very accessible to new patients. The team in HMP Bure saw all new arrivals to the prison at reception. The Mental Health In-reach Team in HMP Littlehey ran weekly drop-in clinics on the wings for patients to discuss any mental health or emotional wellbeing problems they had. The drop-in clinics were an opportunity for patients to receive signposting to appropriate services as well as receive initial mental health assessments where appropriate.

DEMENTIA

Both prisons had developed their dementia pathways since the previous assessment. In HMP Bure, patients with suspected dementia were able to be referred to the Julian Hospital in Norwich. The Julian Hospital is provided by Norfolk and Suffolk NHS Foundation Trust. The hospital did not complete any visits to the prison. There was a visiting charity who ran staff training and dementia groups in the prison.

The dementia pathway in HMP Littlehey was more fully developed, with the Mental Health In-reach Team and the Primary Care Team piloting interventions aimed at improving identification and care for patients with dementia and suspected dementia. Currently all prisoners over the age of 65 are screened for dementia, with a plan to extend this to the over 50s. There is good communications with an old age consultant psychiatrist who can complete consultations over Skype. There were also a number of environmental improvements planned which would be sympathetic to the needs of those with dementia.

LEARNING DISABILITIES

There was a similar prevalence of patients with learning disabilities in both prisons. The rates were also similar to those seen in the previous HNA in 2016. Approximately 2% of the population in both prisons were on the learning disability QOF register. Both sites lack a specialist learning disability nurse, however Care UK are interviewing for the vacant learning disability post in HMP Bure.

PRIMARY CARE

In HMP Littlehey, there was a lead nurse for each of the long-term conditions. This was the aim in HMP Bure, but a number of staffing problems had delayed this from occurring. Care UK had planned some study days to take place to ensure nurses were competent with leading on the various long-term conditions. In both prisons, the GP assisted with the management of those with long-term conditions. Both prisons had healthcare representative schemes. The representatives in HMP Littlehey were active in promoting healthy lifestyles and ran regular blood pressure checks on the wings.

There is high prevalence of long-term conditions in both prisons:

- Prevalence for coronary heart disease in both prisons is 9%. This is an increase of 3% since the previous assessment in 2016.
- Prevalence of hypertension is 24% in both prisons. In HMP Bure, this is an increase of 6% since the previous assessment.
- Prevalence of obesity is 37% in HMP Bure and 30% in HMP Littlehey.
- Prevalence of diabetes is 13% in both prisons.
- Prevalence of COPD is 5% in HMP Bure and 8% in HMP Littlehey.

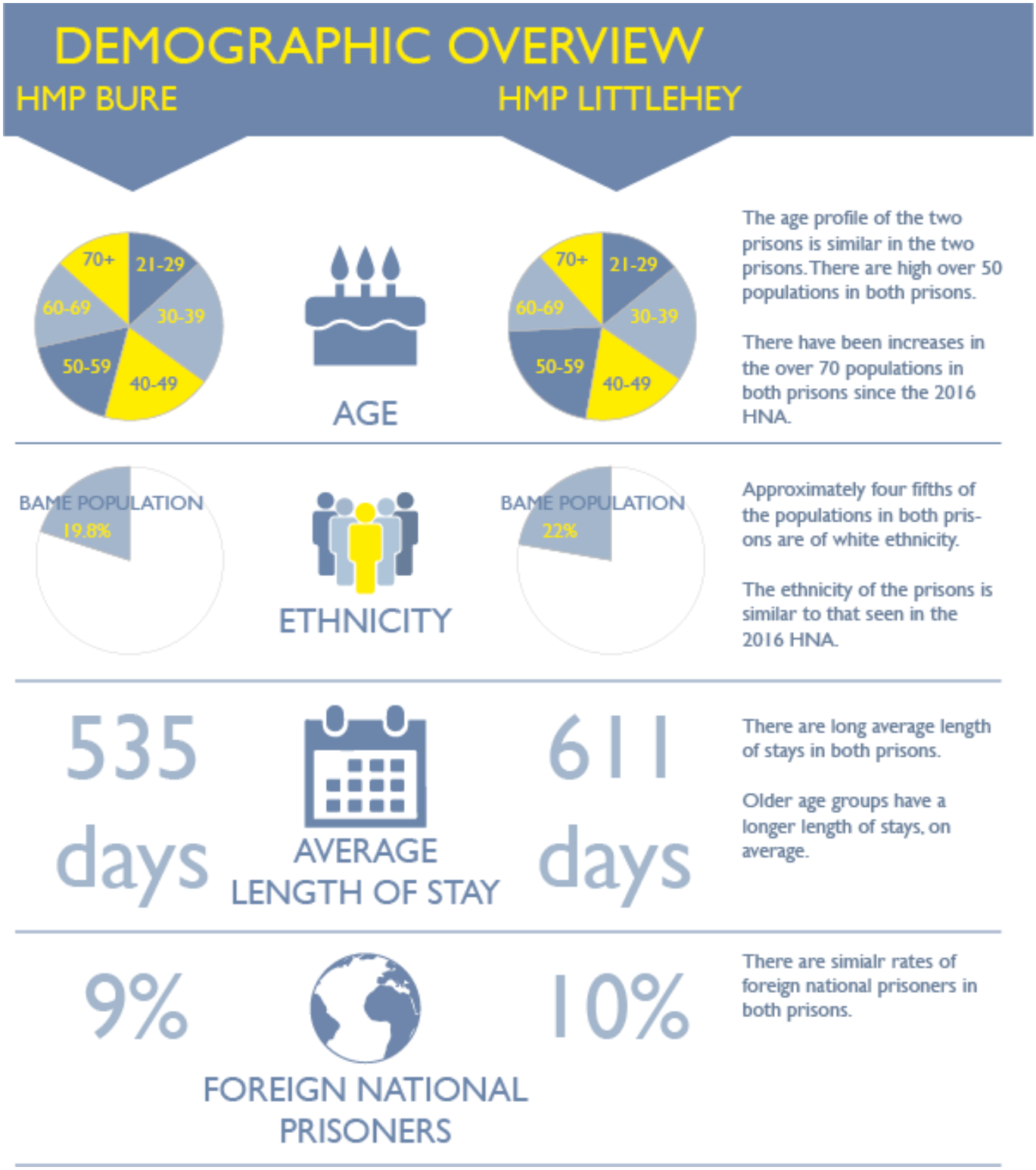
The following two pages provide an overview of similarities and differences between the two prisons.

Figure 1.1.1: Overview of the similarities and differences between the two prisons.

PRISON SIZE	As at September 2019, the population of HMP Littlehey was 1205. This is almost twice the size of the population of HMP Bure which was 653.
AGE PROFILE	The prisons share a similar age profile, with older prisoners accounting for 46-47%. The average age is 48-49 years.
ETHNICITY PROFILE	The prisons share a similar ethnicity profile, with white prisoners accounting for 78-80%.
FNPs	FNPs account for 9-10% of the prisoners in both prisons.
ARMED FORCES	Based on the multiple data sources, HMP Littlehey appears to have a higher rate of prisoners that have served in the armed forces.
OFFENCES	The two prisons have a similar offending profile, with prisoners recorded with an index offence of sexual offences accounting for 88-89% of the total population.
TURNOVER RATE	The turnover rate for both prisons is around 0.5-0.6 per year.
LENGTH OF STAY	For the current population, both the average length of stay and median length of stay are higher in HMP Littlehey than HMP Bure.
PRISONERS NOT ON THE QOF REGISTER	30% in HMP Bure and 34% in HMP Littlehey do not appear on any of the QOF registers.
CVD QOF REGISTER	The prevalence of the CVD related QOF registers are similar across both prisons.
DEPRESSION	There is similar prevalence in the depression QOF register between the two prisons.
SELF-HARM	Self-harm is higher in HMP Littlehey. This is based on a number of data sources including the annual performance reports, MoJ statistics, and local READ codes.

SUBSTANCE MISUSE ENGAGEMENT	Both prisons have a low rate of receptions starting treatment in comparison to prisons of a similar role.
MANDATORY DRUG TESTING	Positive drug tests are low across both prisons.
DRUG FINDS	The number of drug finds across both prisons is low.
IN-TREATMENT SUBSTANCES	Both prisons exhibit a similar drug in-treatment profile, with alcohol being the most prevalent substance.
DIABETES, ASTHMA, EPILEPSY	Based on the QOF register, the prevalence of these conditions is similar across both prisons.
PULMONARY REHABILITATION	This is run in HMP Littlehey only.
OBESITY	Obesity is an issue in both prisons, with around 27-30% of the population classified as obese.
COPD	At 8%, the prevalence of prisoners on the COPD register is higher in HMP Littlehey than the 5% in HMP Bure.
LEARNING DISABILITIES	There is a similar prevalence in the prison. Neither prison has a specialist learning disabilities nurse.
SMOKING	Based on HJIP data, the prevalence of smokers is higher in HMP Bure than HMP Littlehey.
ESCORTS	As a snapshot of the population, HMP Bure gives a figure of 131 compared to 156 in HMP Littlehey. HMP Littlehey also reports a higher rate of cancellations.

Figure 1.1.2: Demographic overview of the two prisons.



1. CAPACITY

1.1. As at September 2019, the population of HMP Littlehey was 1205. This is almost twice the size of the 653 population for HMP Bure.

1.2. In both prisons, the population exceeds the In-Use CNA[6] which is 604 in HMP Bure and 1154 in HMP Littlehey.

1.3. Further analysis shows that both have a number of prisoners held in overcrowded accommodation.

1.4. Below shows the percentage of prisoners held in crowded accommodation broken down by long-term trends and a 2018-19 comparison against other prisons[7].

1.5. Whilst the overcrowding rate has remained stable in HMP Littlehey over the past 5 years, HMP Bure has seen an increase.

Figure 1.1.3: Population size.

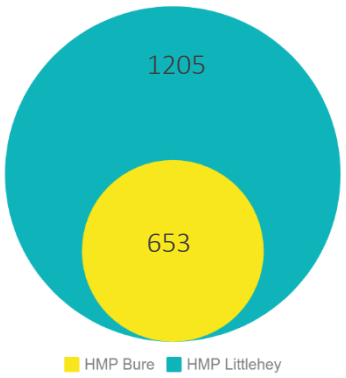


Figure 1.1.4: Long-term trend of prisoners held in crowded accommodation; %.

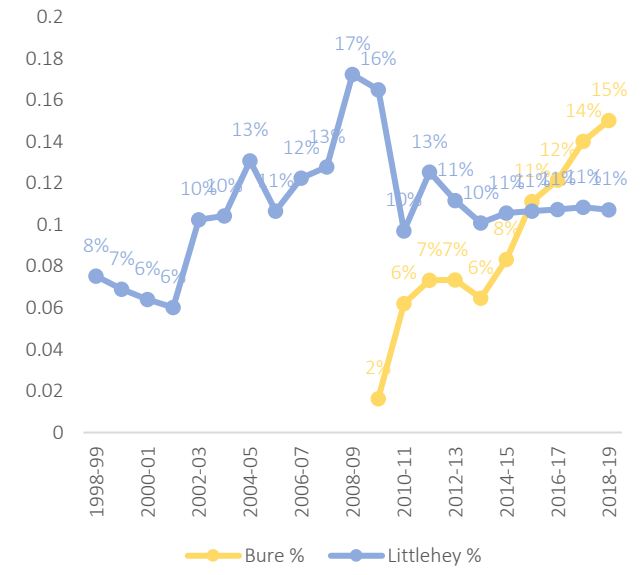
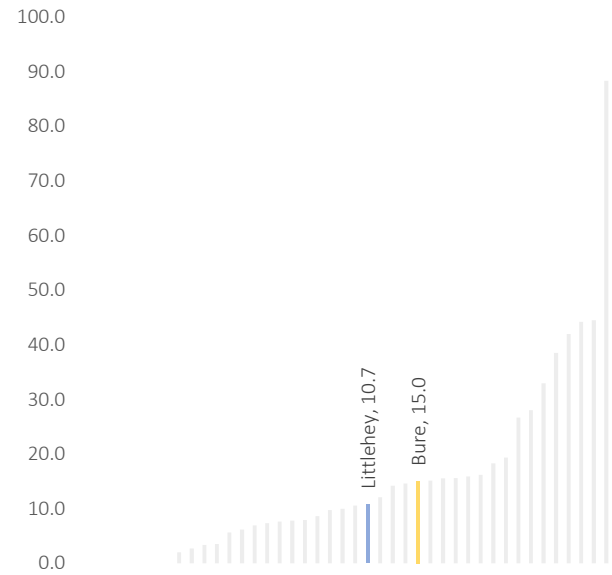


Figure 1.1.5: 2018-19 snapshot comparison against prisons of a similar function.



[6] Certified Normal Accommodation (CNA), or uncrowded capacity, is the Prison Service's own measure of accommodation. CNA represents the good, decent standard of accommodation that the Service aspires to provide all prisoners.

7 Source: NOMS - https://www.gov.uk/government/statistics/annual-hm-prison-and-probation-service-digest-2018-to-2019

2. AVERAGE LENGTH OF STAY

2.1. For the current population, both the average length of stay and median length of stay are higher in HMP Littlehey compared to HMP Bure.

2.2. In both prisons, the average length of stay is longer than the median length of stay. This is due to a small number of prisoners who have a comparatively longer length of stay.

2.3. The analysis by age shows that there is a correlation with the length of stay; the older age groups report a longer average length of stay compared to the younger age groups.

2.4. Comparing the two prisons show similar length of stay for most age groups except for the 30-39 and 60+ age groups which are longer in HMP Littlehey.

Figure 1.1.6: Length of stay; current population.

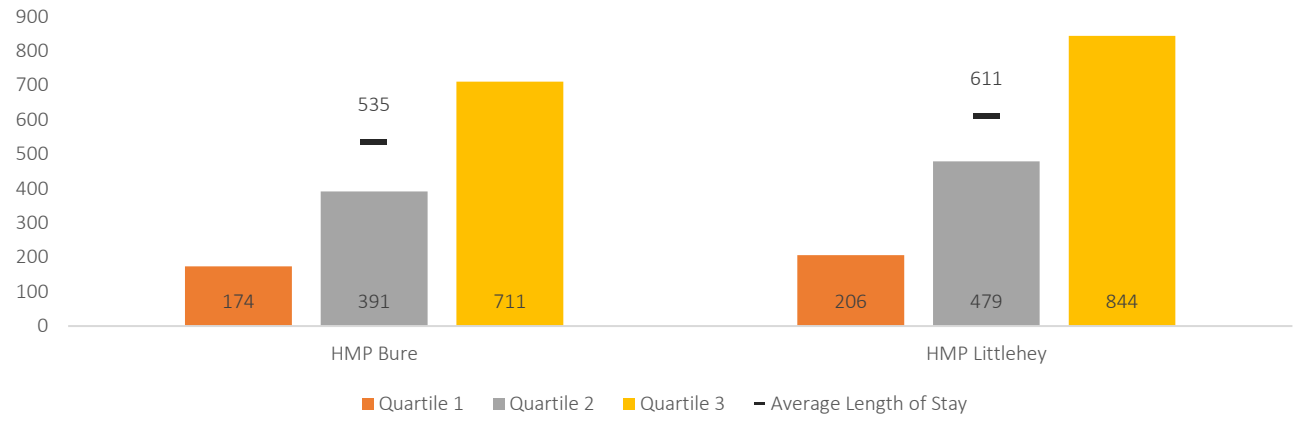


Figure 1.1.7: Average length of stay; current population by age.

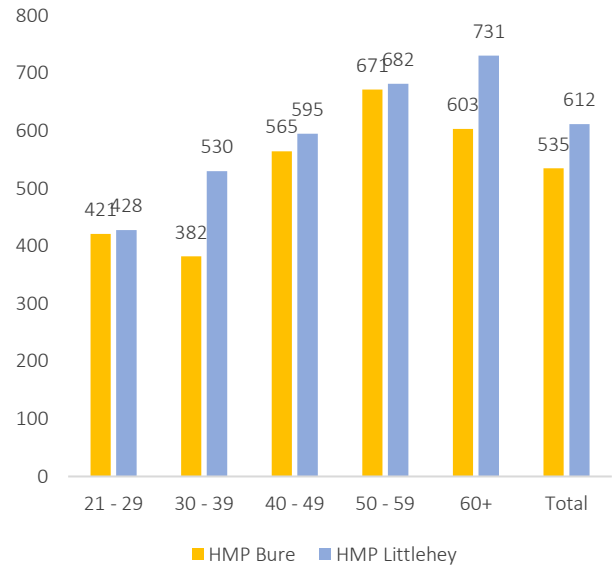
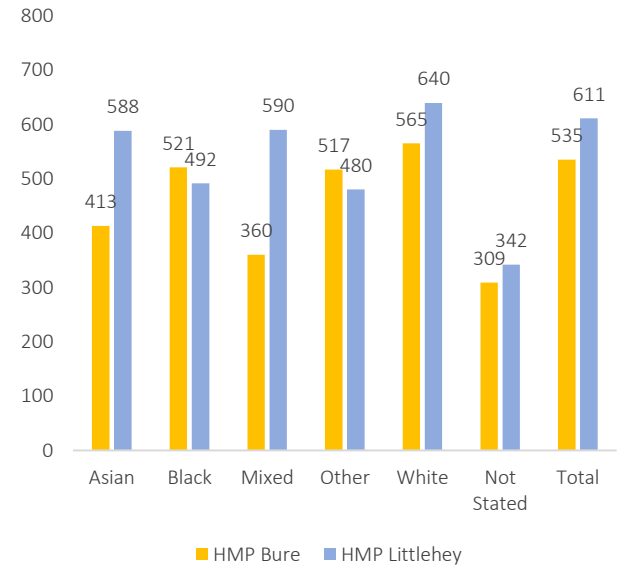


Figure 1.1.8: Average length of stay; current population by ethnicity.



2.5. The turnover rate of 0.5 in HMP Littlehey is slightly lower than that of HMP Bure at 0.6, and is low in the context of the PHE Toolkit definition.

3. DEMOGRAPHICS

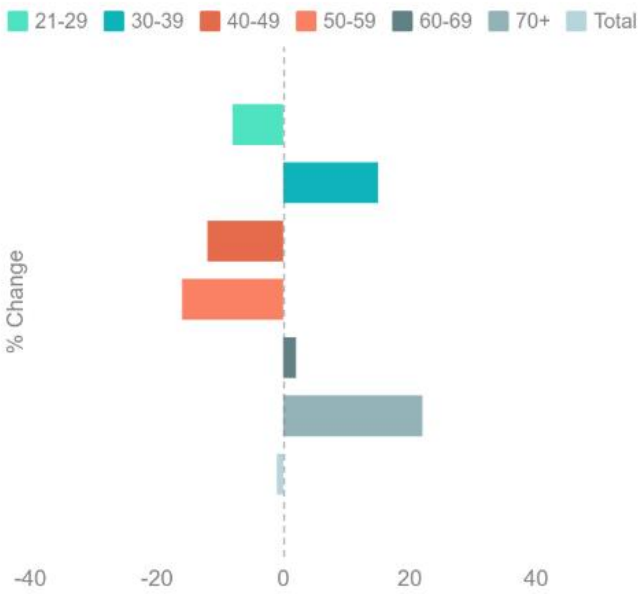
3.1. The age demographics of the two prisons are similar when analysed by 10-year age bands.

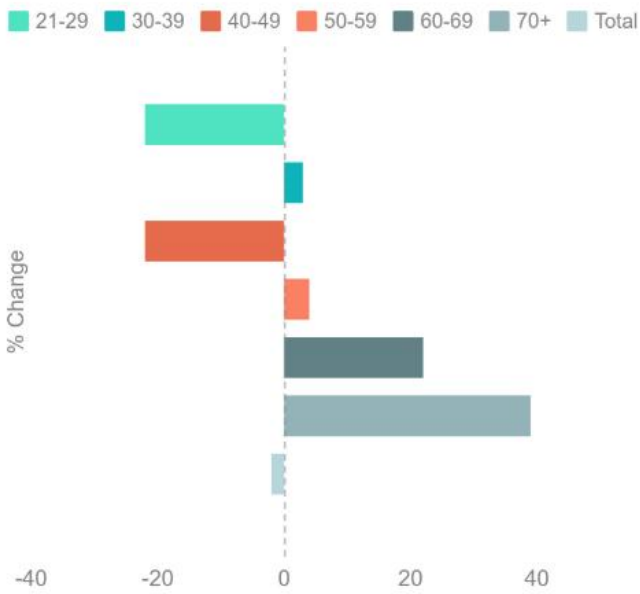
3.2. The main notable difference is that there is a higher rate of 50-59 years olds in HMP Littlehey, which is offset by slightly higher rates across most of the other age groups in HMP Bure.

Figure 1.1.9: Overview of the age demographics of the two prisons.

HMP BURE	HMP LITTLEHEY

ACROSS BOTH PRISONS, ALMOST HALF OF THE POPULATION ARE OVER THE AGE OF 50





BOTH PRISONS SHOW AN INCREASE IN THE NUMBER OF PRISONERS OVER THE AGE OF 70 SINCE THE LAST HNA

3.3. The rate of prisoners of recorded as of White ethnicity is similar across both prisons at around 80%.

4. FOREIGN NATIONAL PRISONERS

4.1. As at June 2019[8], the rate of FNPs across both prisons was similar at 9-10%. For comparison, as at June 2016 HMP Littlehey had a higher rate at 11% compared to 7% in HMP Bure.

4.2. Nationally, foreign national prisoners make up approximately 10% of the population.

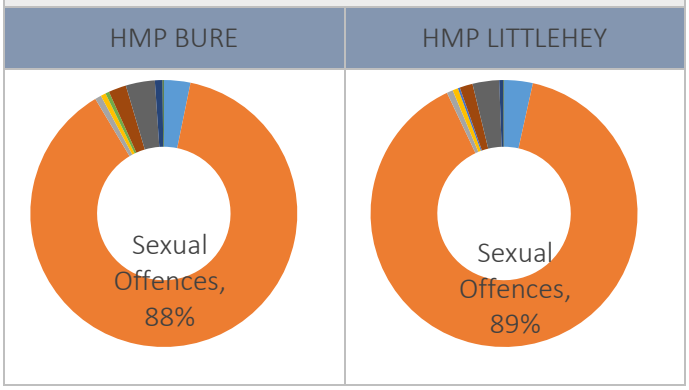
5. OFFENCES

5.1. The two prisons have a similar offending profile, with prisoners recorded with an index offence of sexual offences accounting for 88-89% of the total population.

5.2. This is up slightly from 85% as at June 2016 for both prisons.

5.3. In both prisons, Violence Against the Person accounts for 3% of the population, which is down from 6% recorded for June 2016.

Figure 1.1.10: Offending profile.



6. EX-SERVICE PERSONNEL

6.1. Based on multiple data sources, HMP Littlehey appears to have a significantly higher rate of prisoners that have served in the armed forces.

6.2. READ code "(Ua0T3) Served in armed forces" shows a figure of 12% in HMP Littlehey compared to 4% in HMP Bure, when taking into account any location for the code being entered.

6.3. Research into the health needs of ex-service personnel shows that they are more likely to report feeling depressed and suicidal on arrival to prison. The incidence of physical health problems on arrival into prison was higher among ex-service personnel than the general prisoner population.[9]

[8] https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-october-to-december-2018.
[9] HMIP, (2014), People in prison: Ex-service personnel

7. SCREENS

7.1. In HMP Bure, the retinopathy service visits the prison twice a year, however this is not reflected in the HJIPs. In HMP Littlehey, performance is around 22-25% which is higher than the comparator prison and the national average.

7.2 In HMP Bure, performance for bowel cancer screens has remained stable at 8-9% a year when comparing the 12 months to June 2019 against the 12 months to June 2018. In HMP Littlehey, performance has increased from 7% to 36%.

7.3 Performance for AAA screening in HMP Bure has decreased from 19% for the 12 months to June 2018 to 13% for the 12 months to June 2019, however this rate is still higher than the 5% in HMP Bure, and both the comparator prison and the national average.

7.4 Chlamydia screening has increased from 14% to 35% in HMP Bure, whilst HMP Littlehey has seen a decrease from 31% to 24%.

7.5 For the 12 months to June 2019, 42% of those in HMP Bure eligible for the NHS Physical Health Checks received one. In HMP Littlehey, the rate was higher at 51%.

7.6 For both prisons, performance for 1st reception screens are good. Both prisons report a performance rate of 99-100% over the last two quarters.

7.7 For the Qtr-1 of 2019-20, 92% of receptions in HMP Bure received a 2nd screen compared to 89% in HMP Littlehey. Nationally, performance stood at 88%.

8. QOF ANALYSIS

8.1. Figure 1.1.11 shows the percentage of the current population who do not appear on any of the QOF registers, which may indicate a 'healthy' population.

8.2. The rates are similar across both prisons.

Figure 1.1.11: Rate of prisoners not on any QOF register.

HMP BURE

HMP LITTLEHEY

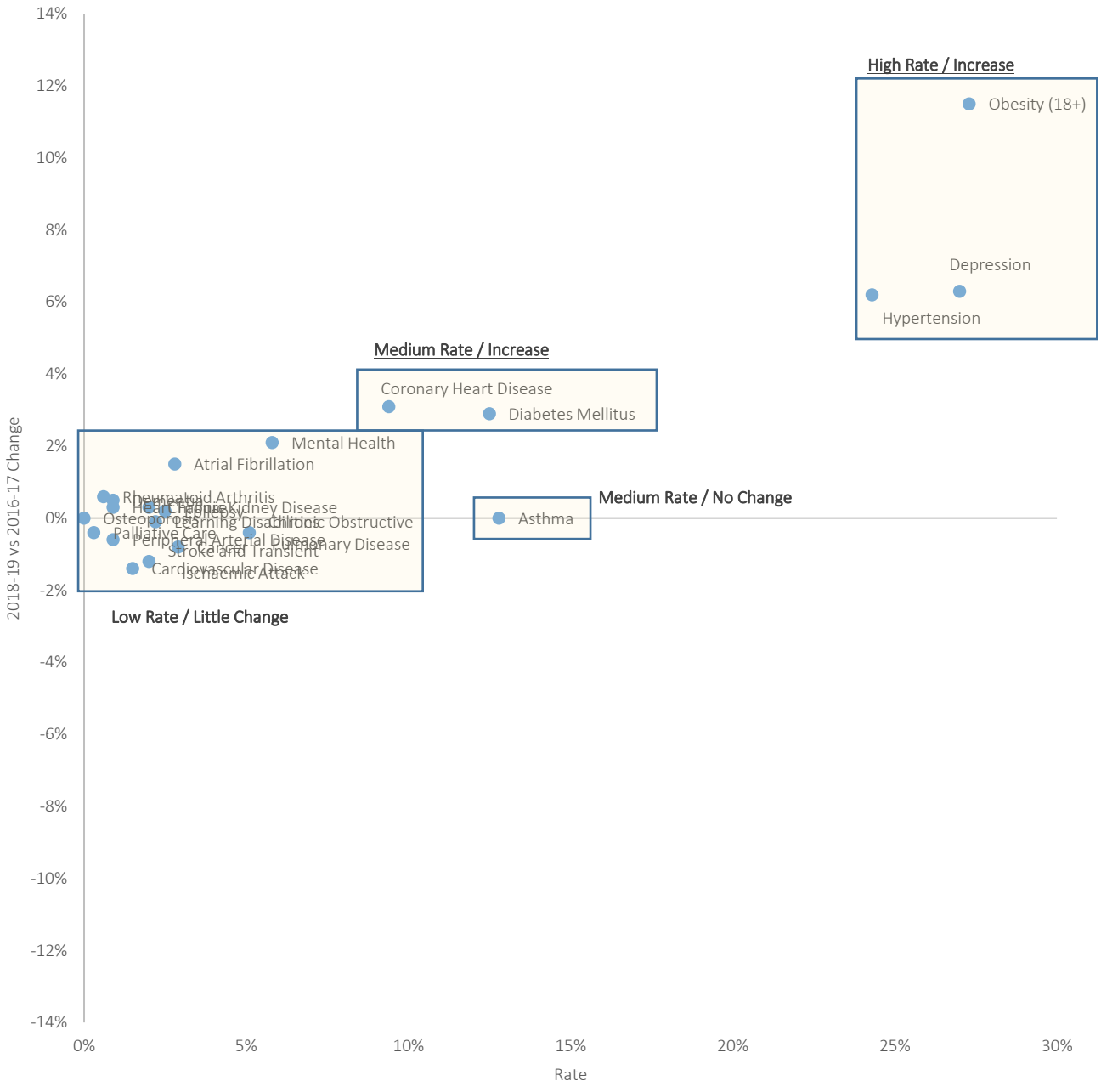
Prison	HMP Bure	HMP Littlehey
Number of Prisoners	636	1257
Number not on any QOF register	191	427
Percentage not on any QOF register	30%	34%

8.3. In general, the prevalence across most registers are similar, however there are a number of QOF registers that show some differences, including mental health which is higher in HMP Bure, and COPD which is higher in HMP Littlehey.

8.4. The following illustrates how the HMP Bure QOF register has changed since the 2016 HSCNA. The X-axis shows the rate[10] with the Y-axis showing the percentage point change since the last HSCNA. This presents the findings into a visual format which highlights a number of areas:

- Obesity, hypertension, and depression have seen an increase since the last HSCNA, and there is a high percentage of the population on these registers. However, the change for obesity is likely to be linked to better recording of BMI.
- There has been no register that has seen a relatively large decrease.
- A high number of the registers have seen little change, and there is a low percentage of the population on these registers.

Figure 1.1.12: Rate and change since the last HSCNA: HMP Bure.

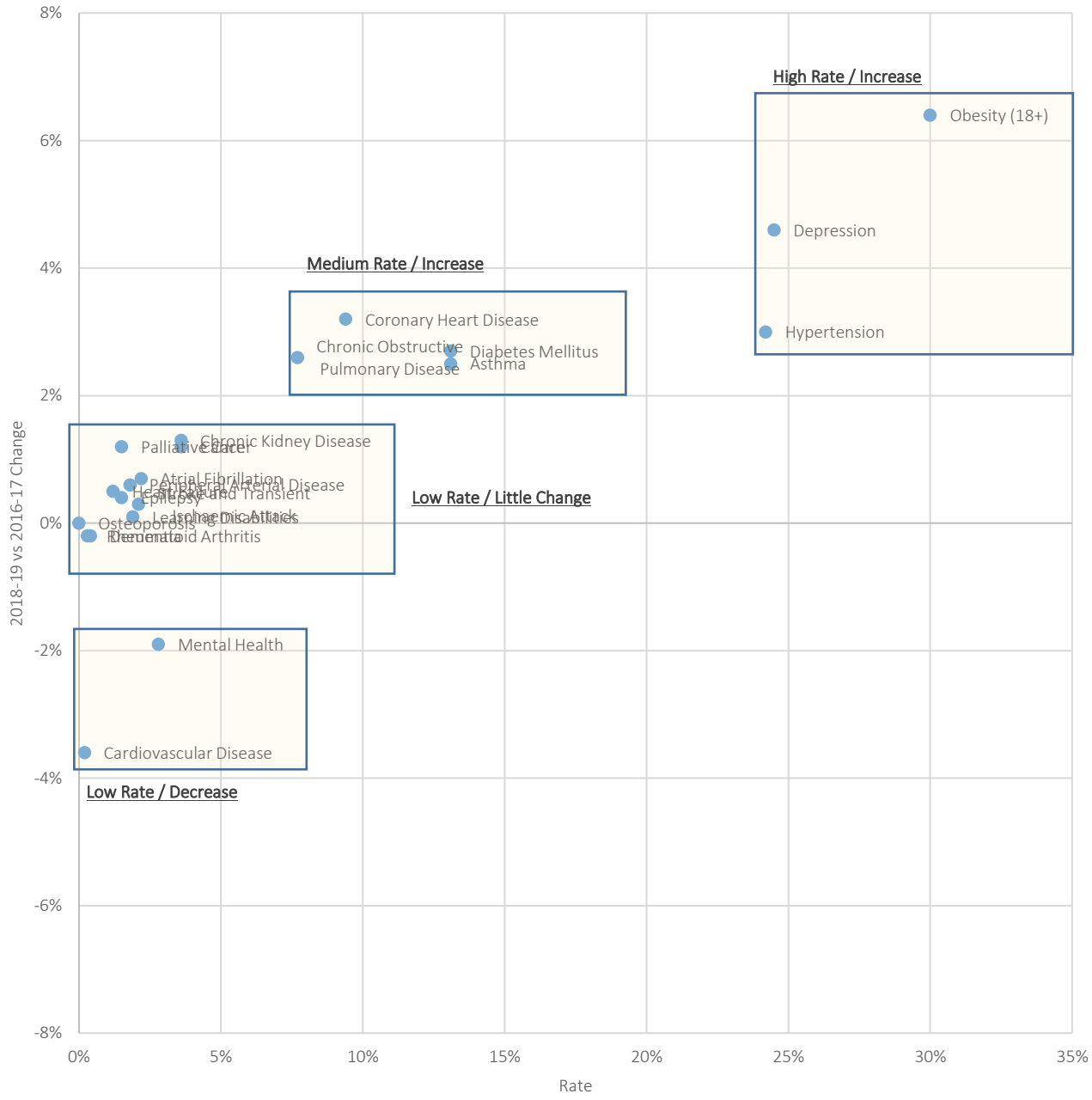


[10] The percentage of the population on the register.

8.5. The following illustrates how the HMP Littlehey QOF register has changed since the 2016 HSCNA. The X-axis shows the rate[11] with the Y-axis showing the change since the last HSCNA. This presents the findings into a visual format which highlights a number of areas:

- Similar to HMP Bure, obesity, hypertension, and depression have seen an increase since the last HSCNA, and there is a high percentage of the population on these registers. However, the change for obesity is likely to be linked to better recording of BMI.
- The mental health and the CVD register have both seen a decrease. A number of age-related diseases including COPD, CHD, and diabetes have seen an increase.

Figure 1.1.13: Rate and change since the last HSCNA: HMP Littlehey.



[11] The percentage of the population on the register.

9. FOCUS GROUPS

9.1. As part of the needs assessment, the researchers ran a number of focus groups in each of the prisons. The interviewers covered a number of topics relevant to capturing health needs in the prisons. Participants were also given latitude to raise any issues that they were concerned about.

9.2. The different roles of the health representatives were highlighted. Health Trainers in HMP Littlehey have a greater remit in terms of the promotion of healthy lifestyles in the prison. Healthcare representatives in HMP Bure mentioned that they would like to be more involved in health promotional activities in the prison.

9.3. The diet was highlighted as an issue in both prisons. In HMP Bure, patients found the diet very carbohydrate heavy. Participants in HMP Littlehey had similar complaints stating that although fruit was offered, it was often rotten and bruised. Another complaint was that advice given in the Diabetic Education Course regarding diet was not possible to follow in the prison.

9.4. A positive implementation in HMP Littlehey was the advertising of clinic waiting times on each wing. This was not implemented in HMP Bure.

10. SURVEYS

10.1. A prisoner survey was run in both prisons.

10.2. The survey had a good response rate. 28% of the population of HMP Bure responded, compared to 9% in HMP Littlehey.

10.3. Analysing the responses by demographics shows that there were higher response rates from older prisoners in both prisons.

10.4. Regarding access:

- In HMP Bure: 50% of respondents said that the doctor was difficult to access, 64% said the dentist was difficult to access and 44% said the optician was difficult to access.
- In HMP Littlehey: 48% of respondents said that the dentist was difficult to access, 38% said that the optician and physiotherapy service was difficult to access

10.5. Regarding quality:

- In HMP Bure: 21% of respondents said that the dental service was of bad quality, 15% of respondents said that the doctor was of bad quality.
- In HMP Littlehey: 15% of respondents said that the mental health service was of bad quality, 13% of respondents said that the physiotherapy service was of bad quality.

10.6. Regarding registration and medication:

- In HMP Bure: 69% of respondents were registered with a GP, 78% of respondents were provided medication, 74% had access to lockable storage.
- In HMP Littlehey: 71% of respondents were registered with a GP, 79% of respondents were provided medication, 44% had access to lockable storage.

10.7. In HMP Bure, 50% of respondents said that waiting times for GP were bad or very bad. There was a lower proportion who thought this in HMP Littlehey.

11. SERVICE PROVISION

11.1. In both prisons, there is an integrated primary and secondary care mental health team.

11.2. In HMP Bure, there is a separately commissioned IAPT service. There is no IAPT service in HMP Littlehey, however the Psychology Team do complete some CBT interventions and talking therapies.

11.3. In HMP Bure, routine referrals will be screened and assessed within two working days. In HMP Littlehey, the target time for an assessment is 5 working days.

11.4. The table below shows the number of patients who were on the caseload of the Mental Health Team, as at September 2019. There was a lower percentage of patients on the caseloads of the primary and secondary care teams in HMP Littlehey.

Figure 1.1.14: Mental health caseload numbers.

Caseload	HMP Bure	HMP Littlehey
Primary Care Caseload	30 (5%)	38 (3%)
Secondary Care Caseload	19 (3%)	5 (<1%)

12. IDENTIFICATION

12.1. There are some differences in the approach of the mental health teams in the two prisons.

12.2. In HMP Bure, the Mental Health Team see all new arrivals to the prison at the point of reception. This allows patients with mental health difficulties to be identified at the earliest possible opportunity. The team can also address immediate action plans if patients are in crisis. Referrals are also received via the other usual routes (healthcare, prison staff etc.)

12.3. In HMP Littlehey, referrals are received from the healthcare reception screen, healthcare, wing staff, the offender management unit, and the programmes team.

12.4. Analysis of the mental health conditions identified at reception show that there are higher rates identified at HMP Bure. For example, in HMP Bure 17% of new receptions have a history of depression, compared to 9% in HMP Littlehey. It is possible that this is related to the presence of a mental health nurse at reception.

12.5. There is also a higher number of patients identified at reception in HMP Bure as having used mental health medication in the past.

12.6. In HMP Littlehey, the Mental Health In-reach Team run a weekly drop-in session on each wing where they can speak to prisoners who may have a mental health or wellbeing need. This has increased access to the team and helped reduce the time spent by the team on mental health assessments.

13. TRAUMA INFORMED SERVICES

13.1. 29% of prisoners report having experienced emotional, physical or sexual abuse as a child. Limited availability of trauma informed mental health services can lead to poor responses to this client group.[12]

12 PHE Toolkit.

13.2. Both prisons offered trauma informed interventions. In HMP Bure, both the Wellbeing Service and the Mental Health Team offered trauma focussed interventions. In HMP Bure, the Wellbeing Service focussed on singular traumatic events.

13.3. The Psychology Department at HMP Littlehey is trauma informed and provides compassion focused therapy.

13.4. In HMP Littlehey, patients with moderate needs relating to trauma were seen by the assistant psychologist. The clinical and principal psychologist provided one-to-one interventions for individuals with complex trauma needs. There were currently 7 patients awaiting to see the clinical and principal psychologists.

13.5. There is no EMDR[13] offered in either prison.

14. COMMON MENTAL HEALTH DISORDERS

14.1. Both prisons had high rates of patients on the QOF register for depression. In HMP Bure, 27% of patients were on the QOD register for depression, compared to 25% in HMP Littlehey.

14.2. The QOF register for depression in both prisons show that there were lower rates for over 60-year olds compared to other age groups. This does not tie in with research, which links poor health with depression.[14]

14.3. In HMP Bure, mild to moderate mental health issues, including depression, anxiety, low-level PTSD, and mood management are managed on the primary mental health case load. Patients can be held on this caseload if they are waiting for an intervention from the Wellbeing Team, who offer IAPT therapies.

14.4. In HMP Bure, 30% of the population were prescribed an antidepressant[15]. This data was not available for HMP Littlehey.

14.5. There were similar rates of prescribing in the two prisons for the following antidepressants: Mirtazapine and Sertraline

14.6. In HMP Littlehey, mental health practitioners agreed that the majority of patients are referred to the team for problems with anxiety, low mood, PTSD, stress, and emotionally unstable personality disorder. There are a number of groups run in the prison aimed at patients with common mental health difficulties. The more popular groups can have a wait time of approximately 3 to 4 months.

15. DEMENTIA

15.1. In HMP Bure, patients with suspected dementia can be given an initial assessment by the GP. Further assessments are completed by the Julian Hospital in Norwich. There are also dementia groups run by the Forget-me-not charity in the prison.

15.2. At the time of this assessment, there was one patient diagnosed with dementia in the prison.

15.3. In HMP Littlehey, the Mental Health In-reach Team and Healthcare are piloting a dementia pathway in the prison. The pilot will have been running for 6 months at the end of October 2019, when there is due to be a review.

- At the time of this assessment, all prisoners over the age of 65 will get a screen for dementia. There is a plan for this to be widened to cover all prisoners over the age of 50, including current residents.

[13] Eye Movement Desensitization and Reprocessing (EMDR) is a psychotherapy treatment that was originally designed to alleviate the distress associated with traumatic memories

[14] British Journal of Psychiatry, (2001), Hidden psychiatric morbidity in elderly prisoners

[15] Care UK (August 2019), Prescribing Quality Indicator Dashboard.

- Healthcare have access to an old age consultant psychiatrist who can complete consultations via Skype.
- In terms of the environment, the Mental Health In-reach Team are creating a dementia garden and there are plans for a choir and band for patients with dementia.

15.4. In HMP Littlehey, there were 2 residents with a confirmed diagnosis of dementia, with a further 8 awaiting assessment by the senior occupational therapist. There were 10 residents on the waiting list for the Cognitive Skills Therapy Group.

16. TRANSFERS

16.1. Below shows the number of mental health secure assessments[16] for the 12 months to June 2019 in comparison to the 12 months to June 2018, taken from the HJIPs.

16.2. The number of assessments in HMP Bure has decreased from 3 to 0 over the two periods. HMP Littlehey has also seen a decrease over the 2 periods from 7 to 4 assessments.

16.3. As a snapshot for June 2019, there were no patients awaiting second assessment[17] or awaiting transfer[18] in HMP Bure. In HMP Littlehey, there was 1 patient awaiting second assessment and 1 patient awaiting transfer.

Figure 1.1.15: Number of mental health secure assessments.

	HMP Bure			
Key Performance Indicator/Information Measure	YT June 2018	YT June 2019		
Mental Health Secure Assessment	3	0		

16.4. In HMP Bure there were no transfers for the 12 months to June 2019 compared to 6 for the previous period. Of the 6 transfers for the 12 months to June 2018, only 1 was completed within the recommended 14 days.

[16] Number of prisoners who received an initial psychiatric assessment, where transfer was deemed appropriate, under the terms of the Mental Health Act. NB. This refers to the number of initial assessments where a decision to create a formal referral was reached. Initial assessment is defined as that occurring in the originating location, prior to any referral decision.
[17] The number of patients awaiting 2nd assessment, where referral has been made, after being deemed suitable by prison assessment.
[18] Number awaiting MH transfer, deemed as appropriate following 2nd assessment.

17. OVERVIEW

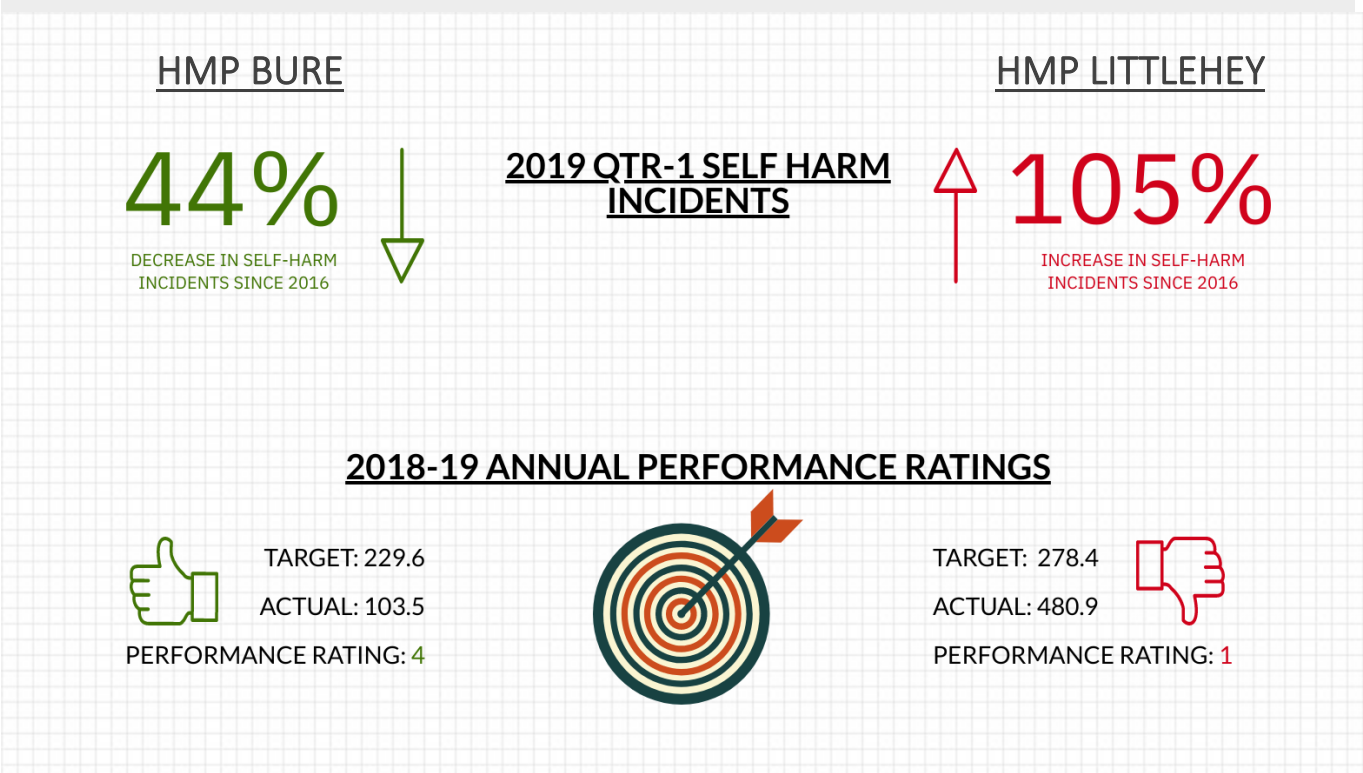
17.1. A range of indicators suggest that self-harm is more of an issue in HMP Littlehey than in HMP Bure.

17.2. In 2016, there were on average 9 self-harm incidents per month in HMP Bure. For 2018, this reduced to 6 per month; for Qtr-1 of 2019, this further reduced to 5 a month, which equates to a 44% decrease.

17.3. The Safer Custody Lead in the prison stated that since March 2019, there had been three new prisoners transferred into the prison who have had multiple self-harm incidents. It was reported that in July 2019 there were 46 self-harm incidents.

17.4. The 2018-19 annual performance ratings give a rate of 481 self-harm incidents per 1000 prisoners[19] for HMP for Littlehey compared to 104 in HMP Bure. The rate in HMP Littlehey far exceeds the set target resulting in a poor performance rating. In contrast, HMP Bure was well within the target resulting in a top performance rating.

17.5. Across a range of self-harm related READ codes, the rates are higher in HMP Littlehey, although codes relating to thoughts and history of attempted suicide is higher in HMP Bure. This may be linked to the higher rates of self-harm incidents in HMP Bure that required hospital attendance.



[19] See Annual Performance Ratings for full definition.

18. ACCT

18.1. In HMP Bure, there were 5 open ACCT documents at the time of this assessment. There was good cooperation between the Mental Health Team and the Safer Custody Team regarding the management of those on an open ACCT document.

19. POLICIES

19.1. There is a Suicide Prevention and Self-Harm Management Strategy in HMP Littlehey.

20. OVERVIEW

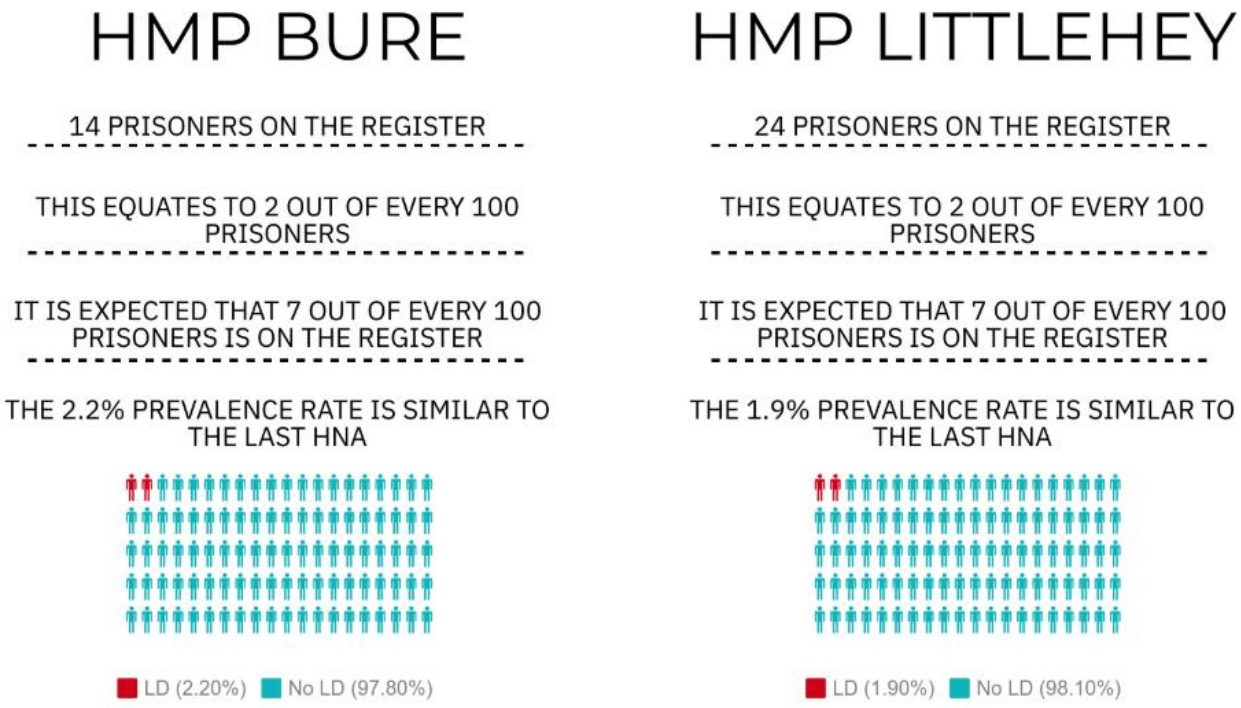
20.1. In both prisons, patients with learning disabilities are managed by the Mental Health Team.

20.2. There are no learning disability specialist nurses in either prison.

20.3. There is no specific learning disabilities policy in either prison.

20.4. In both prisons, patients with learning disabilities have an annual health check completed.

Figure 1.1.17: Overview of learning disabilities across the two prisons.



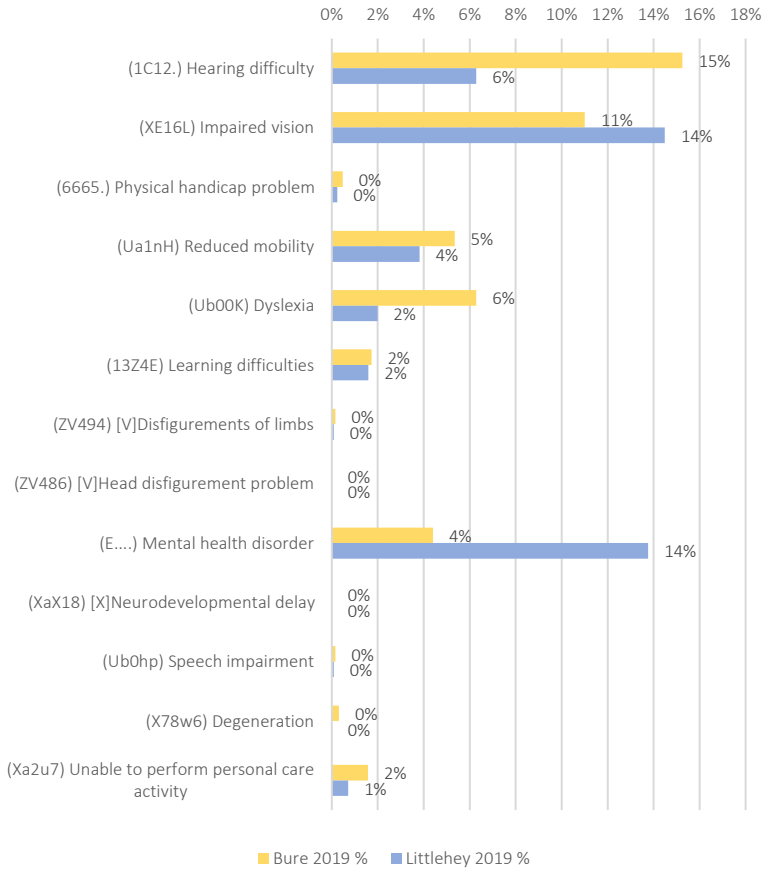
21. RECEPTION SCREEN

21.1. As part of the reception screen, there is a section which covers 'disabilities'. The following chart shows the rate for the READ codes associated with this area for the current population.

21.2. The rate of prisoners recorded with '(E....) Mental health disorder' is significantly higher in HMP Littlehey than HMP Bure, despite a lower rate of prisoners on the mental health register in HMP Littlehey.

21.3. Issues relating to hearing difficulty and impaired vision are two of the more prevalent social care related READ codes used. The rate of prisoners recorded with reduced mobility is similar across the two prisons at 4-5%.

Figure 1.1.18: Prevalence of READ codes associated with the disabilities section of the reception screen.



Read code	Bure 2019 #	Littlehey 2019 #
(1C12.) Hearing difficulty	97	79
(XE16L) Impaired vision	70	182
(6665.) Physical handicap problem	3	3
(Ua1nH) Reduced mobility	34	48
(Ub00K) Dyslexia	40	25
(13Z4E) Learning difficulties	11	20
(ZV494) [V]Disfigurements of limbs	1	1
(ZV486) [V]Head disfigurement problem	0	0
(E....) Mental health disorder	28	173
(XaX18) [X]Neurodevelopmental delay	0	0
(Ub0hp) Speech impairment	1	1
(X78w6) Degeneration	2	0
(Xa2u7) Unable to perform personal care activity	10	9

22. SOCIAL CARE PATHWAY

22.1. There were clear social care pathways in both prisons.

22.2. Norfolk County Council for HMP Bure, and Cambridgeshire County Council for HMP Littlehey, had identified a number of social care assessors to complete assessments.

22.3. In HMP Bure, care packages are delivered by Care UK. In HMP Littlehey, a private care agency provides carers to deliver care.

22.4. In HMP Littlehey, there are prisoner carers who assist prisoners with non-personal care tasks. A bell system has been set up, so that a prisoner can contact another prisoner directly if they need help.

23. HEARING DIFFICULTIES

23.1. Both prisons had a significant number of patients with a hearing difficulty.

23.2. There was no visiting audiology service in either prison.

23.3. Patients were waiting a long time for a community audiology appointment. In HMP Littlehey, the researchers met a patient who had been waiting for an audiology appointment for a year and a half.

23.4. In HMP Littlehey, healthcare trainers had been given training in the servicing and cleaning of hearing aids. In HMP Bure, a healthcare assistant was liaising with the National Deaf Association to arrange training days for the maintenance of hearing aids.

24. DEATHS BY NATURAL CAUSES

24.1. The population of HMP Littlehey is almost twice that of HMP Bure, however the number of deaths over the last few years is comparatively higher.

24.2. For the 12 months to June 2018 there were 11 deaths by natural causes in HMP Littlehey compared to 3 in HMP Bure. For the 12 months to June 2019, there were 6 in HMP Littlehey and 0 in HMP Bure.

24.3. In HMP Littlehey, there is a visiting palliative care specialist who visits the prison one day a week. The specialist was working with all patients who required palliative care, including those with cancer. The specialist worked closely with patients and their families. At the time of this assessment, there were 20 patients on the palliative care register.

25. SERVICE PROVISION

25.1. Phoenix Futures provide psychosocial services in both HMP Bure and HMP Littlehey.

25.2. The teams in both prisons operate an open-referral process including self-referrals. The Psychosocial Team also see every new arrival to the prison as part of the prison induction. This is an opportunity to deliver harm minimisation advice and provide information about the service.

25.3. HMP Littlehey had recently updated their Drug Strategy. At the time of this assessment, the Drug Strategy document in HMP Bure was being updated and was not available for inclusion in this assessment.

25.4. There were low numbers of patients with a clinical substance misuse need in both prisons; at the time of this assessment, there were 2 patients in HMP Bure and 11 in HMP Littlehey. Prescribing was managed by nurse prescribers within the Primary Care Team.

25.5. Need for Naloxone and Naltrexone was low.

25.6. In HMP Bure, a range of psychosocial groups are run. Groups include:

- Early Recovery Programme
- Relapse Prevention Programme
- Emotional Management Programme
- Healthy Coping and Network of Support
- Developing Effective Communication (a group for those prisoners who have been in custody for a long time and must communicate with other agencies including the Parole Board)
- Moving on Programme (for those who are being released or moving on to an open prison)
- Phoenix Recovery Gym Programme (12 sessions, including 9 active gym sessions and work on sleep hygiene, nutrition, and stress management)
- Mindfulness programme (run by a trained peer supporter).

26. MANDATORY DRUG TESTS

26.1. The nature of the populations of HMP Bure and HMP Littlehey means that there is a much lower percentage of positive random mandatory drug tests than in the rest of the prison population.

26.2. In the 12 months to March 2019, the rate of positive random mandatory drug tests in HMP Bure was 1.8%; the rate in HMP Littlehey was 1.4%. The national rate is 10.4%.

26.3. Positive tests for opiates make up the majority of positive tests, however, numbers are still small; 5 positive tests in HMP Bure and 10 in HMP Littlehey. Staff said that the majority of positive opiate tests related to misuse of medication.

27. DRUG FINDS

27.1. Both prisons had low numbers of drug finds.

27.2. There has been a low number of drug finds in HMP Bure, with only one recorded in the prison.

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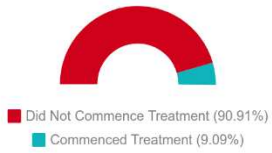
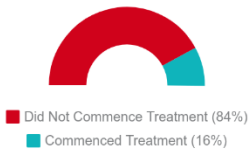
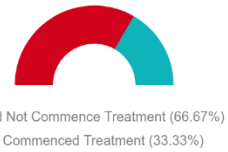
28. CONTINUITY OF CARE

28.1. In HMP Bure, there were 22 transfers to the community during the analysed time period, of which only 2 (9%) were recorded as commencing treatment. This is low when compared to prisons of a similar role which stands at 45%, and nationally which is 34%.

28.2. In HMP Bure, there were 25 transfers to another prison during the analysed time period, of which only 4 (16%) were recorded as commencing treatment. This is low when compared to prisons of a similar role which stands at 41%, and nationally which is 55%.

Figure 1.1.19: Continuity of care.

Transfers to community.		Transfers to prison.	
HMP Bure	HMP Littlehey	HMP Bure	HMP Littlehey
			

29. INTRODUCTION

29.1. In HMP Bure, long-term condition care is still being developed. There is a plan to nominate a lead nurse for each long-term condition. Study days for each condition were planned for September 2019.

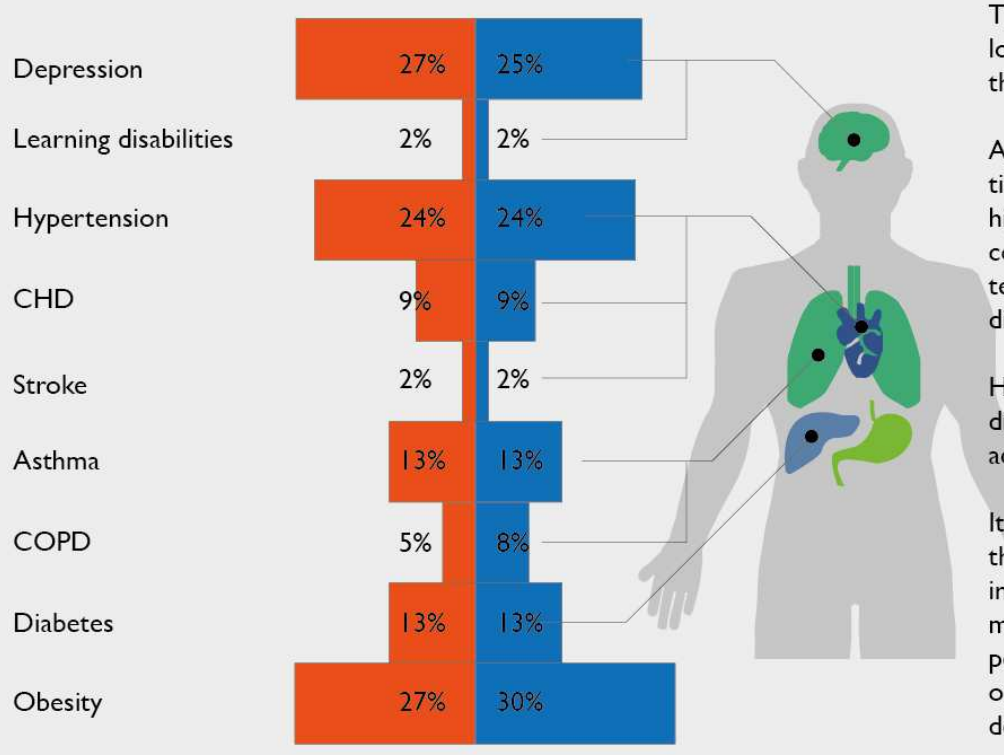
29.2. In HMP Bure, there is a visiting advanced nurse practitioner who sees patients and completes some long-term condition management.

29.3. In HMP Bure, healthcare is delivered from a main healthcare unit. There is also a clinic space located on residential unit 7. The room is isolated and requires two healthcare staff to be present in the room for it to be used.

30. HEALTH PROMOTION

30.1. There were healthcare representatives in both prisons.

OVERVIEW OF LONG-TERM CONDITIONS



The prevalence of long-term conditions across the two prisons are similar.

A key feature of the population of both prisons are the high rates of heart related conditions such as hypertension and coronary heart disease.

High rates of obesity and diabetes are also present across both populations.

It is also worth highlighting the high rates of depression in the prison, with approximatey a quarter of the popoulation in both prisons on the QOF register for depression.

31. ASTHMA

31.1. In HMP Bure, there was plan for a nurse to undergo training for the treatment of patients with asthma. In the interim, patients with asthma were being managed by the GP.

31.2. Spirometry was completed in both prisons.

31.3. Both prisons had a higher than expected prevalence of asthma identified at reception and on the QOF register.

31.4. In HMP Bure, the QOF scores indicated that annual reviews for patients with asthma are not always completed. This was related to a lack of suitably trained nursing staff over the past 12 months.

32. CANCER

32.1. In HMP Bure, there were no patients undergoing cancer treatment at the time of this assessment, however there were 19 (2.9%) patients on the QOF cancer register, compared to 24 (3.7%) for the 2016 HSCNA.

32.2. In both prisons, two-week referrals were classed as urgent referrals and took priority over routine appointments.

32.3. In HMP Bure there were links with a local hospice.

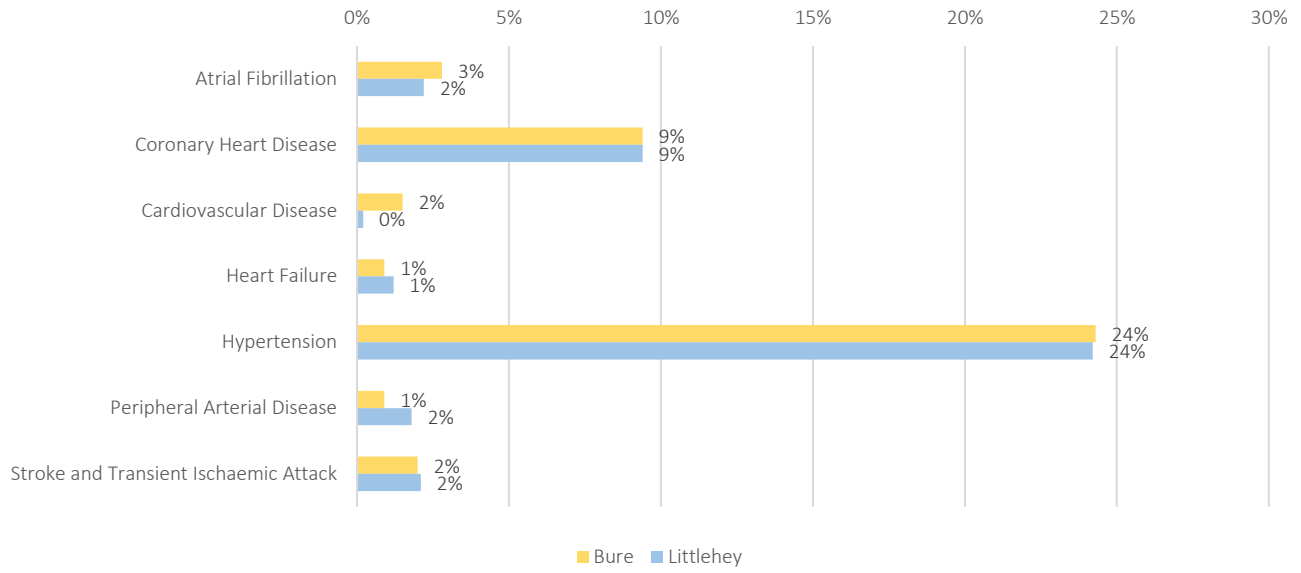
33. CARDIOVASCULAR DISEASE

33.1. The prevalence of patients on CVD related QOF registers was similar across both prisons.

33.2. Around a quarter of the population in the two prisons were listed on the hypertension register, compared to 14% nationally.

33.3. 9% of the population of both prisons are listed with coronary heart disease compared to 3% nationally.

Figure 1.1.21: Prevalence of the QOF registers associated with cardiovascular disease.



33.4. The analysis comparing the CVD QOF register against 2016 shows a mixed picture, notably an increase for hypertension and coronary heart disease, and a decrease for the rate of those on the cardiovascular disease register.

33.5. In HMP Bure, there is a nurse with a special interest in cardiovascular disease. The nurse manages patients with heart disease and hypertension.

33.6. There are no cardiac rehabilitation clinics in either prison. A specialist physiotherapist had delivered a cardiac rehabilitation programme in HMP Littlehey, however this service was discontinued due to a lack of engagement from patients.

33.7. Both prisons show generally good performances across a range of QOF indicators relating to cardiovascular disease.

34. COPD

34.1. COPD coverage is limited in the PHE Toolkit and does not provide an estimated prevalence rate.

34.2. Despite having a similar age profile, there is a higher rate of COPD in HMP Littlehey (7.7%) compared to HMP Bure (5.1%).

34.3. In HMP Bure, there was a similar rate of patients on the QOF register for COPD as there was in 2016. HMP Littlehey had seen an increase (5.1% to 7.7%).

34.4. In HMP Bure, there was no lead respiratory nurse. A study day was planned for September 2019. While nursing staff were being upskilled, the condition was managed by the GP.

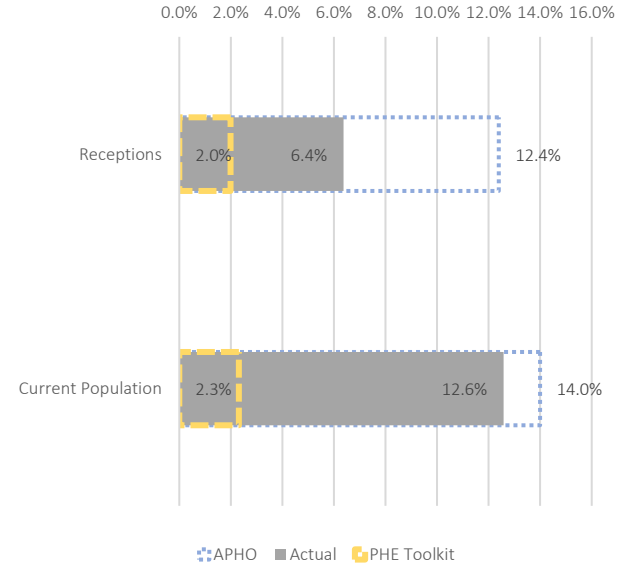
35. DIABETES

35.1. The following charts include the expected prevalence rates calculated from both the PHE Toolkit and the APHO model. The key points from the analysis are:

- The expected prevalence calculated from the APHO model is significantly higher than the PHE Toolkit.
- The expected prevalence across the two prisons is similar.

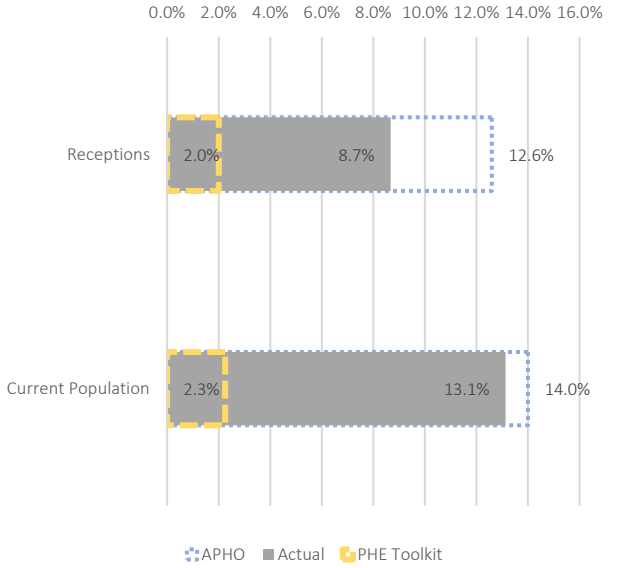
- The expected prevalence of the current populations is slightly higher than those coming through reception, which is due to the difference in the turnover rates of the different age groups.
- The actual prevalence in both prisons show a higher rate for the current population compared to those coming through reception. This could indicate that those with diabetes are not being identified at reception or are developing diabetes once they are in prison.
- The actual prevalence on the QOF register is slightly lower than the expected prevalence.

Figure 1.1.22: Expected and actual prevalence of diabetes in HMP Bure.



	Expected Prevalence (PHE)	Expected Prevalence (APHO)	Actual Prevalence
Receptions (YT Aug 2019)	7	47	24
QOF (Sep 19)	15	89	80

Figure 1.1.23: Expected and actual prevalence of diabetes in HMP Littlehey.



	Expected Prevalence (PHE)	Expected Prevalence (APHO)	Actual Prevalence
Receptions (YT Aug 2019)	12	74	51
QOF (Sep 19)	28	176	165

35.2. In HMP Bure, patients with diabetes are monitored by the GP. There is a plan in place for a nurse to lead on the condition management, however diabetes training had not taken place in the prison at the time of this assessment.

35.3. There is a structured diabetes education course (DESMOND[20]) run in HMP Littlehey. Patients found the course useful, however they felt that they were limited in their ability to follow the advice due to the limited availability of a healthy diet.

35.4. In HMP Bure, approximately half of those on the diabetes QOF register had had a foot examination. This compared with 85% in HMP Littlehey.

36. EPILEPSY

[20] DESMOND is the acronym for Diabetes Education and Self Management for Ongoing and Newly Diagnosed.

36.1. The expected prevalence for both prisons is 2.0%. Looking at the actual prevalence in HMP Bure, both those identified at reception and those on the QOF register, at 2.4-2.5%, is slightly higher than the expected rate.

36.2. In both prisons, the GP leads on the care of patients with epilepsy.

36.3. Healthcare can make recommendations to the prison regarding where a patient is located. This means that those with epilepsy can be located in a shared cell.

37. OBESITY

37.1. Of the 636 current prisoners in HMP Bure, 602 (95%) had a BMI recorded after their arrival at the prison. This is a much higher rate than the last HNA where only 360 (56%) of the 645 prisoners had a BMI recorded. This is reflected in the low rate of prisoners on the obesity register in 2016.

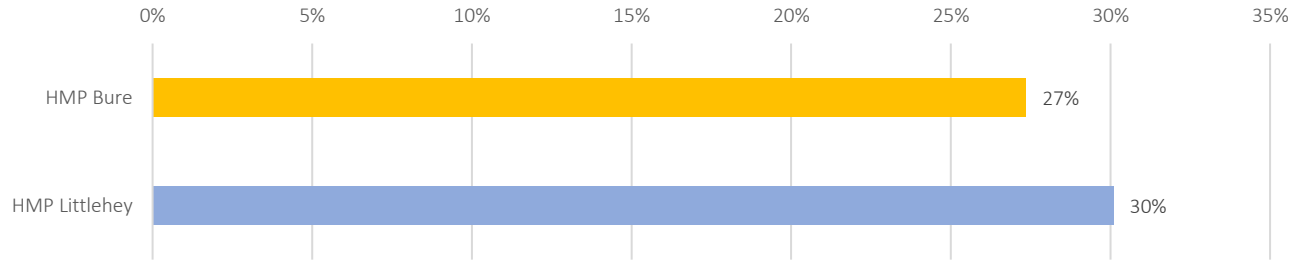
37.2. The analysis of the QOF register shows that the rate of obesity is similar across both prisons, however the low rate of BMI recorded in HMP Littlehey may indicate the true rate of obesity is higher.

37.3. Of note is the high rate of obesity amongst older patients in HMP Littlehey. 39% of over 60s are on the QOF obesity register, compared with 31% in HMP Bure.

Figure 1.1.24: Analysis of the QOF obesity register.

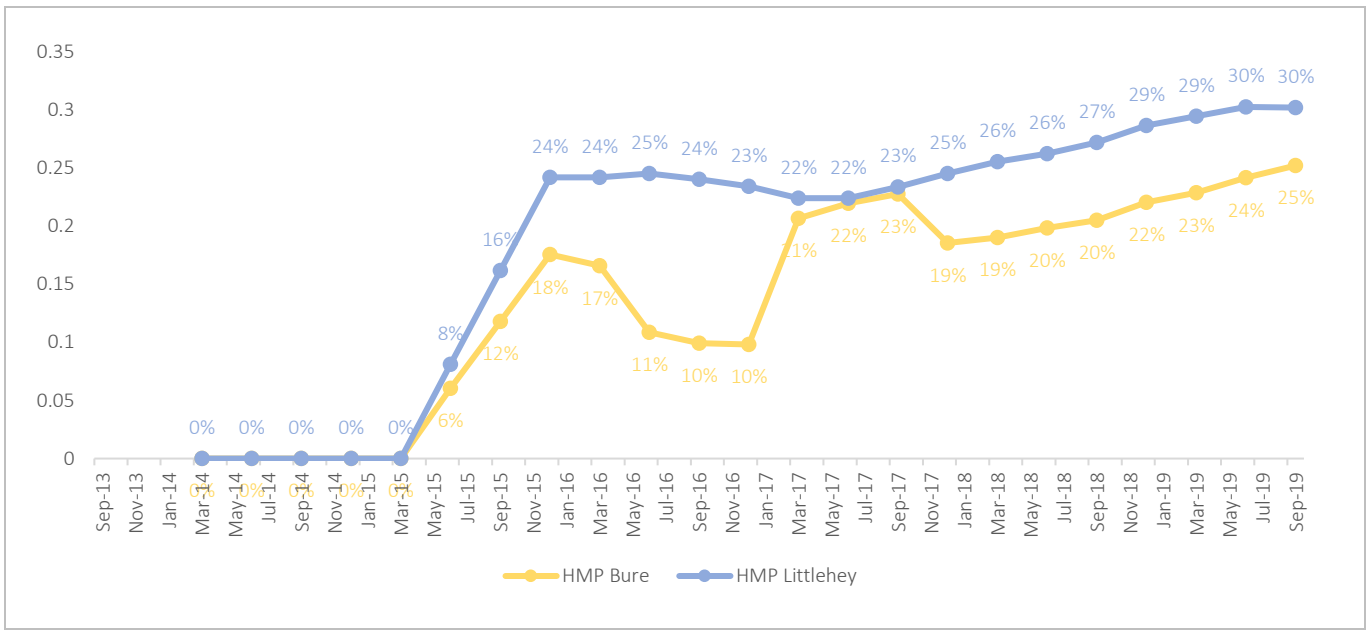
HMP BURE	HMP LITTLEHEY

Comparison of the QOF obesity register across the two prisons.



37.4. Below shows the long-term trend analysis of the obesity QOF register. It can be observed that the rate of obesity has seen a steady increase over the last 18 months. As highlighted on the previous page, the increase in better recording of the BMI for prisoners may be a reason for the increase on the OQF register.

Figure 1.1.25: Long-term trend analysis of the obesity QOF register; rolling 3 month average.



37.5. There are no weight monitoring clinics run in HMP Bure. Weight loss sessions are available in the gym.

37.6. In HMP Littlehey, Healthcare run health monitoring sessions. Prisoner Health Representatives also have access to weighing scales.

PHARMACY

38. OVERVIEW

38.1. In both prisons, medication is dispensed by an offsite pharmacy. In HMP Bure, medication is dispensed by Sigma Pharmaceuticals, in HMP Littlehey, Lloyds Pharmacy.

38.2. There is no pharmacist provision in HMP Bure. This means that the pharmacy is not involved in medication reconciliation (RPS Standard 1.1) or pharmacy led clinics (Standard 8.3).[21]

38.3. Minor ailment schemes are present in both prisons.

ESCORTS AND BEDWATCHES

39. OVERVIEW

39.1. The monthly average cancelations have seen a decrease in HMP Bure whilst HMP Littlehey has seen a big increase.

COMMUNICABLE DISEASES

[21] RPS (2017), *Professional Standards for optimising medicines for people in secure environments*.

40. HEPATITIS

40.1. In both prisons, patients are offered a blood test as part of the secondary health screen. This includes a test for hepatitis C.

40.2. In HMP Bure, there is a visiting hepatology nurse who manages patients undergoing hepatitis C treatment.

41. SEXUAL HEALTH

41.1. There is no visiting GUM specialist in HMP Bure. Sexual health problems are managed by nursing staff. There is an option to refer patients to the community if they need specialist help.

41.2. Condoms and dental dams are available for patients to request in HMP Littlehey. Condoms are available in HMP Bure.

PRISON OVERVIEW

OVERVIEW

	HMP BURE
YEAR BUILT	HMP Bure opened in 2009.
PRISON TYPE INCLUDING ROLE	HMP Littlehey is a category C training prison holding men convicted of a sexual offence.
HISTORICAL CHANGES	HMP Bure is built on part of the former RAF Coltishall site, seven miles north of Norwich. Constructed in 2009, the prison is a mix of new buildings and converted RAF accommodation and Service buildings. A new unit, housing 120 prisoners, was constructed in September 2013.
RESIDENTIAL UNITS AND DESCRIPTION	There are 7 residential units. The majority of cells are single occupancy. Residential unit 7 holds prisoners with greater health needs. All cells have integral sanitation and showers and one is wheelchair accessible.

FUTURE CHANGES

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

HMP BURE	
CAPACITY OF THE PRISON – CAN THE PRISON PHYSICALLY HOLD ANY MORE PRISONERS?	
There are a number of factors that could increase the capacity of a prison. Firstly, is there capacity within the existing units for more prisoners to be housed? There is a mixture of single and double cells in both prisons. It is possible that the single cells could be converted to double cells; however, there were no plans for this to happen at the time of this HSCNA. In HMP Bure, the prison was carrying extra places due to cells on residential block 7 being doubled. Secondly, is there any opportunity for the prison to expand? Both prisons have a large amount of external space which could conceivably be built upon; however, there were no plans for this to happen. Any increase in capacity would depend on NOMS policy, funding, and planning approval.	
PRISON RECONFIGURATION	
A reconfiguration of the prison could lead to changes in the demographics of the population. Prison reconfiguration can be driven by wider prison reorganisation plans. Reconfiguration can change the function of prisons, which in turn will impact on the demographics of the population. At the time of this HSCNA, there were no plans to change the roles of the prisons.	

CAPACITY

Figures 1.2.1 and 1.2.2 provide a summary of the Certified Normal Accommodation (CNA[22]), the operational capacity, and the population as at September 2019 for HMP Bure and HMP Littlehey. In both prisons, the population exceeds the In-Use CNA6 which is 604 in HMP Bure and 1154 in HMP Littlehey.

Figure 1.2.3 shows the population size of HMP Bure and HMP Littlehey against all prisons in England and Wales. This illustrates the difference in population size of the two prisons, with HMP Littlehey ranking in the top 10 prisons in England & Wales.

Figure 1.2.1: Population numbers of HMP Bure; September 2019.[23]

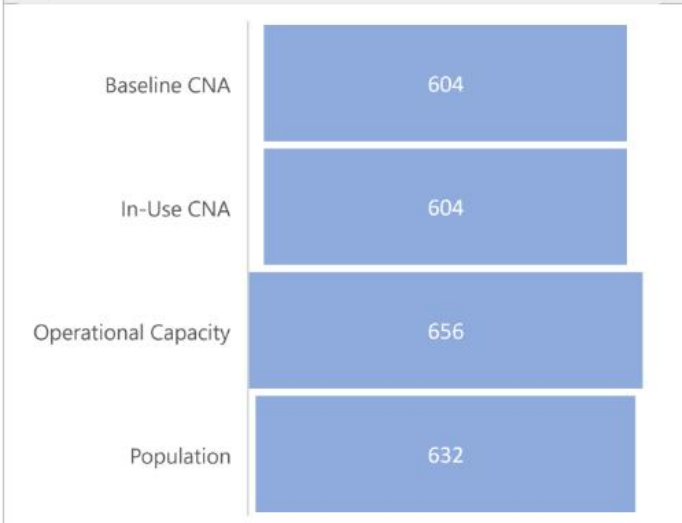
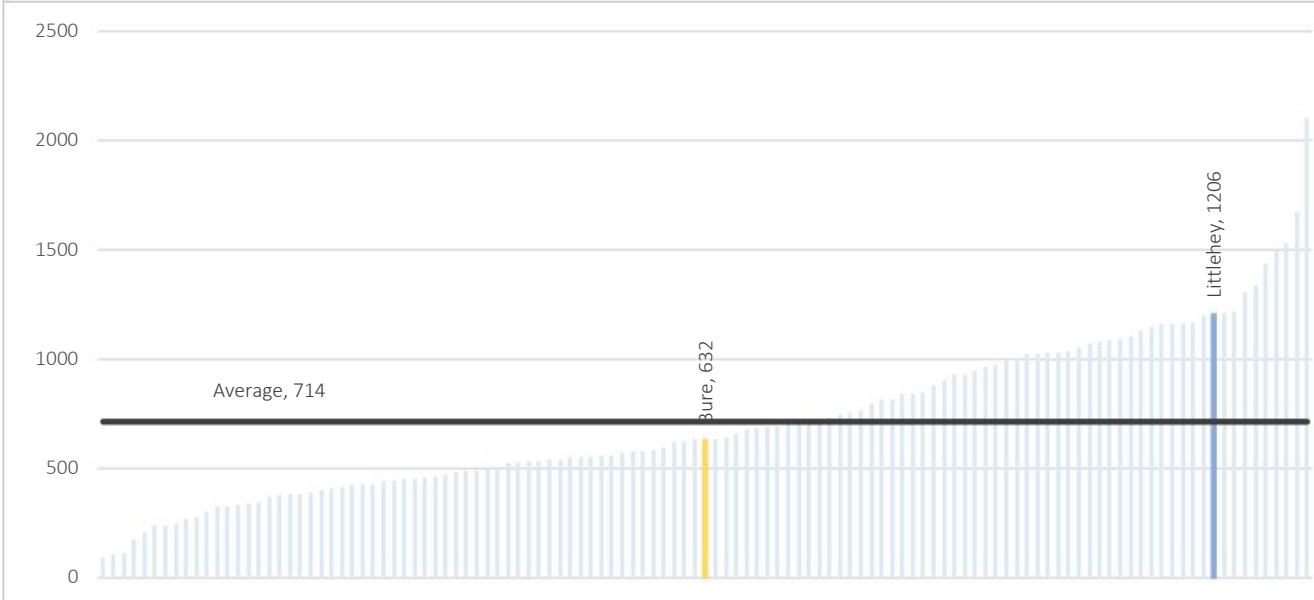


Figure 1.2.3: The population size of HMP Bure and HMP Littlehey ranked against all prisons in England and Wales.[24]

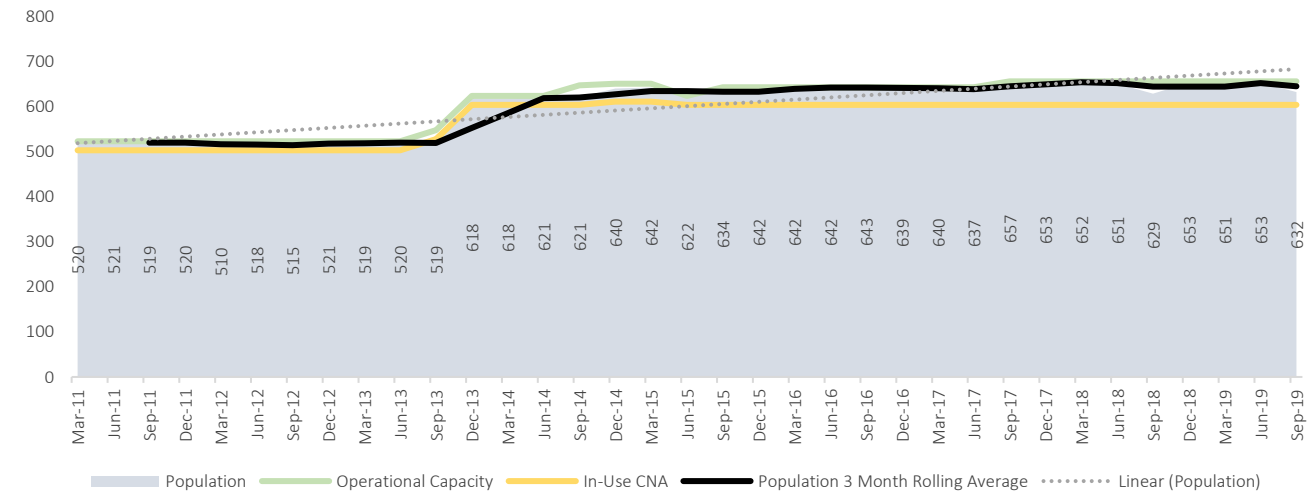


[22] Certified Normal Accommodation (CNA), or uncrowded capacity, is the Prison Service's own measure of accommodation. CNA represents the good, decent standard of accommodation that the Service aspires to provide all prisoners.
[23] https://www.gov.uk/government/statistics/prison-population-figures-2019.
[24] Ibid.

LONG-TERM TREND

The following figures shows the long-term population trends across HMP Bure and HMP Littlehey. The population in HMP Bure has remained relatively stable over the last year at around 640 prisoners. The population increased by approximately 100 in 2013 following the opening of a new wing.

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



The figures below show the percentage of prisoners held in crowded accommodation broken down by long-term trends and a 2018-19 comparison against other prisons.[25]

Figure 1.2.6: Long-term trend of prisoners held in crowded accommodation; %.

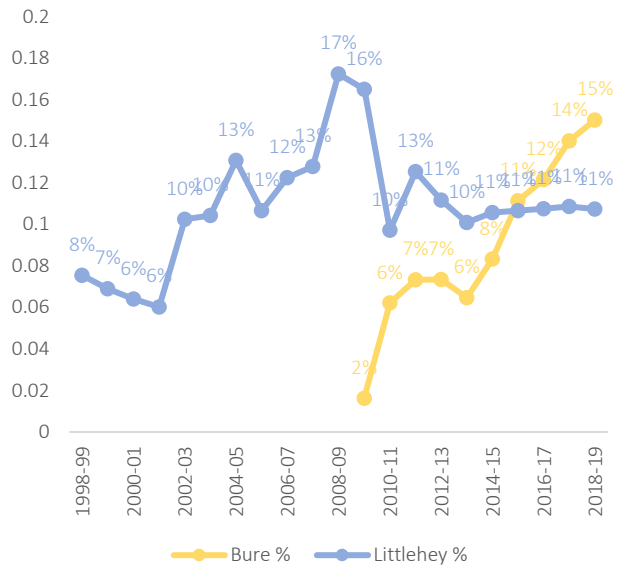
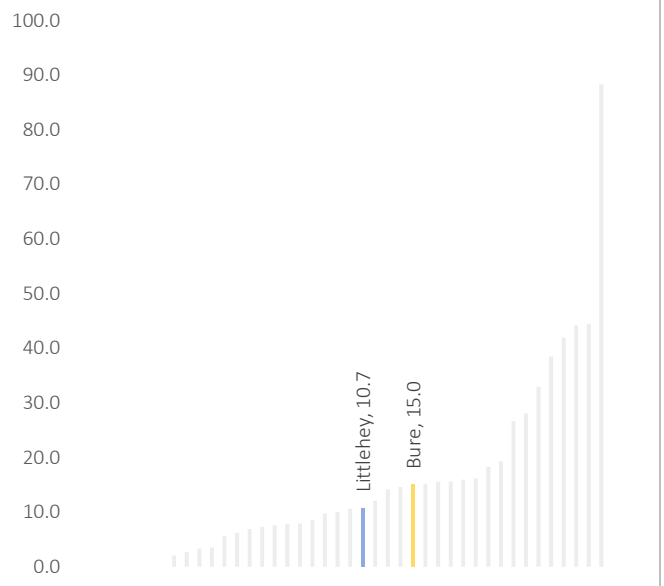


Figure 1.2.7: 2018-19 snapshot comparison against prisons of a similar function.



The following table shows the actual number of prisoners held in crowded accommodation as a snapshot at year-end, 2012-13 to 2018-19.

Figure 1.2.8: Total number of prisoners held in crowded accommodation, 2012-13 to 2018-19.

Prison	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
HMP Bure	38	36	53	71	78	91	97

25 Source: NOMS - https://www.gov.uk/government/statistics/annual-hm-prison-and-probation-service-digest-2018-to-2019

LENGTH OF STAY

AVERAGE LENGTH OF STAY

For the current population, both the average length of stay and median length of stay are higher in HMP Littlehey compared to HMP Bure.

In both prisons, the average length of stay is longer than the median length of stay. This is due to a small number of prisoners who have a comparatively longer length of stay.

Figure 1.2.9: Length of stay; current population.

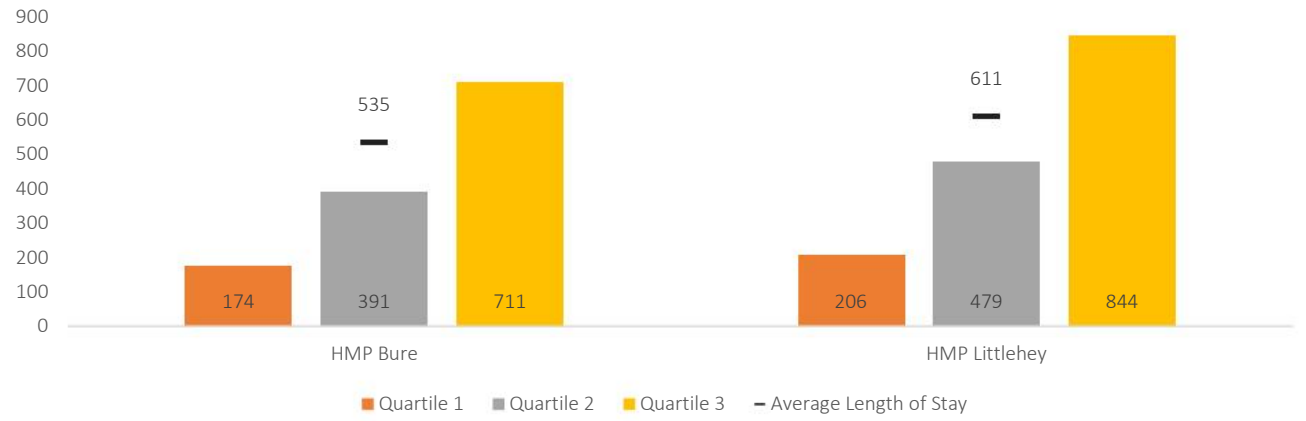
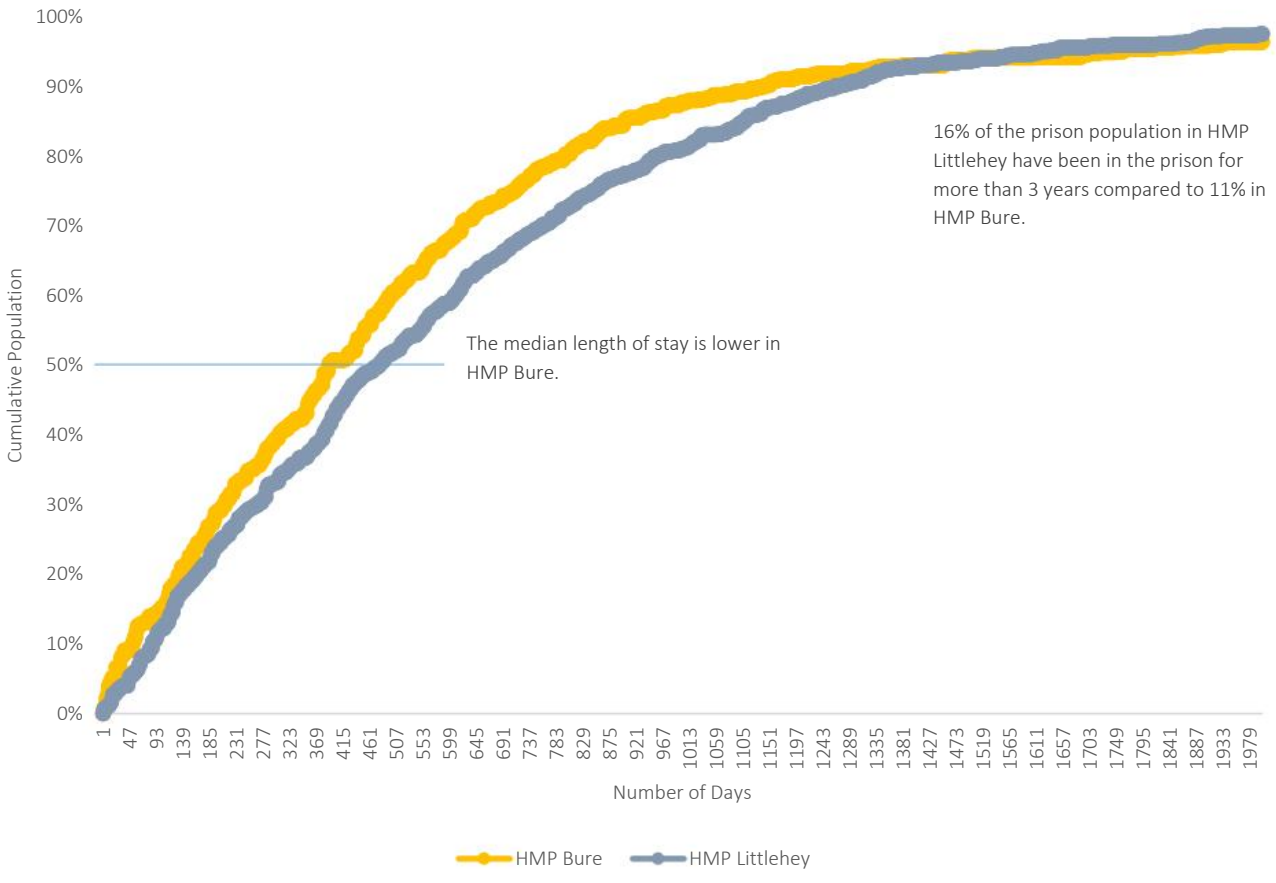


Figure 1.2.10: Length of stay; current population by cumulative distribution.



The analysis by age shows that there is a correlation in the length of stay: the older age groups report a longer average length of stay compared to the younger age groups. Comparing the two prisons show similar length of stay for most age groups except for the 30-39 and 60+ age groups, which is longer in HMP Littlehey.

An alternative method of analysing the average length of stay is looking at those that left the establishment as shown in figure 1.2.13 and figure 1.2.14.

Figure 1.2.11: Average length of stay; current population by age.

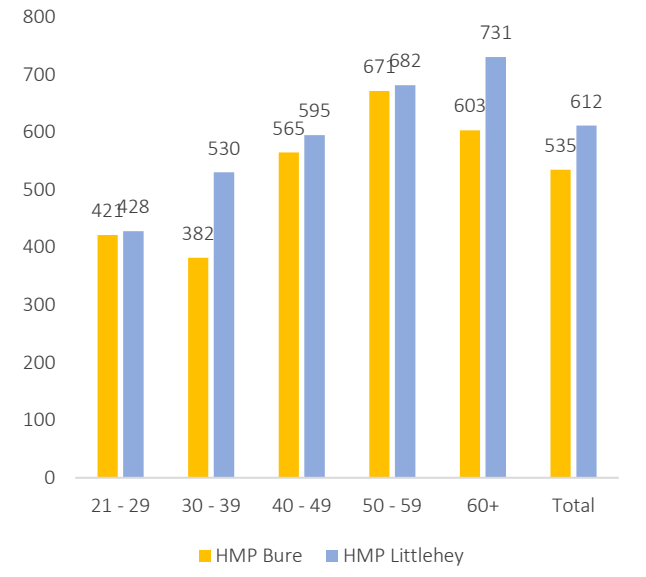


Figure 1.2.12: Average length of stay; current population by ethnicity.

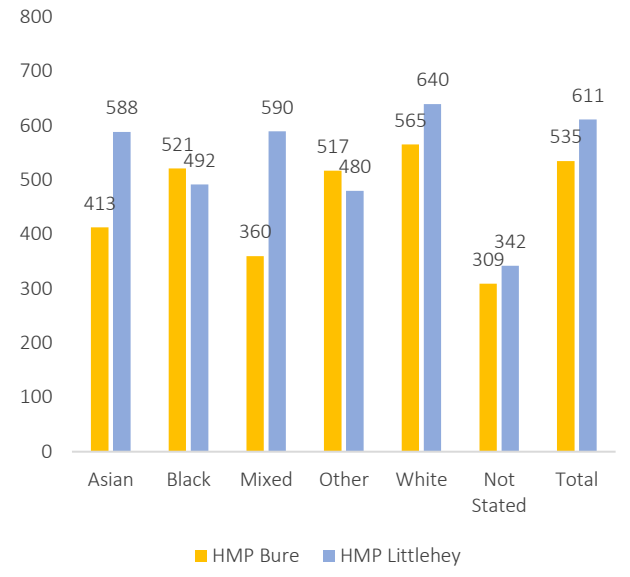


Figure 1.2.13: Average length of stay; deductions by year in HMP Bure.

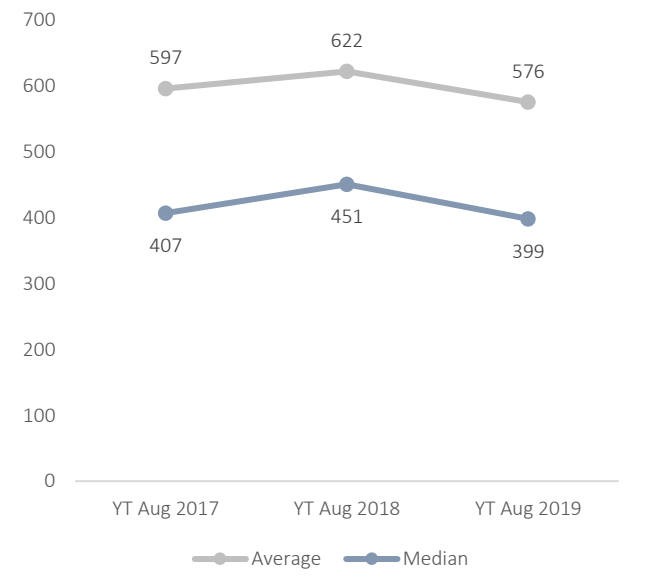
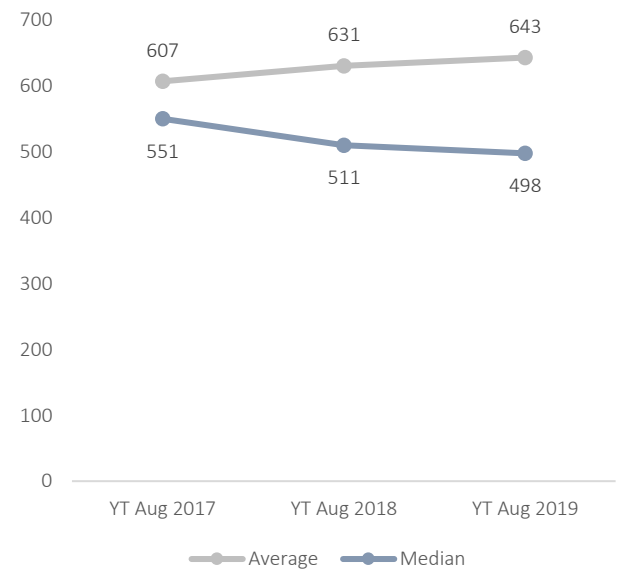


Figure 1.2.14: Average length of stay; deductions by year in HMP Littlehey.



RECEPTIONS AND TURNOVER RATE

The turnover rate is the number of times each place (operational capacity) is used per year (number of receptions). The PHE Toolkit states that 'Health needs in a prison that has a turnover of 2 or 3 will have a higher volume of need than would be apparent from a snapshot of the prison population'.

The turnover rate in HMP Littlehey is slightly lower than that of HMP Bure, and is low in the context of the PHE Toolkit definition.

Figure 1.2.15: Number of receptions[26] in HMP Bure over the past 3 years.

HMP Bure	YT Aug 2017	YT Aug 2018	YT Aug 2019
Operational Capacity	646	656	656
Receptions	399	429	377
Turnover Rate	0.6	0.7	0.6

Figure 1.2.16: Number of receptions[27] in HMP Littlehey over the past 3 years.

HMP Littlehey	YT Aug 2017	YT Aug 2018	YT Aug 2019
Operational Capacity	1220	1220	1220
Receptions	666	670	588
Turnover Rate	0.5	0.5	0.5

[26] Based on registration dates recorded on SystmOne.
[27] Based on registration dates recorded on SystmOne.

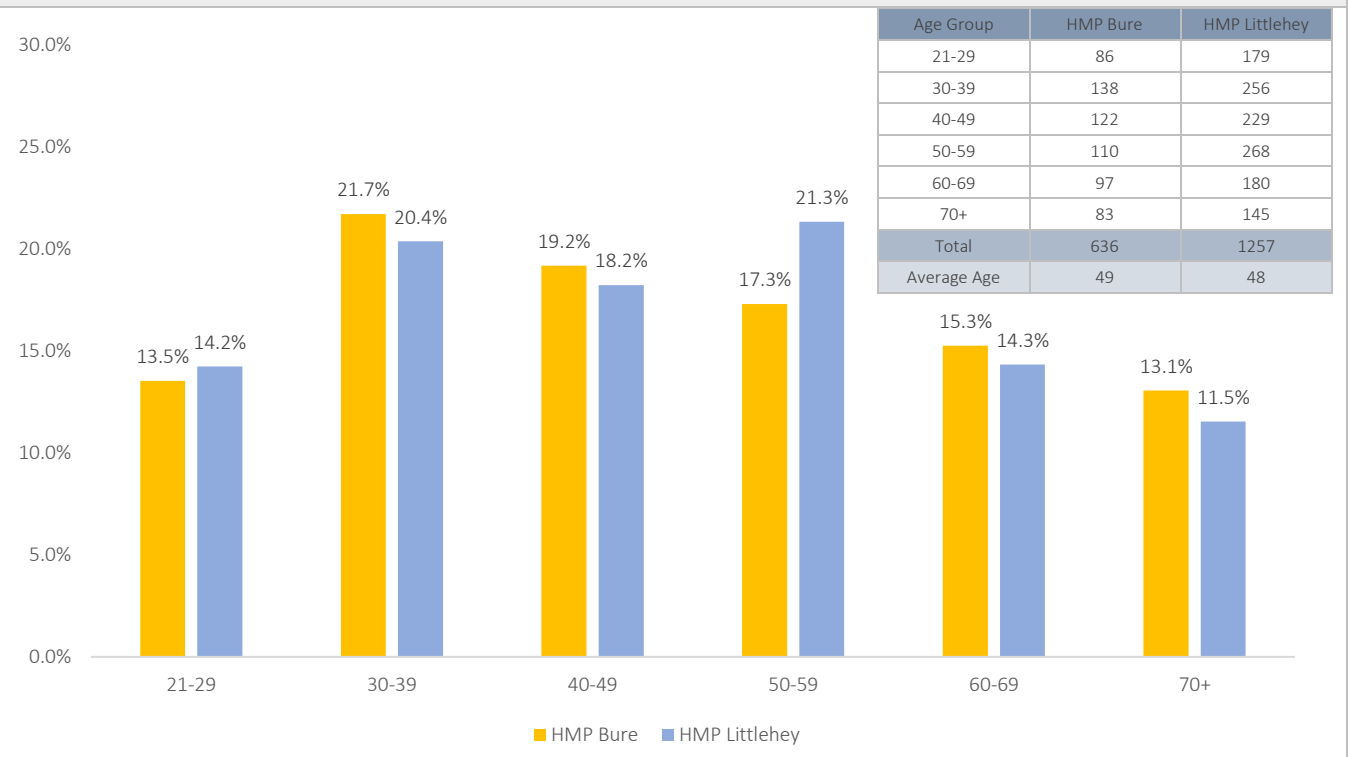
AGE

Figure 1.2.17: Overview of the age demographics.

HMP BURE	HMP LITTLEHEY

The age demographics of the two prisons are similar when analysed by 10-year age bands. The main notable difference is that there is a higher rate of 50-59 years olds in HMP Littlehey, which is offset by slightly higher rates across most of the other age groups in HMP Bure.

Figure 1.2.18: Snapshot population as at September 2019.[28]



Age Group	HMP Bure	HMP Littlehey
21-29	86	179
30-39	138	256
40-49	122	229
50-59	110	268
60-69	97	180
70+	83	145
Total	636	1257
Average Age	49	48

46% of the population in HMP Bure are over the age of 50, which is the same as that reported in 2016. However, within this age group there have been some changes, with a decrease seen in the 50-59 age group and an increase in the 70+ age group.

Figure 1.2.19: Change in age demographics when comparing 2019 against 2016.

Age Group	HMP Bure				HMP Littlehey			
	2016 S1	2019 S1	# Change	% Change	2016 S1	2019 S1	# Change	% Change
21-29	93	86	-7	-8%	229	179	-50	-22%
30-39	120	138	18	15%	249	256	7	3%
40-49	138	122	-16	-12%	294	229	-65	-22%
50-59	131	110	-21	-16%	257	268	11	4%
60-69	95	97	2	2%	148	180	32	22%
70+	68	83	15	22%	104	145	41	39%
Total	645	636	-9	-1%	1281	1257	-24	-2%

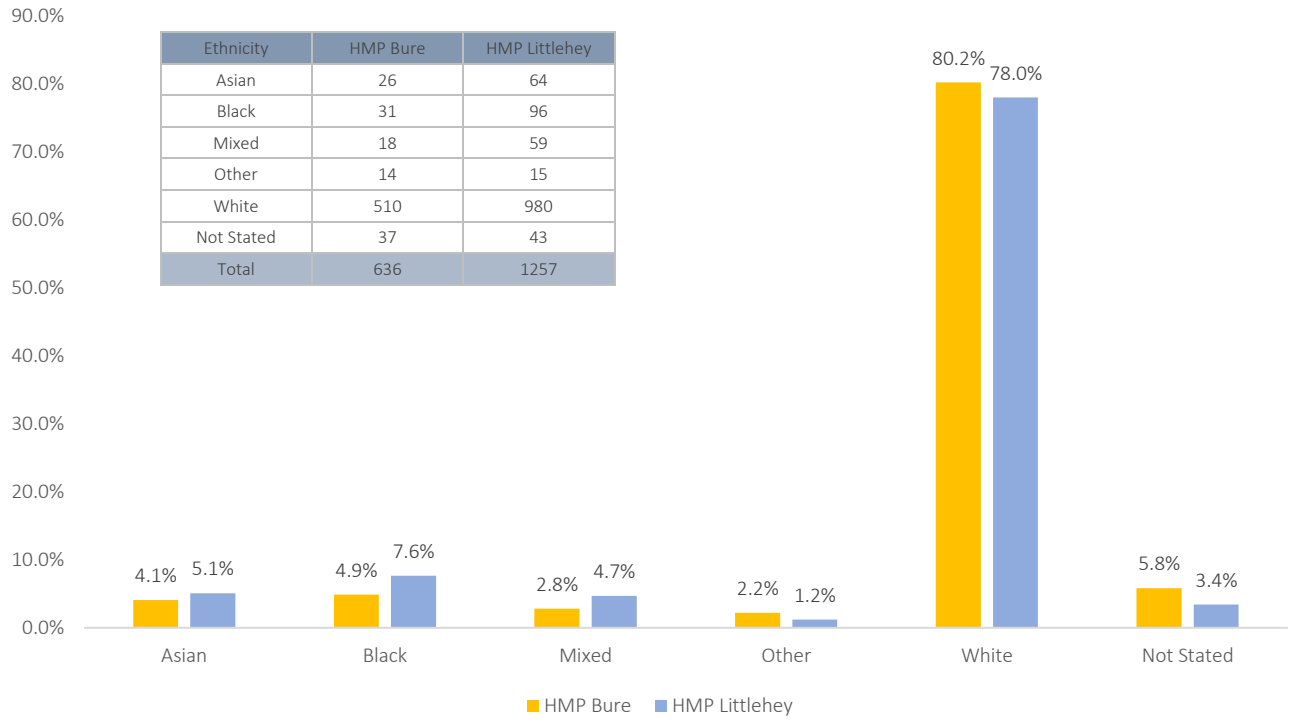
[28] SystmOne Data.

ETHNICITY

The rate of prisoners recorded as being of White ethnicity is similar across both prisons, at around 80%.

Figure 1.2.20: Snapshot population as at September 2019.

Ethnicity	HMP Bure	HMP Littlehey
Asian	26	64
Black	31	96
Mixed	18	59
Other	14	15
White	510	980
Not Stated	37	43
Total	636	1257



The following table shows the change in ethnicity demographics when comparing 2019 against 2016. Due to the number of prisoners recorded as "not stated" on SystmOne, caution should be taken when comparing the two datasets.

Figure 1.2.21: Change in ethnicity demographics when comparing 2019 against 2016.

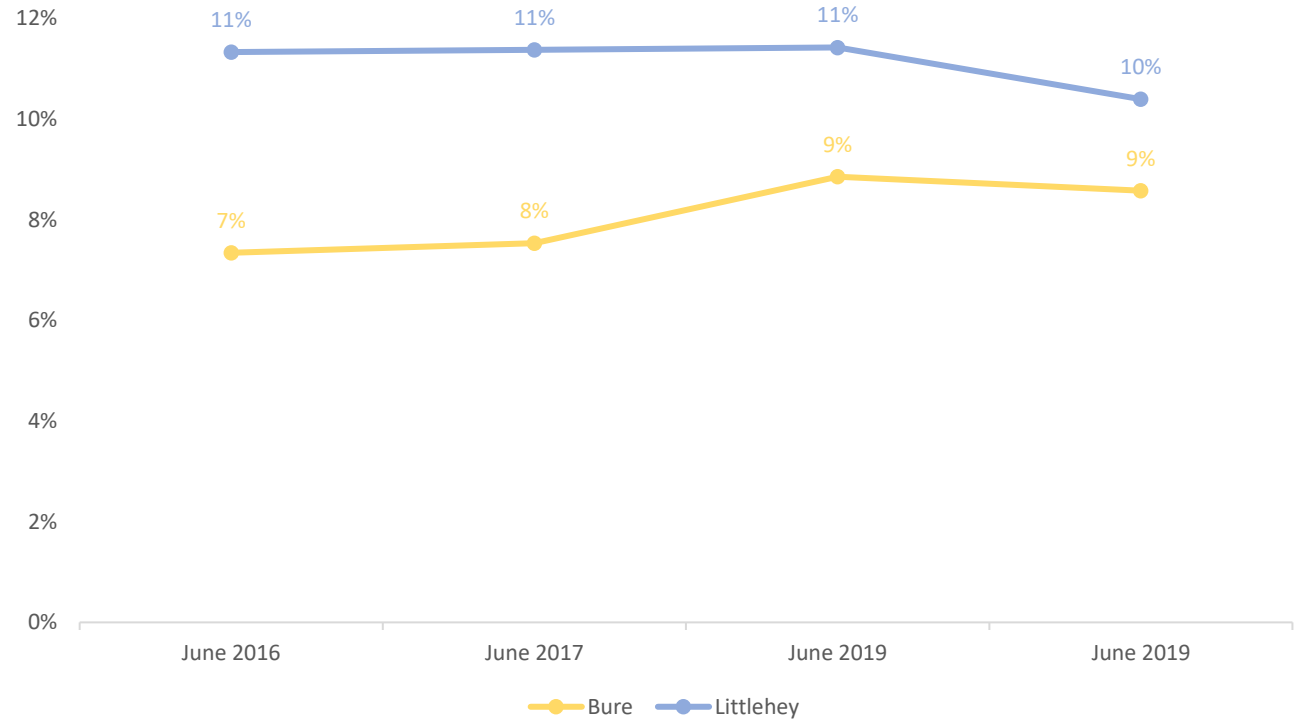
Ethnicity	HMP Bure							
	2016 S1	2019 S1	# Change	% Change				
Asian	33	26	-7	-21%				
Black	43	31	-12	-28%				
Mixed	16	18	2	13%				
Other	9	14	5	56%				
White	521	510	-11	-2%				
Not Stated	23	37	14	61%				
Total	645	636	-9	-1%				

FOREIGN NATIONAL PRISONERS[29]

As at June 2019, the rates of FNPs across both prisons were similar, at 9-10%. For comparison, as at June 2016 HMP Littlehey had a higher rate at 11% compared to 7% in HMP Bure.

Nationally, the average is around 10%.

Figure 1.2.22: Long-term trend of the FNP population.



Bure	June 2016	June 2017	June 2018	June 2019
A British National	593	589	597	596
B Foreign National	47	48	58	56
C Not Recorded	0	0	0	1
Total	640	637	655	653
Littlehey	June 2016	June 2017	June 2018	June 2019
A British National	1071	1072	1070	1085
B Foreign National	137	138	138	126
C Not Recorded	1	3	0	1
Total	1209	1213	1208	1212

[29] https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-october-to-december-2018.

OFFENCES[30]

Below shows the offending profile of the two prisons as at June 2019. The two prisons have a similar offending profile, with prisoners recorded with an index offence of sexual offences accounting for 88-89% of the total population. This is up slightly from the 85% recorded as at June 2016 for both prisons.

Figure 1.2.23: Change in offending profile between June 2016 and June 2019; HMP Bure.

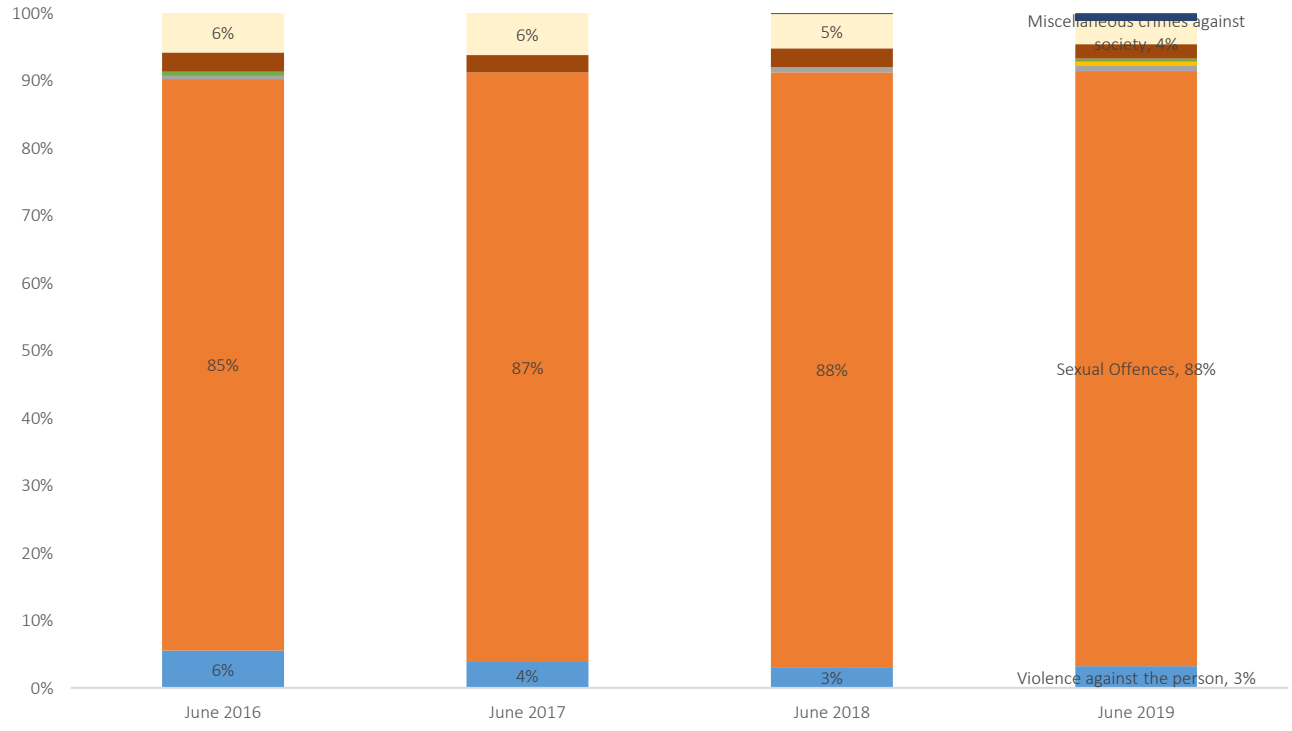
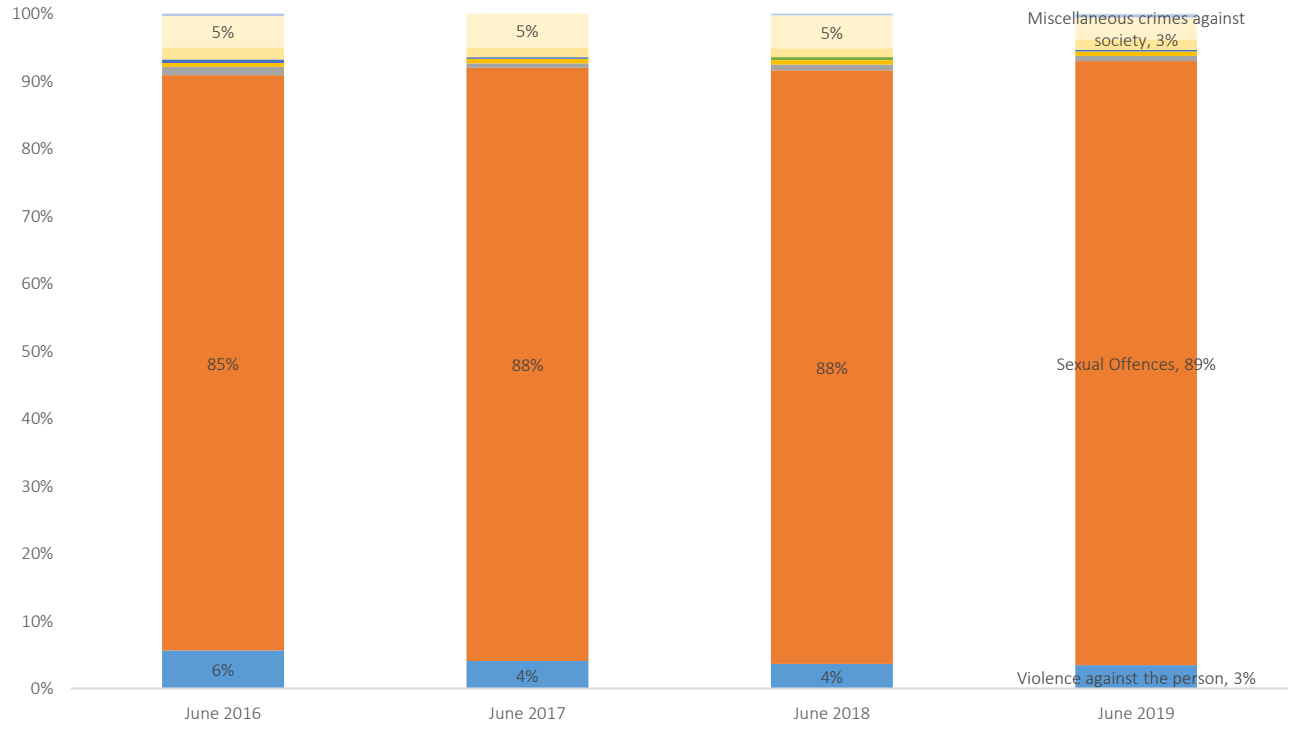


Figure 1.2.24: Change in offending profile between June 2016 and June 2019; HMP Littlehey.



[30] https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-october-to-december-2018.

EX-SERVICE PERSONNEL

As highlighted in the HMIP report *People in prison: Ex-service personnel*, "the number of ex-Service personnel in prison is a contentious issue; accurate figures have proven notoriously difficult to ascertain and the exact number of ex-Service personnel in custody is currently unknown" [31].

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

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

- Analysis of the Defence Analytical Services Agency (DASA) data showed that older ex-Service personnel were also overrepresented in the prisoner population: 29% of ex-Service personnel in prison were over 55 compared to 9% of the general prisoner population.
- Service in the Armed Forces may, in some cases, also lead to an increased risk of alcohol misuse and mental health difficulties, including anxiety, depression and post-traumatic stress disorder (PTSD). Therefore, it is likely that those ex-Service personnel who do come into contact with the criminal justice system may be affected by one or more of these vulnerabilities.
- Ex-Service personnel were more likely to be serving longer sentences: 63% reported that their sentence was over 4 years (compared with 53% of the general prisoner population); 39% reported that their sentence was over 10 years (compared with 26% of the general prisoner population).
- On arrival into prison, ex-Service personnel were as likely as the general prisoner population to report problems around issues such as alcohol (17%) and mental health (15%).
- Ex-Service personnel were more likely to report feeling depressed or suicidal on arrival into prison (18% compared with 14%).
- The incidence of physical health problems on arrival into prison was higher among ex-Service personnel than the general prisoner population (24% compared with 13%).
- A higher proportion of prisoners identifying as ex-Service personnel stated that they had a disability (34% compared with 19% of the general prisoner population).
- Identification is not, presently, routine, and even in those places where it is common practice, many who have served in the Armed Forces have reservations about self-identifying, both because of a feeling of shame at behaviour contrary to the ethos of the Armed Forces and because of fears for personal safety given high-profile attacks on former service personnel.

Figure 1.2.25 shows the number of prisoners that have served in the armed forces based on a number of sources. Based on the multiple data sources, HMP Littlehey appears to have a significantly higher rate of prisoners that have served in the armed forces. READ code "(Ua0T3) Served in armed forces" shows a figure of 12% in HMP Littlehey compared to 4% in HMP Bure, when taking into account any location for the code being entered.

Figure 1.2.25: The number of prisoners who have served in the Armed Forces.

SOURCE	HMP Bure	HMP Littlehey
SystmOne - (0912.) Member of armed forces	10 (1.6%) – Recorded in HMP Bure. 25 (3.9%) – Recorded in any establishment.	23 (1.8%) – Recorded in HMP Littlehey. 31 (2.5%) – Recorded in any establishment.

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

SystmOne - (Ua0T3) Served in armed forces	0 (0.0%) – Recorded in HMP Bure. 26 (3.9%) – Recorded in any establishment.	109 (8.7%) – Recorded in HMP Littlehey. 154 (12.3%) – Recorded in any establishment.
SystmOne - (XaX3N) Military veteran	16 (2.5%) – Recorded in HMP Bure. 32 (5.0%) – Recorded in any establishment.	10 (0.8%) – Recorded in HMP Littlehey. 21 (1.7%) – Recorded in any establishment.
NOMIS	DATA NOT RECEIVED	DATA NOT RECEIVED

HEALTHCARE OVERVIEW

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

HMP BURE	
DESCRIPTION OF HEALTHCARE	
OPENING TIMES	
The Healthcare Centre is open: Monday to Friday 8.00am - 6.30pm Saturday and Sunday 8.00am – 5.30pm	
PATIENT PATHWAY	
Patients normally see a nurse prior to a GP. There are a range of medications available via a PGD. If required the nurse can refer the patient on to the advanced nurse prescriber or GP.	.
HEALTHCARE APPLICATION PROCESS	
Patients can complete a paper application form and hand in to healthcare staff on the wings.	
TELEMEDICINE	
There is no telemedicine in the prison.	
RECEPTION/DISCHARGE PROCESS	
Reception is staffed by a primary care nurse. Mental health nurses also see all new patients at reception.	
LOCATIONS	

NUMBER	ROOM
HEALTHCARE	
5	Clinic rooms
1	Dental suite
RESIDENTIAL UNIT 7	
1	Treatment room

NUMBER	ROOM

The mental health team moved office to create an extra clinic room. Healthcare are also trying to turn another room in the healthcare area into a clinic room. There is a treatment room located on residential unit 7, however because it is isolated it requires two healthcare staff to be located there.	
PROVIDER	
Healthcare Provider (HMP Bure)	
Psychosocial Provider	
Dentist (HMP Bure)	

SCREENS

The following table provides an overview of the screens listed in the PHE Toolkit. The charts include the performance in HMP Bure and HMP Littlehey, with additional information covering the performance of the regional and national averages.

RETINAL SCREENING UPTAKE

Definition: The % of patients that underwent screening of the total patients eligible during the reporting period.

Parity with prior outcomes: Yes.

Indicator Status 2019-20: Unchanged.

Provision

In both prisons, the retinopathy service visits twice a year.

Figure 1.3.1: Comparison

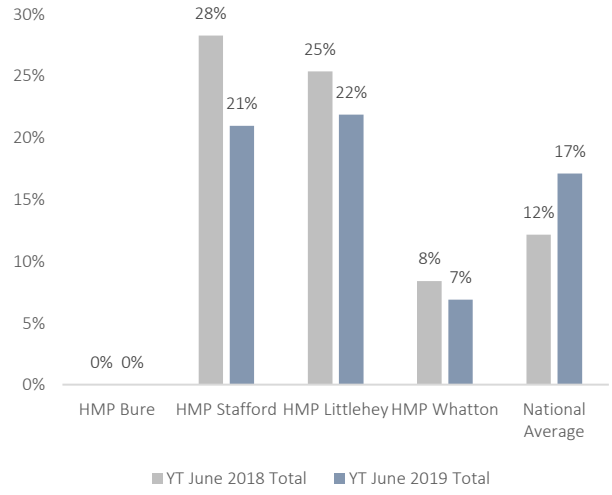


Figure 1.3.2: Actual numbers.

HMP Bure				
	YT June 2018 Total	YT June 2018 Average	YT June 2019 Total	YT June 2019 Average
Denominator	785	65	909	76
Numerator	0	0	0	0
%	0.0%		0.0%	

HMP Littlehey				
	YT June 2018 Total	YT June 2018 Average	YT June 2019 Total	YT June 2019 Average
Denominator	619	52	718	60
Numerator	157	13	157	13
%	25.4%		21.9%	

BOWEL CANCER SCREENING

Definition: The % of patients that underwent screening of the total patients eligible during the reporting period.

Parity with prior outcomes: Yes.

Indicator Status 2019-20: Revised.

Provision

In both prisons, healthcare liaise with the national bowel cancer screening hub regarding eligible patients. Healthcare manage the distribution and collection of kits.

Figure 1.3.3: Comparison.

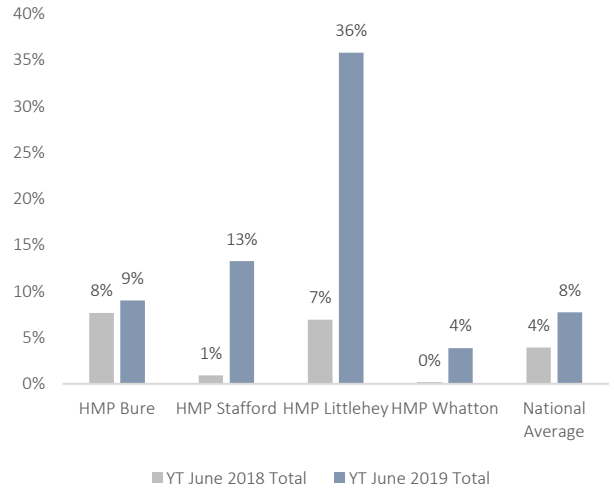


Figure 1.3.4: Actual numbers.

HMP Bure				
	YT June 2018 Total	YT June 2018 Average	YT June 2019 Total	YT June 2019 Average
Denominator	222	19	489	41
Numerator	17	1	44	4
%	7.7%		9.0%	

ABDOMINAL AORTIC ANEURYSM (AAA) SCREENING UPTAKE

Definition: The % of patients that underwent screening of the total patients eligible during the reporting period.

Parity with prior outcomes: Yes.

Indicator Status 2019-20: Revised.

Provision

In HMP Bure, healthcare liaise with the mobile screening unit. The unit come into the prison whenever the list of eligible patients is large enough to justify the running of the clinic.

In HMP Littlehey, the AAA screening unit visits the prison twice a year.

Figure 1.3.5: Comparison.

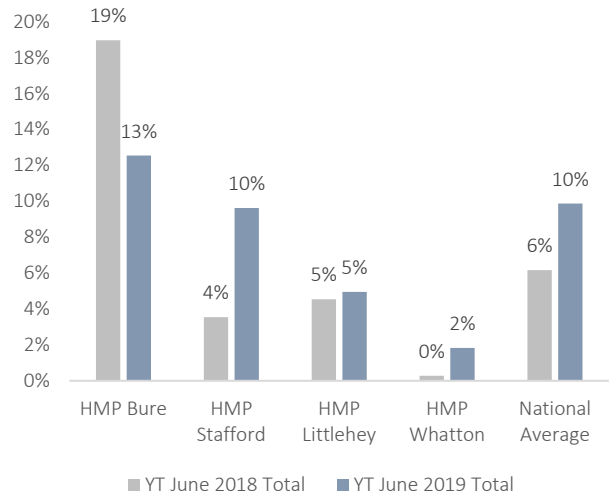


Figure 1.3.6: Actual numbers.

HMP Bure				
	YT June 2018 Total	YT June 2018 Average	YT June 2019 Total	YT June 2019 Average
Denominator	174	15	231	19
Numerator	33	3	29	2
%	19.0%		12.6%	

CHLAMYDIA SCREENING UPTAKE

Definition: The % of patients that underwent screening of the total patients eligible during the reporting period.

Parity with prior outcomes: Yes.

Indicator Status 2019-20: Unchanged.

Provision

In HMP Bure, chlamydia screening is offered to all those patients who are under 25. This occurs at the secondary health screen. Patients over the age of 25 can request a screen.

Figure 1.3.7: Comparison

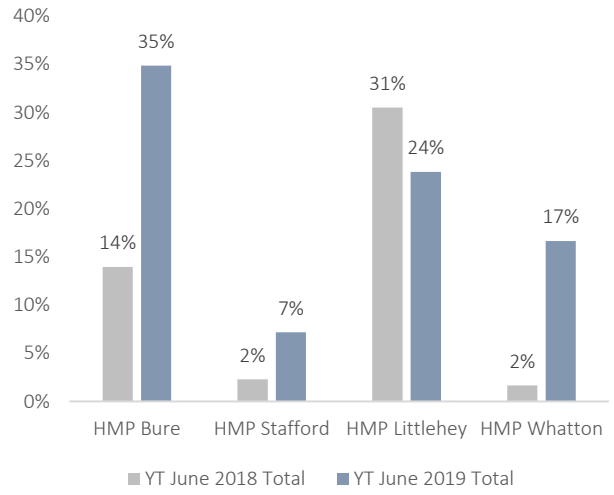
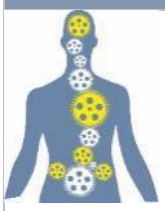


Figure 1.3.8: Actual Numbers

HMP Bure				
	YT June 2018 Total	YT June 2018 Average	YT June 2019 Total	YT June 2019 Average
Denominator	43	4	86	7
Numerator	6	1	30	3
%	14.0%		34.9%	

NHS PHYSICAL HEALTH CHECK SCREENING UPTAKE



Definition: The % of patients that underwent screening of the total patients eligible during the reporting period.

Parity with prior outcomes: Yes.

Indicator Status 2019-20: Guidance enhanced.

Provision

In HMP Bure, healthcare run the NHS physical healthcare checks with eligible patients. Healthcare staff also collect routine yearly blood samples from patients over 50. Over 50's clinics are also run.

In HMP Littlehey, Healthcare run physical health checks. Eligible patients are invited to attend the appointment and are given health promotion literature.

Figure 1.3.9: Comparison

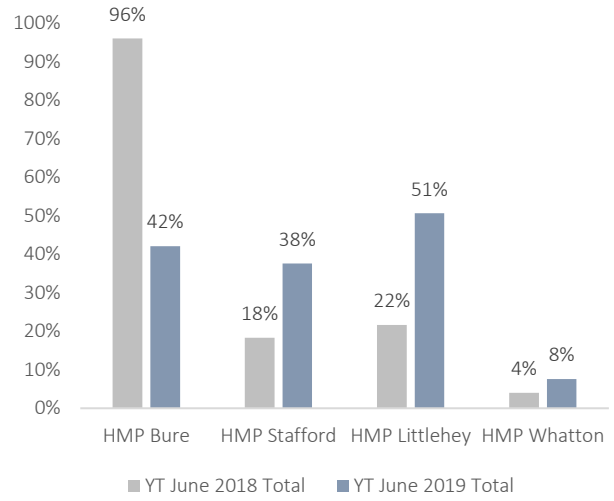


Figure 1.3.10: Actual Numbers

HMP Bure				
	YT June 2018 Total	YT June 2018 Average	YT June 2019 Total	YT June 2019 Average
Denominator	150	13	266	22
Numerator	144	12	112	9
%	96.0%		42.1%	

RECEPTION SCREENS

Below shows the performance for 1st and 2nd reception screens. For both prisons, performance for 1st reception screens are good. Both prisons report a performance rate of 99-100% over the last two quarters.

For the Qtr-1 of 2019-20, 92% of receptions in HMP Bure received a 2nd screen compared to 89% in HMP Littlehey. Nationally, performance stood at 88%.

Figure 1.3.11: Reception screen performance.

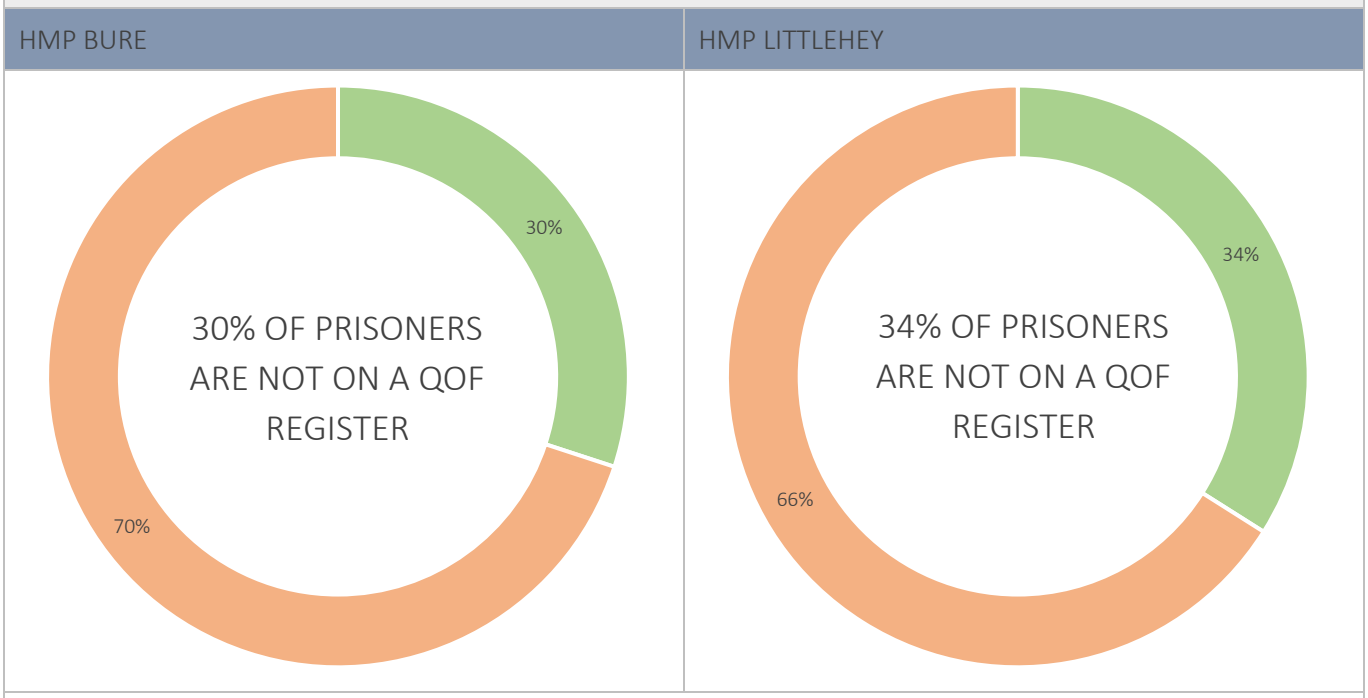
Prison	Indicator Description	East of England - Average	National Average	Apr-19	May-19	Jun-19	Average performance - 2019/20 Q1	Average performance - 2018/19 Q4	YTD Performance
HMP Bure	1st Reception screens	100%	99%	100%	100%	100%	100%	99%	99%
	2nd Reception screens	79%	88%	97%	97%	69%	92%	99%	98%

QOF ANALYSIS

The following chapter contains a series of analyses relating to the QOF registers, providing an overview of the prevalence across a number of health conditions. As both prisons use the same framework, the analyses provide a good baseline for comparison.

The first area of analysis looks at the rate of prisons that are not on any of the QOF registers. This analysis may indicate the number and rate of the population that are 'healthy' as they are not listed on any of the registers. An alternative view may indicate that a certain number of those in this cohort have not been identified and are classified as unmet need. In these instances, the use of an expected prevalence rate will further inform the analysis. This can be found in the individual chapters for the health conditions. The rate of prisoners not on any of the QOF registers is similar across both prisons.

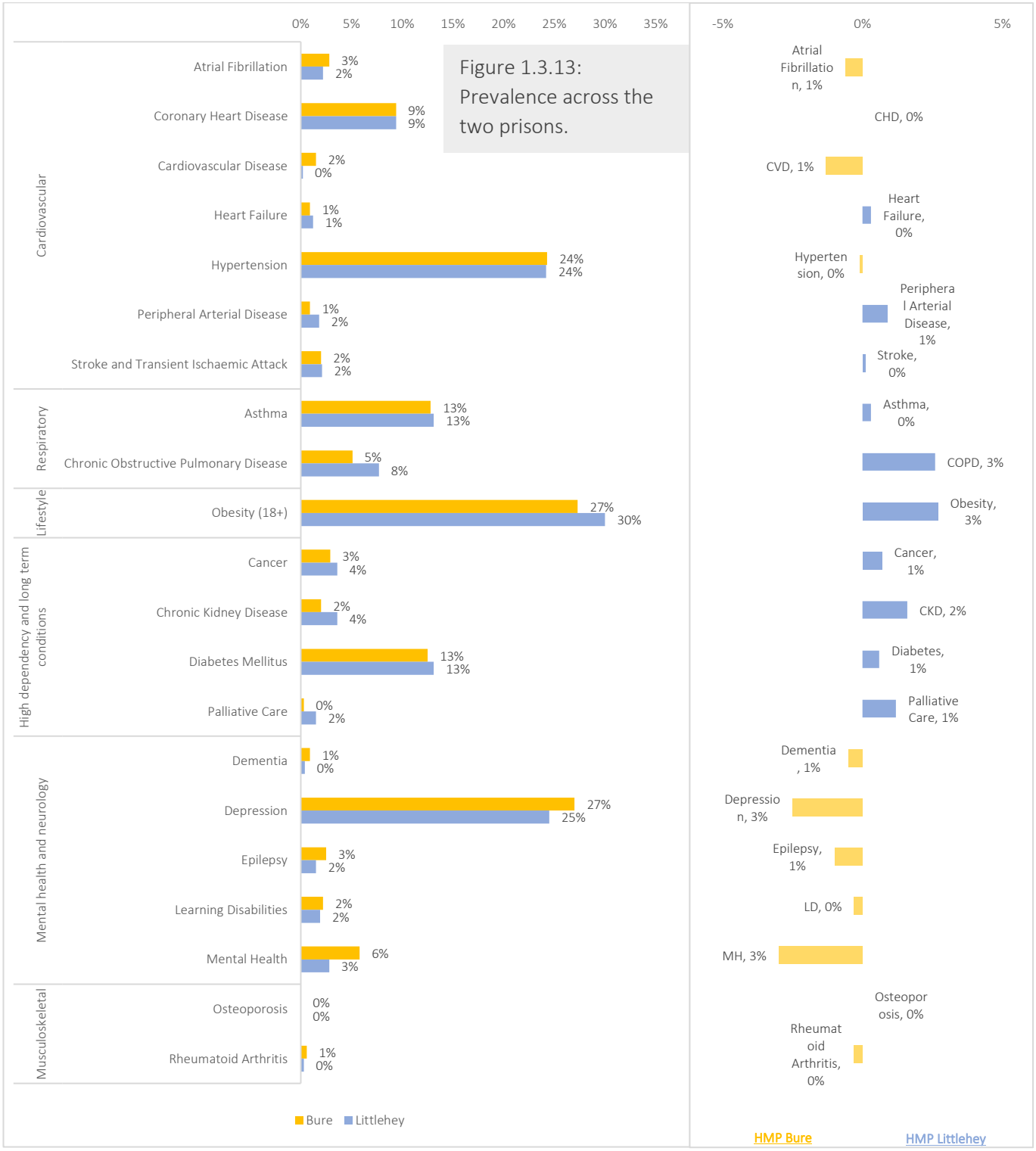
Figure 1.3.12: Rate of prisoners not on any QOF register.



Prison	HMP Bure	HMP Littlehey
Number of Prisoners	636	1257
Number not on any QOF register	191	427
Percentage not on any QOF register	30%	34%

Figure 1.3.13 on the following page shows the prevalence across the two prisons as at September 2019. The chart on the right shows the percentage point difference of the QOF registers between the two prisons.

In general, the prevalence across most registers is similar, however there are a number of QOF registers that show some differences, including mental health which is higher in HMP Bure, and COPD which is higher in HMP Littlehey.



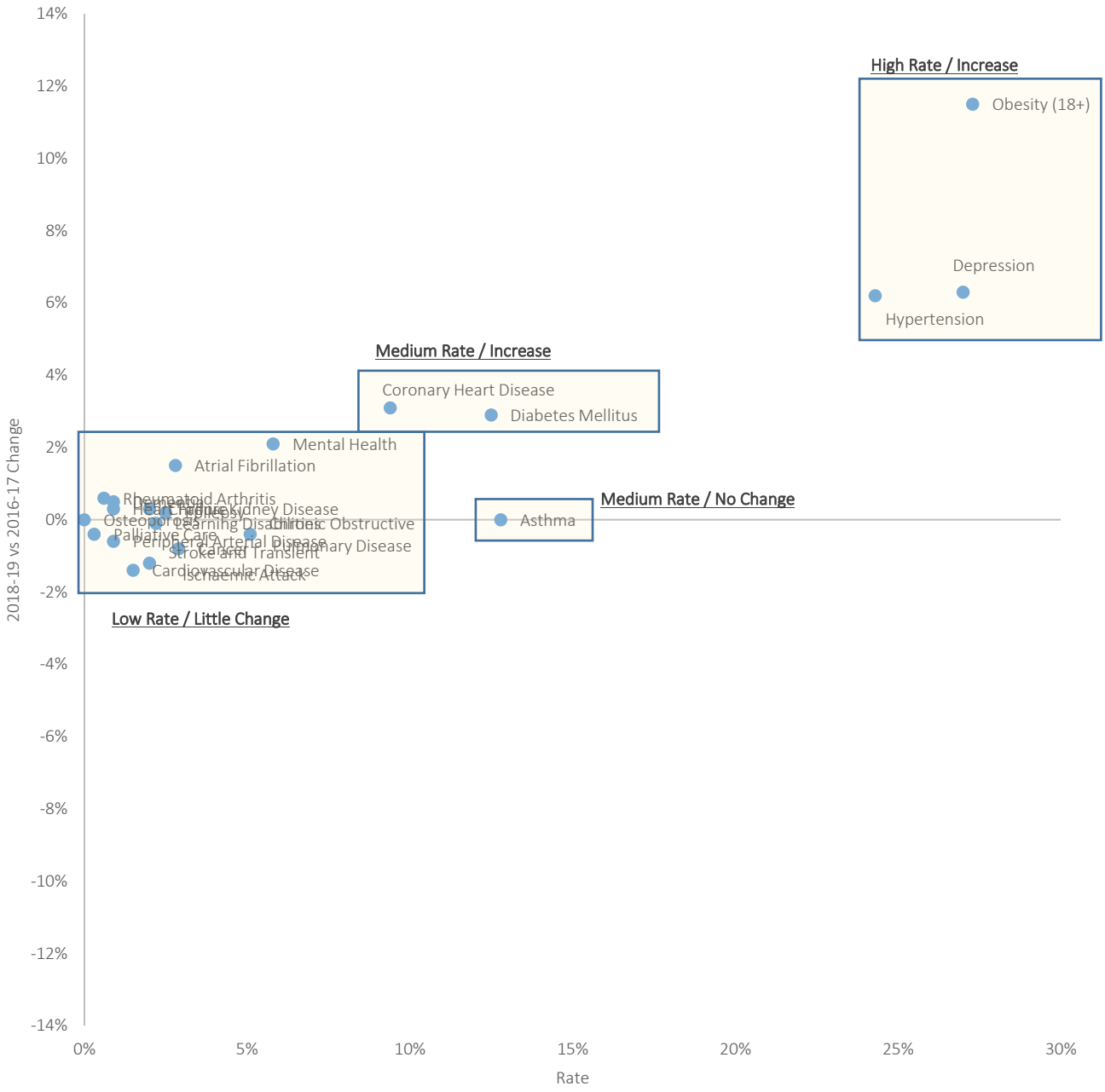
This chart shows the prevalence of the QOF registers across the two prisons.

This chart shows the percentage point difference of the QOF registers between the two prisons.

The following illustrates how the HMP Bure QOF register has changed since the 2016 HSCNA. The X-axis shows the rate[32] with the Y-axis showing the percentage point change since the last HSCNA. This presents the findings into a visual format which highlights a number of areas:

- Obesity, hypertension, and depression have seen an increase since the last HSCNA, and there is a high percentage of the population on these registers. However, the change for obesity is likely to be linked to better recording of BMI.
- There has been no register that has seen a relatively large decrease.
- A high number of the registers have seen little change, and there is a low percentage of the population on these registers.

Figure 1.3.14: Rate and change since the last HSCNA: HMP Bure.

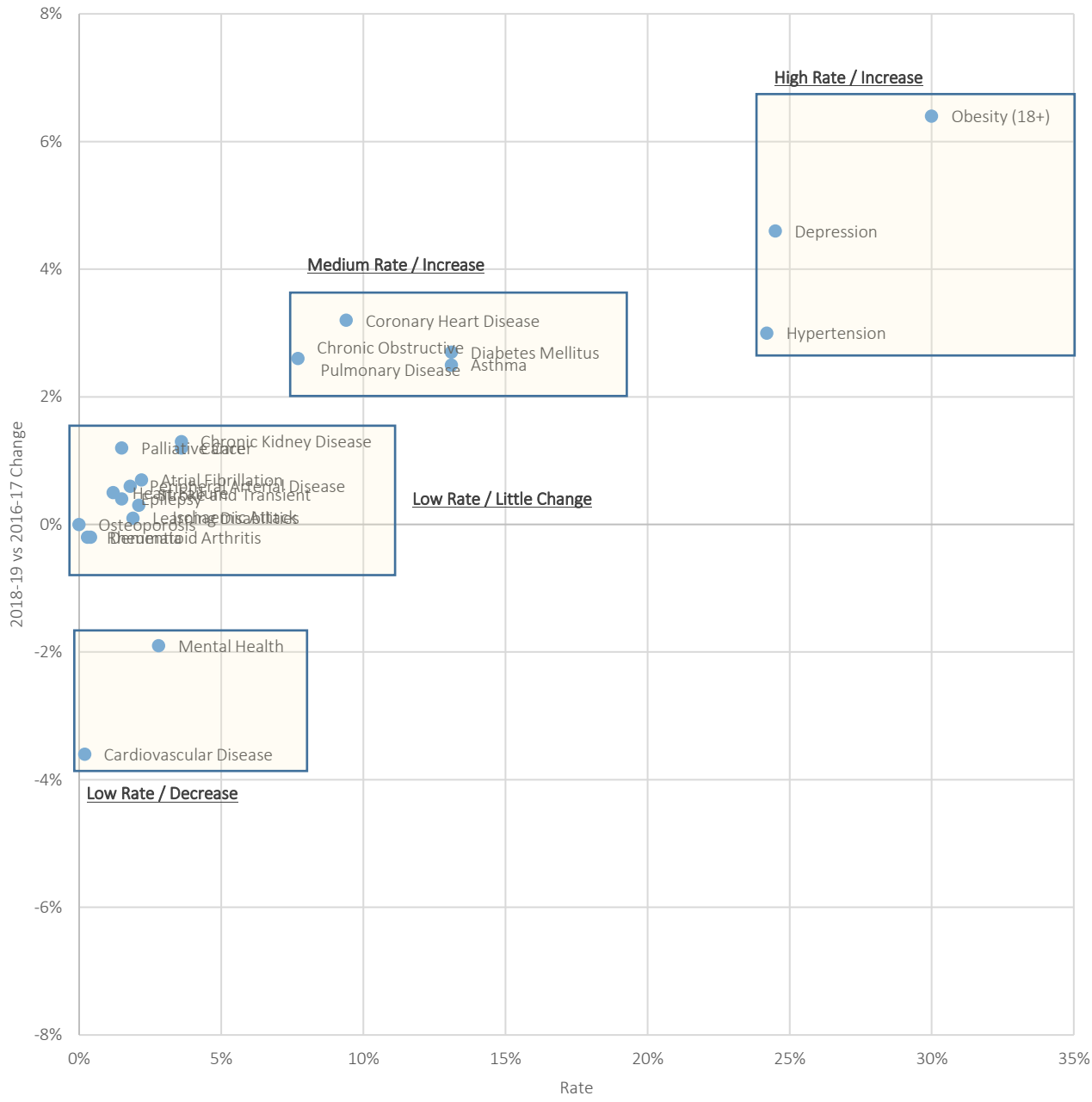


[32] The percentage of the population on the register.

The following illustrates how the HMP Littlehey QOF register has changed since the 2016 HSCNA. The X-axis shows the rate[33] with the Y-axis showing the change since the last HSCNA. This presents the findings into a visual format which highlights a number of areas:

- Similar to HMP Bure, obesity, hypertension, and depression have seen an increase since the last HSCNA, and there is a high percentage of the population on these registers. However, the change for obesity is likely to be linked to better recording of BMI.
- The mental health and the CVD register have both seen a decrease.
- A number of age-related diseases including COPD, CHD, and diabetes have seen an increase.
- A high number of the registers have seen little change, and there is a low percentage of the population on these registers.

Figure 1.3.15: Rate and change since the last HSCNA: HMP Littlehey.



[33] The percentage of the population on the register.

DATA OVERVIEW

HMIP	
HMP BURE	
• The last HMIP inspection was 27 March–7 April 2017.	•
INDEPENDENT MONITORING BOARDS	
HMP BURE	
• The last IMB report covered 1 August 2017 to 31 July 2018 and was published December 2018.	•

ANNUAL PRISON PERFORMANCE RATINGS

OVERVIEW

- The Annual Prison Performance Ratings are derived from the Prison Performance Tool (PPT) which was introduced in April 2018 for the 2018/19 reporting year, replacing the Custodial Performance Tool used in 2017/18. All prison performance ratings reflect performance between 1st April 2018 and 31st March 2019.
- In the PPT, overall performance in each prison is rated on a 1 to 4 scale. The different ratings are 4: Performance is exceptional; 3: Performance is acceptable; 2: Performance is of concern and 1: Performance is of serious concern. Note, this is a slight change from the rating definitions used in the Custodial Performance Tool in 2017/18.
- There are also differences in the way ratings are calculated. Some compare performance to target, some are set nationally to reflect consistent expectations across the estate, whereas others are specific to each prison considering a range of local factors.

PRISON FUNCTIONS

- Prisons are classified by their predominant prison function. A number of prisons are multi-functional and hold a range of types of prisoner. In these cases, the predominant function has been reported in the Annual Prison Performance Ratings 2018/19.

COMPARATOR GROUPS

- The 2018/19 comparator groups of prisons can be found below. A statistical methodology is used to calculate the comparator groups. A number of contextual variables are used to determine a statistical score for each prison.

Prison	Comparator Prison							
	1	2	3	4	5	6	7	8
Bure	Usk	Ashfield	Stafford	Dartmoor	Whatton	Littlehey	Channings Wood	Huntercombe

Prison	Comparator Prison							
	1	2	3	4	5	6	7	8
Littlehey	Whatton	Wymott	Bure	Stafford	Moorland	Usk	Ashfield	Northumberland

SYSTMONE	
HMP BURE	HMP LITTLEHEY
• Data from SystmOne was accessed during September 2019. • This covers QOF, reception screening prevalence, and READ code prevalence. • Where historical analysis was included, 12 months to June 2019 against the 12 months to June 2017 and the 12 months to June 2018 were used.	
HJIPS	
HMP BURE	HMP LITTLEHEY
• The HJIPs is used to provide performance background to the different health areas. • Comparisons against comparator prisons and national averages have been included. • Where historical analysis was included, 12 months to June 2019 against the 12 months to June was used. • Some indicators may have been changed, therefore comparison against the previous year was not possible.	
NDTMS	
HMP BURE	HMP LITTLEHEY
• The latest available data covers Qtr-1 of 2019-20. • Historical analysis of rates compares Qtr-1 of 2019-20 against the full years of 2017-18 and 2018-19.	
POPULATION AND DEMOGRAPHIC DATA	
HMP BURE	HMP LITTLEHEY
• A number of data sources were used. • In general, SystmOne was used when analysis of health conditions was involved. • Analysis of general demographic information used data from C-NOMIS and MoJ Statistics. This is due to limitations in SystmOne in some areas such as religion, ethnicity, and sentence type.	
ENGAGEMENT	
HMP BURE	HMP LITTLEHEY
• Face to face and telephone interviews were completed with healthcare leads. • Face to face and telephone interviews were completed with lead officers in each prison. • Patient focus groups were completed in each prison. • Existing patient forum minutes were used to inform the needs assessment.	

ENGAGEMENT

FOCUS GROUPS	
HMP BURE	
INTRODUCTION	
As part of the needs assessments, the researchers ran a number of focus groups in each of the prisons. The interviewers covered a number of topics relevant to capturing health needs in the prisons. Participants were also given latitude to raise any issues that they were concerned about.	
In HMP Bure, the healthcare representative supervisor arranged a number of meetings with healthcare representatives.	
ROLES OF HEALTHCARE REPRESENTATIVES	
Healthcare representatives described their roles in the prison. Roles include: • Delivering appointments • Reminding patients about their prescriptions Representatives said that they would like to be more involved in health promotional activities and had requested information leaflets from healthcare.	
SELF-MANAGEMENT OF HEALTH	
Patients were concerned about the diet in HMP Bure. It was highlighted that the menu was very carbohydrate heavy. Participants in the focus groups said that there was good access to exercise in the prison. One patient said that he had managed to lose weight in the prison. There was a general complaint that a number of groups at the gym were cancelled. Patients fed back that there had been an improvement in the waiting times to collect medication from the pharmacy.	
APPOINTMENTS	
The feedback around waiting times was mixed. One patient highlighted that the wait to see the GP was approximately 2 weeks. However, another patient said that he had to wait 8 to 10 weeks for a GP appointment. Long waits for the nurse practitioner clinic were also reported. It was a common concern amongst participants that the waiting times for the dentist and the optician were	

too long. One patient said that he had to wait 6 and a half months to see the dentist.	
MENTAL HEALTH	
Some participants had attended groups run by the Wellbeing Team (IAPT). Feedback for the service was good, with participants getting good help with depression in particular.	

SURVEYS

INTRODUCTION

For this HSCNA, the Researchers designed two surveys that were distributed across HMP Bure and HMP Littlehey. One survey was aimed at staff, with the other survey aimed at prisoners. There was a low response to the staff survey.

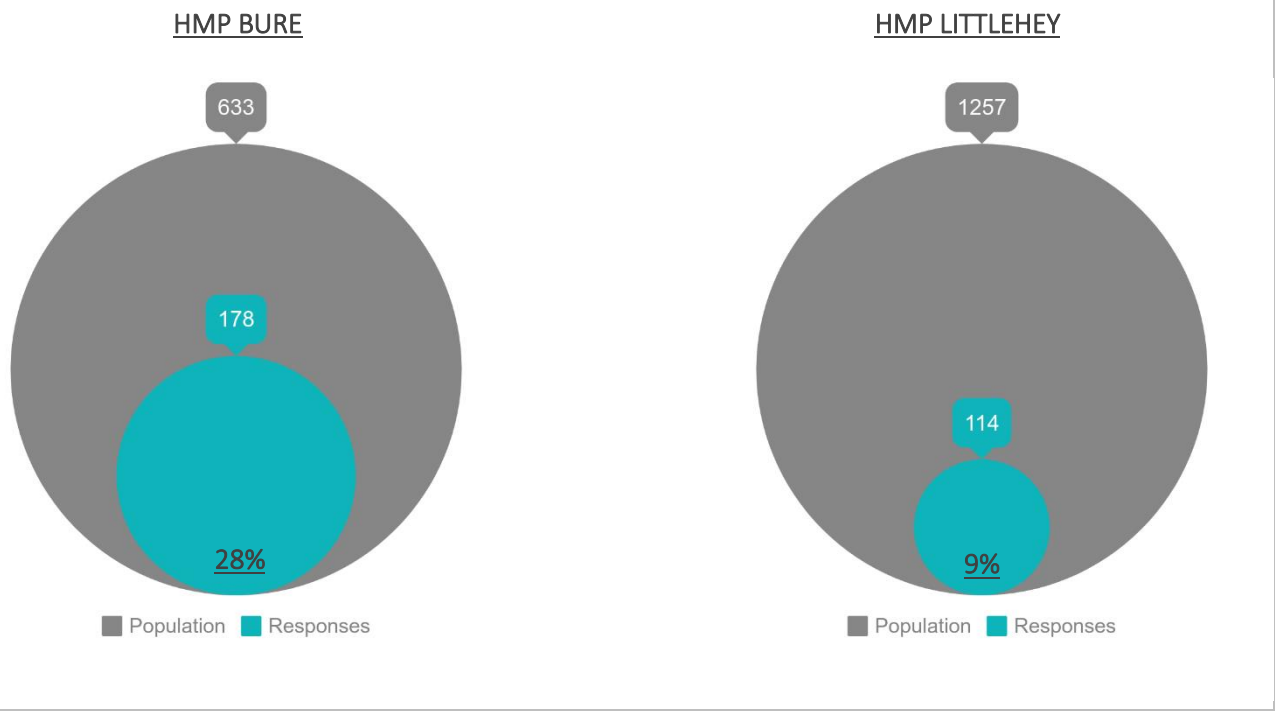
The prisoner survey was designed in conjunction with the Health and Justice Projects Officer for NHS England Midlands & East. The survey included questions on physical and mental health issues, ease of accessing services, quality of services, areas for improvement, and a section on substance misuse issues.

The surveys included opportunities for prisoners and staff to leave free text comments. The complete set of comments are available on request.

RESPONSE RATE

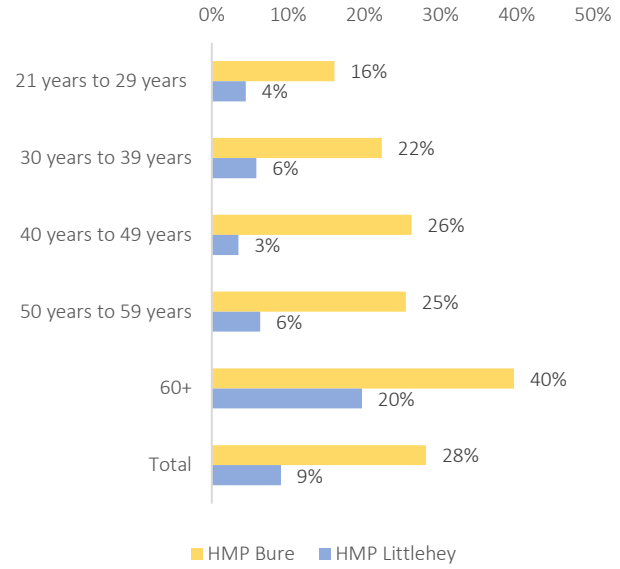
The diagram below shows the response rate for the prisoner surveys in both prisons. 28% of the population of HMP Bure responded, compared to 9% in HMP Littlehey.

Figure 2.2.1: Survey response rates



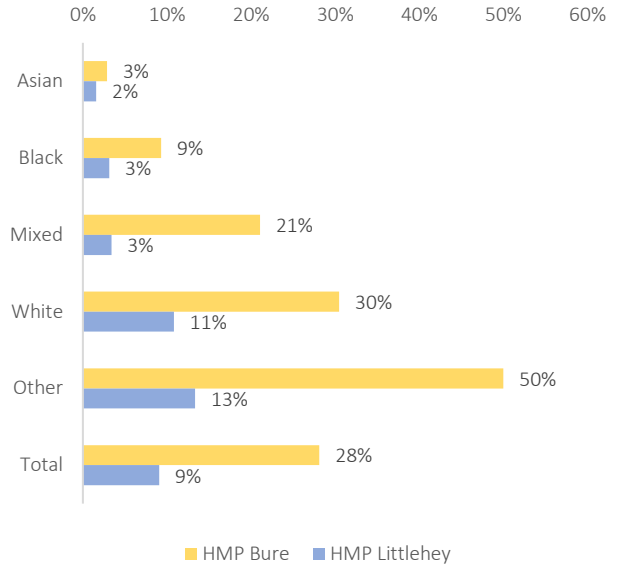
- Analysing the responses by demographics shows that there were higher response rates from older prisoners in both prisons.

Figure 2.2.2: Response rate by age.



Age Group	HMP Bure		HMP Littlehey	
	Population	Survey	Population	Survey
21 years to 29 years	87	14	179	8
30 years to 39 years	139	31	256	15
40 years to 49 years	122	32	229	8
50 years to 59 years	106	27	268	17
60+	179	71	325	64
Not Stated	0	3	0	2
Total	633	178	1257	114

Figure 2.2.3: Response rate by ethnicity.



Age Group	HMP Bure		HMP Littlehey	
	Population	Survey	Population	Survey
Asian	35	1	64	1
Black	43	4	96	3
Mixed	19	4	59	2
White	525	160	980	106
Other	10	5	15	2
Not Stated	1	4	43	0
Total	633	178	1257	114

In HMP Bure, a higher proportion of respondents found the dentist and doctor difficult to access than in HMP Littlehey. In HMP Littlehey, the pharmacy service were more visible than in HMP Bure, with only 2% of respondents stating that the Littlehey service was difficult to access.

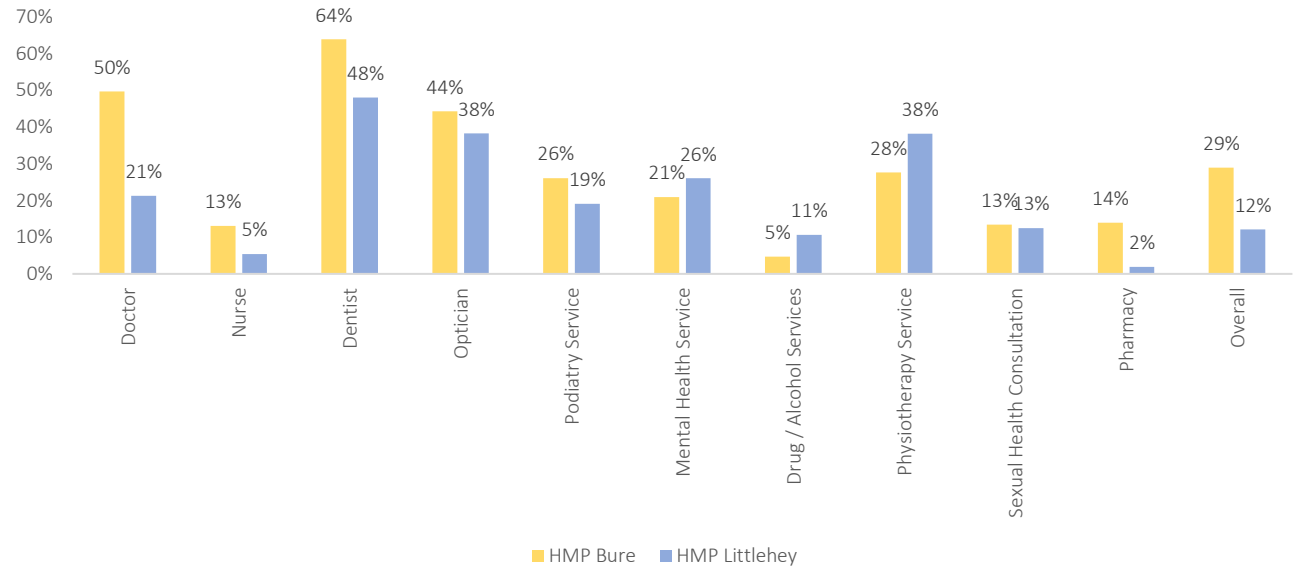
In HMP Bure,

- 50% of respondents said that the doctor was difficult to access.
- 64% said the dentist was difficult to access.
- 44% said the optician was difficult to access.

In HMP Littlehey,

- 48% of respondents said that the dentist was difficult to access.
- 38% said that the optician and physiotherapy service was difficult to access.

Figure 2.2.4: Access to services; % answering "difficult"



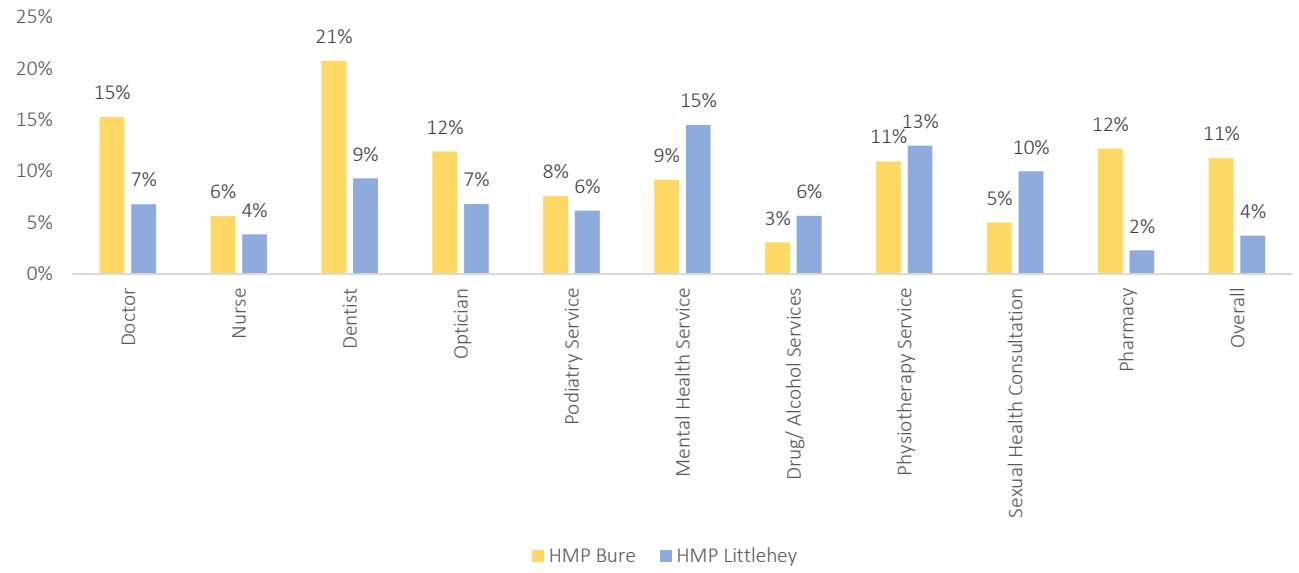
HMP Bure	Doctor	Nurse	Dentist	Optician	Podiatry Service	Mental Health Service	Drug / Alcohol Services	Physiotherapy Service	Sexual Health Consultation	Pharmacy	Overall
Good	45	100	24	43	29	38	34	19	14	92	56
Neither	36	46	32	40	56	45	47	57	57	38	52
Bad	80	22	99	66	30	22	4	29	11	21	44
Not Answered	17	10	23	29	63	73	93	73	96	27	26
Answered	161	168	155	149	115	105	85	105	82	151	152

The doctor and dentist service in HMP Bure had lower ratings than those in HMP Littlehey. Overall, healthcare in HMP Bure had lower ratings than that in HMP Littlehey.

In HMP Bure,

- 21% of respondents said that the dental services was of bad quality.
- 15% of respondents said that the doctor was of bad quality.
-

Figure 2.2.5: Quality of services; % answering "bad"



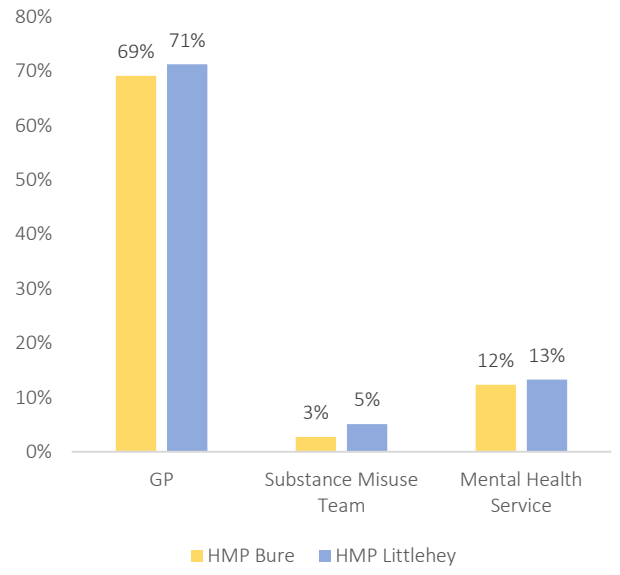
HMP Bure	Doctor	Nurse	Dentist	Optician	Podiatry Service	Mental Health Service	Drug/ Alcohol Services	Physiotherapy Service	Sexual Health Consultation	Pharmacy	Overall
Good	101	126	65	73	45	39	27	27	15	77	83
Neither	32	25	42	45	40	40	36	46	42	38	35
Bad	24	9	28	16	7	8	2	9	3	16	15
Not Answered	21	18	43	44	86	91	113	96	118	47	45
Answered	157	160	135	134	92	87	65	82	60	131	133

Similar proportions of respondents were registered with a GP, substance misuse team, and mental health service in the two prisons. Regarding medication, lower proportions of respondents had access to lockable storage in HMP Littlehey.

In HMP Bure,

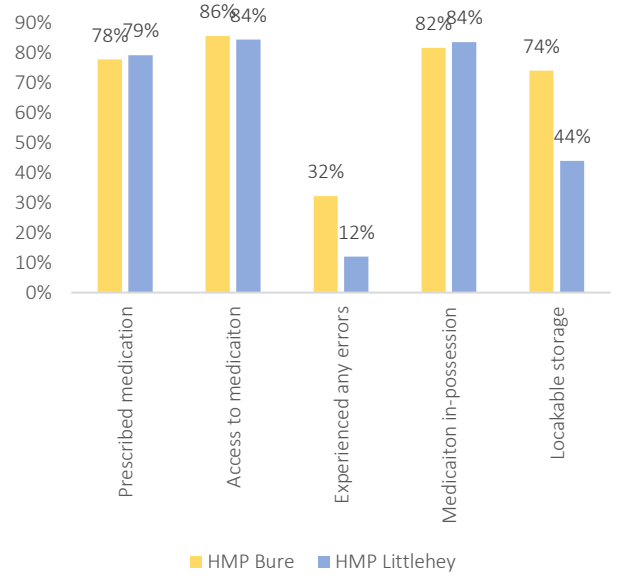
- 69% of respondents were registered with a GP
- 78% of respondents were provided medication.
- 74% had access to lockable storage.

Figure 2.2.6: Registered



HMP Bure	GP	Substance Misuse Team	Mental Health Service
Yes	119	4	19
No	53	143	135
Not Answered	6	31	24
Answered	172	147	154

Figure 2.2.7: Medication



HMP Bure	Prescribed medication	Access to medication	Experienced any errors	Medication in-possession	Locakable storage
Yes	137	137	55	134	129
No	39	23	116	30	45
Not Answered	2	18	7	14	4
Answered	176	160	171	164	174

The tables below show prisoners opinions on a number of possible healthcare issues in the prisons. In HMP Bure, 50% of respondents said that waiting times for GP were bad or very bad. There was a lower proportion who thought this in HMP Littlehey.

HMP Bure	Information on healthcare services for prison staff	Information on healthcare services for patients	Waiting times for GPs	Waiting times for Nurses	Being informed of appointments on time	Escorting of patients to healthcare appointments	Escorting of patients to external appointments	Mental health training for prison and healthcare staff	Information on healthy lifestyles	Healthcare facilities
Very Good	13%	17%	10%	18%	26%	18%	23%	10%	14%	16%
Good	28%	44%	21%	36%	45%	22%	28%	15%	26%	46%
Neither	41%	22%	19%	19%	15%	54%	37%	51%	35%	23%
Bad	14%	13%	28%	20%	10%	4%	8%	13%	19%	8%
Very Bad	4%	4%	22%	7%	4%	2%	5%	10%	6%	6%
Answered	141	169	174	175	177	149	160	138	162	158

SPECIALIST PATHWAYS

MENTAL HEALTH

OVERVIEW

INTRODUCTION

Mental health is covered in the PHE Toolkit. The Toolkit provides an overview, prevalence rates, and suggested data sources.[34]

The key points are:

- "...a recent Audit Office report shows that just 7% of short sentence prisoners accessed help from mental health services while nearly 60% of remand prisoners have a common mental disorder and 10% a psychotic disorder".
- "In a study of prisoners, 72% of male, and 71% of female prisoners were found to suffer from 2 or more mental disorders (including personality disorder, psychosis, neurosis, alcohol misuse and drug dependence), 20% suffered from 4."
- "Presence of concurrent mental health and substance misuse problems can lead to difficulties in accessing support from either service."
- "The 2007 adult psychiatric morbidity survey shows that male remand prisoners are 20 times more likely to suffer psychosis and 20 times more likely to entertain suicidal thoughts than the general population."
- "Many people in contact with the criminal justice system have experience of interpersonal trauma, particularly women offenders. This has been linked to the onset of a range of mental health problems including post-traumatic stress disorder, depression, anxiety disorders and substance misuse."
- "29% of prisoners report having experienced emotional, physical or sexual abuse as a child, with the percentage much higher among women prisoners."
- "Limited availability of trauma informed mental health services can lead to poor responses to this client group."

ADDITIONAL LITERATURE

Published in 2009, the Bradley Review[35] looked specifically at diverting people with learning disabilities and mental health problems away from the criminal justice system.

The Bradley Review used a number of existing research papers for evidence, including *Too Little Too Late: An Independent Review of Unmet Mental Health Need in Prison*[36], *Bromley Briefings Factfile*[37], *No One Knows*[38], and the *Survey for the Office for National Statistics on Psychiatric Morbidity among Prisoners*.[39]

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

- At any one time, 10% of the prison population have serious mental health problems.

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

- 96% of prisoners with mental disorders returned to the community without supported housing, including 80% of those who had committed the most serious offences; more than three quarters had been given no appointment with outside carers.
- There are now more people with mental health problems in prison than ever before.
- Self-harm and suicide rates are significantly higher in the prison population compared to the general population.
- People from black, Asian and minority ethnic (BAME) communities with mental health problems represent about 10% of the UK population, but in prison, this rises to approximately 20%.
- There is conflicting research on the effect of prison on the mental health of prisoners. A paper released by Advances in Psychiatric Treatment[40] argued that imprisonment is detrimental to mental health. However, in 2010, the results of a study by the Offender Health Research Network (OHRN)[41] indicate that prison does not have a universally detrimental effect on mental health.

Coid et al.[42] found less mental ill-health among Afro-Caribbean prisoners than among white prisoners, although these findings may partially be explained by a failure to recognise mental illness in Afro-Caribbean prisoners by healthcare staff[43] and a reluctance to seek help for mental health problems among these prisoners. This reflects the difficult relationship between Afro-Caribbean communities and mental health services.[44]

The *Sainsbury Centre for Mental Health Report* (2002) suggests that treatment of people from BAME communities is hampered by mutual mistrust between professionals in mental health and people from BAME groups. The study concludes that too often, black people come to the attention of mental health services at a late stage and are often severely ill before they begin to receive treatment.

POLICY AND GUIDANCE

In February 2016 an Independent Mental Health Taskforce published *The Five-Year Forward View for Mental Health*[45]. This made a series of recommendations for the NHS and government to improve outcomes in mental health by 2020-21, including ending the practice of sending people out of their local area for inpatient care and increasing access to talking therapies.

In October 2017, the Government commissioned a review of the Mental Health Act 1983, in response to concerns about rising rates of detention and the disproportionate use of the Act among people from black, Asian and minority ethnic (BAME) groups. An interim report was published in May 2018 and flags several areas for change, such as 'advance planning' decisions so patients' preferences about their care receive suitable consideration. The review is also gathering evidence on the use of the Act among people from BAME groups[46].

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

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

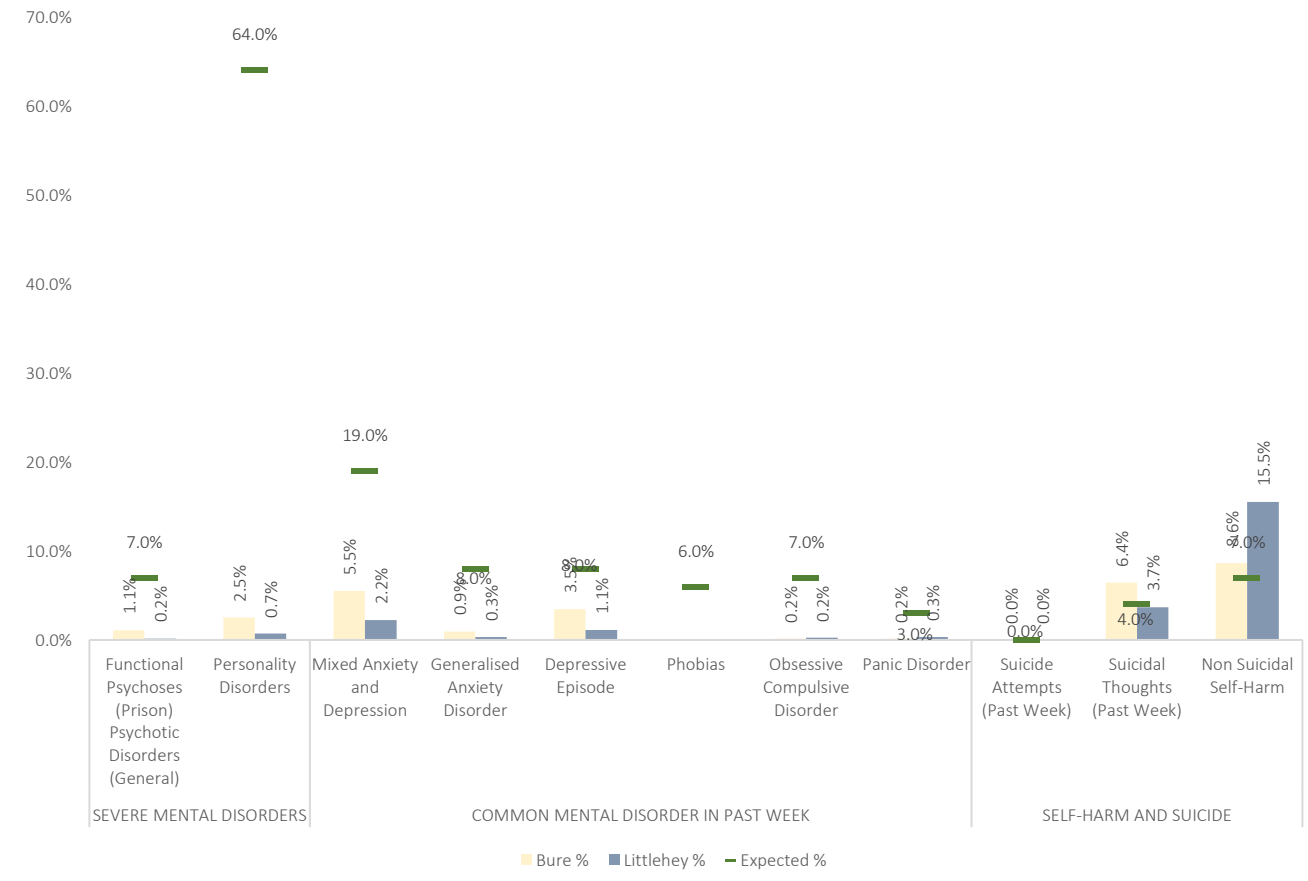
[40] Birmingham, L., 'The Mental Health of Prisoners', *Advances in Psychiatric Treatment*, (2003, 9 (3) pp. 191-199).
[41] OHRN (2010), *The pathway of prisoners with mental health problems through prison health services and the effect of the prison environment on the mental health of prisoners*.
[42] Coid, J., 'Ethnic differences in prisoners', *The British Journal of Psychiatry*, Dec 2002.
[43] Knight, L. and Stephens, M., 'Mentally Disordered Offenders in Prison: A Tale of Neglect', *International Journal of Criminology*, 2009.
[44] The Sainsbury Centre for Mental Health (2002), *Breaking the Circles of Fear*.
[45] Mental Health Taskforce to the NHS in England (2016), *The Five-Year Forward View for Mental Health*.
[46] House of Commons Library (2018), *Mental Health Policy in England.*

PREVALENCE

PHE TOOLKIT

The following information relates to the expected prevalence rates found in the PHE Toolkit, and the actual prevalence for the current population using the most relevant READ codes. For Severe Mental Disorders and Common Mental Disorder in Past Week, the actual prevalence across both prisons is lower than the expected rate. For Self-Harm and Suicide, the rates appear high, however this is likely to be due to no direct comparable READ code being used. Across the majority of codes, the rates are higher in HMP Bure.

Figure 3.1.1: Expected prevalence in comparison to actual prevalence.



COMMON MENTAL DISORDER IN PAST WEEK		HMP Bure			
		Expected #	Expected %	READ #	READ %
SEVERE MENTAL DISORDERS	Functional Psychoses (Prison) Psychotic Disorders (General)	45	7.0%	7	1.1%
	Personality Disorders	407	64.0%	16	2.5%
COMMON MENTAL DISORDER IN PAST WEEK	Mixed Anxiety and Depression	121	19.0%	35	5.5%
	Generalised Anxiety Disorder	51	8.0%	6	0.9%
	Depressive Episode	51	8.0%	22	3.5%
	Phobias	38	6.0%		
	Obsessive Compulsive Disorder	45	7.0%	1	0.2%
	Panic Disorder	19	3.0%	1	0.2%
SELF-HARM AND SUICIDE	Suicide Attempts (Past Week)	0	0.0%	0	0.0%
	Suicidal Thoughts (Past Week)	25	4.0%	41	6.4%
	Non Suicidal Self-Harm	45	7.0%	55	8.6%

RECEPTION SCREEN

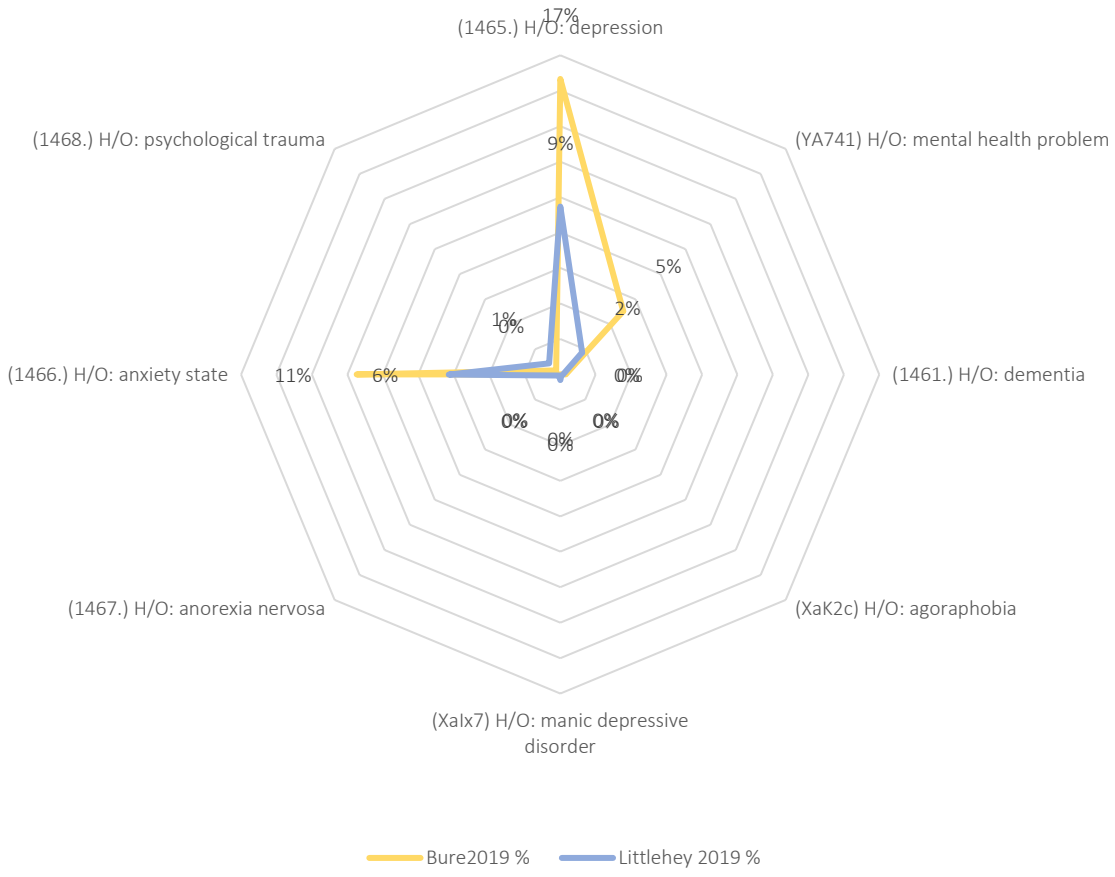
The reception screen in the two prisons are slightly different. In both prisons, the main part of the screen is completed by a primary care nurse. In HMP Bure, a mental health nurse also sees all new arrivals to the prison at reception.

The following analysis is broken down into the separate areas of the mental health section of the reception screen.

Page 1:

- The rates are for the current population.
- These codes were introduced as part of the 2018 National Templates.
- These codes were not used in previous HSCNAs, therefore no comparisons can be made.
- There are higher rates in HMP Bure than HMP Littlehey across a number of codes.

Figure 3.1.2: Prevalence for the current population; READ codes collected at reception screen. Page 1.

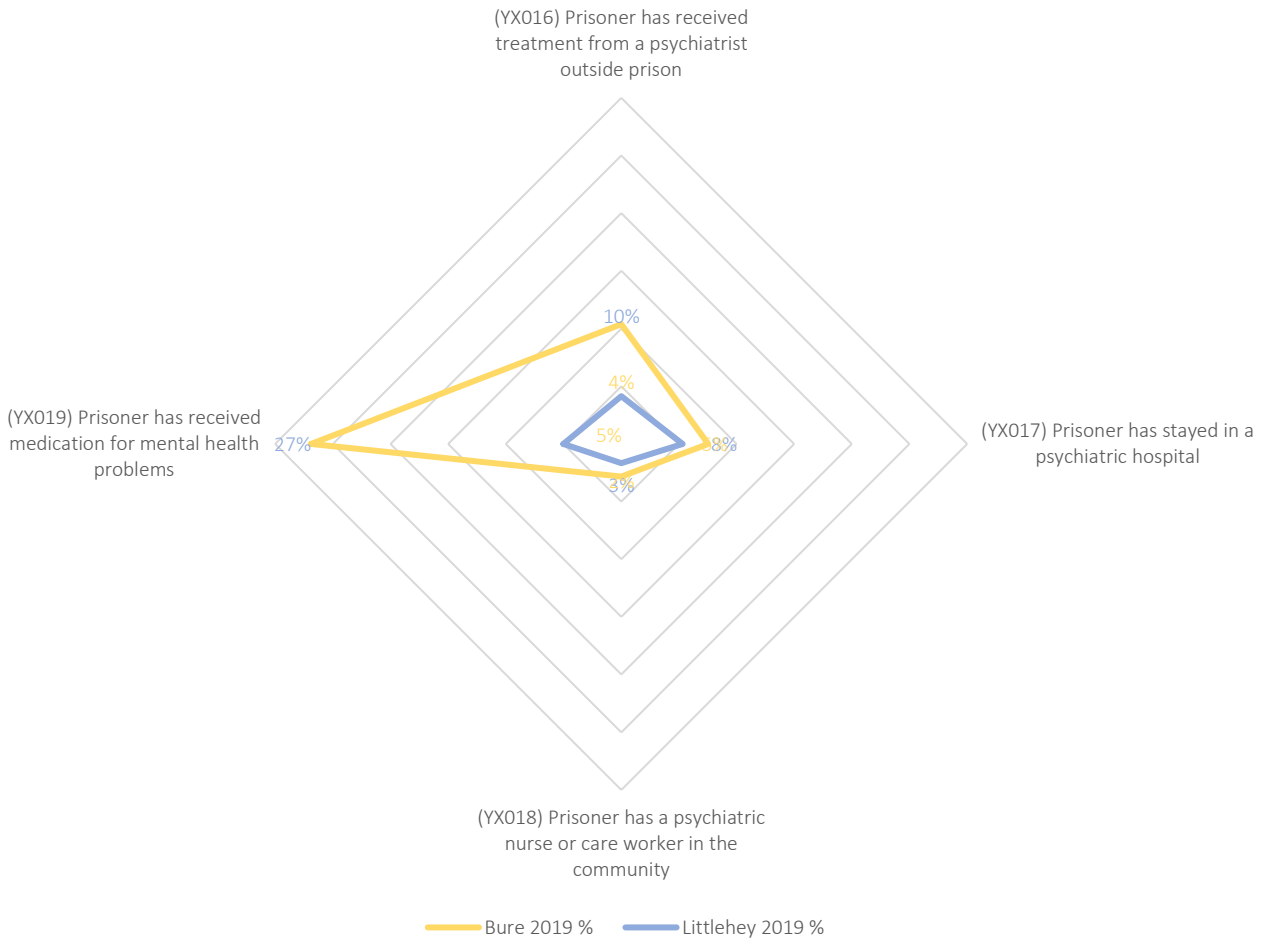


Read code	Bure 2019
(1465.) H/O: depression	106
(1468.) H/O: psychological trauma	2
(1466.) H/O: anxiety state	73
(1467.) H/O: anorexia nervosa	0
(XaIx7) H/O: manic depressive disorder	0
(XaK2c) H/O: agoraphobia	0
(1461.) H/O: dementia	2
(YA741) H/O: mental health problem	32

Page 2 – Section A:

- The rates are for the current population.
- There are higher rates in HMP Bure than HMP Littlehey across a number of codes.
- The rates appear low in HMP Littlehey, particularly for prisoners receiving medication for mental health problems.

Figure 3.1.3: Prevalence for the current population; READ codes collected at reception screen. Page 2 – Section A.



Read code	Bure 2019 #
(YX016) Prisoner has received treatment from a psychiatrist outside prison	66
(YX017) Prisoner has stayed in a psychiatric hospital	48
(YX018) Prisoner has a psychiatric nurse or care worker in the community	18
(YX019) Prisoner has received medication for mental health problems	171

Page 2 – Section B:

This page relates to self-harm and can be found in the self-harm chapter.

QOF REGISTER

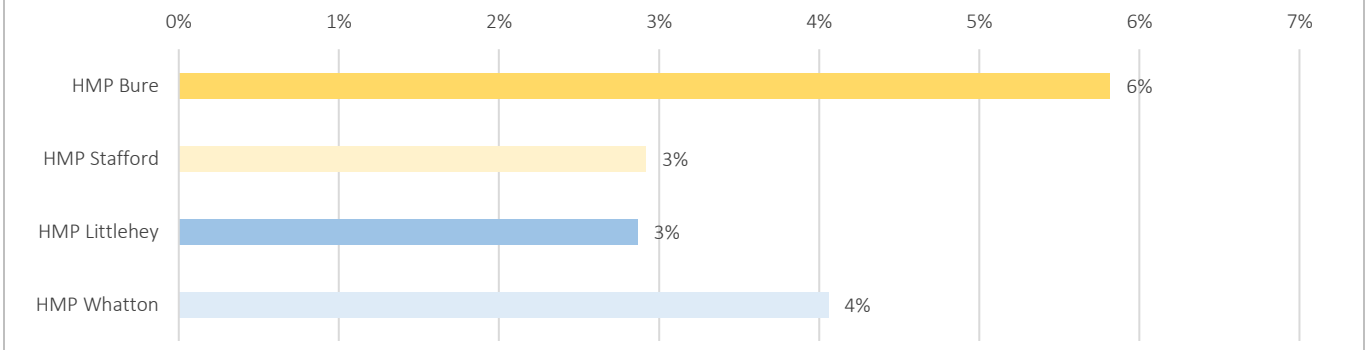
HMP Bure has a higher rate of the current population on the mental health QOF register than HMP Littlehey.

The analysis by age shows a different pattern across both prisons. In HMP Littlehey, excluding the 60+ age group, the prevalence range between the different age groups does not vary greatly. In comparison, the 40-49 age group in HMP Bure exhibits a higher rate than the other age groups.

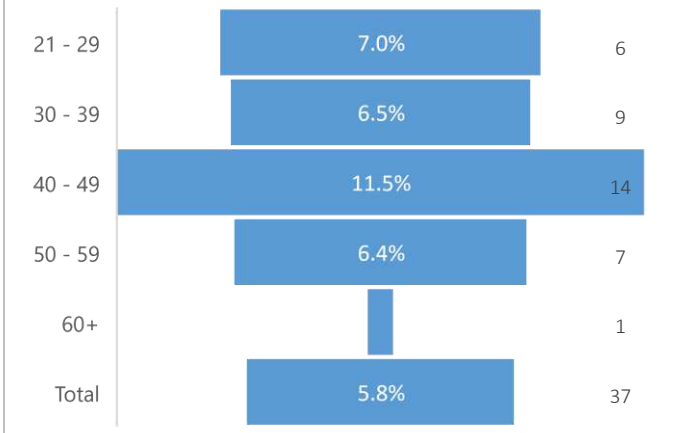
Figure 3.1.4: Analysis of the QOF mental health registers.

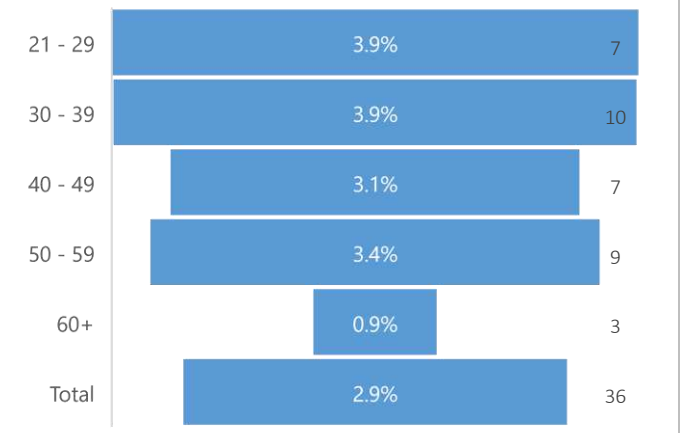
HMP BURE	HMP LITTLEHEY

Comparison of the QOF mental health registers across the two prisons.

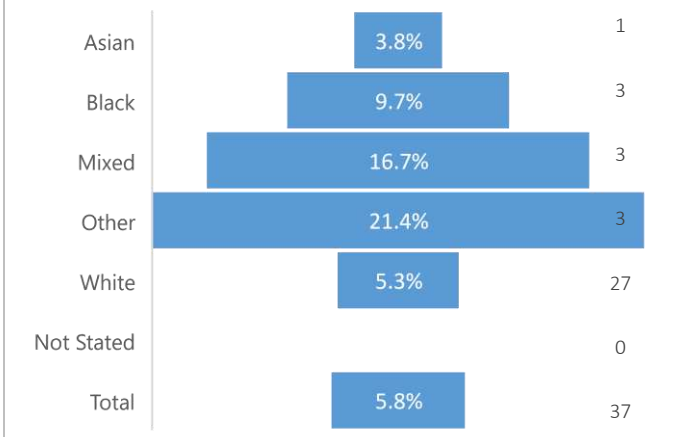


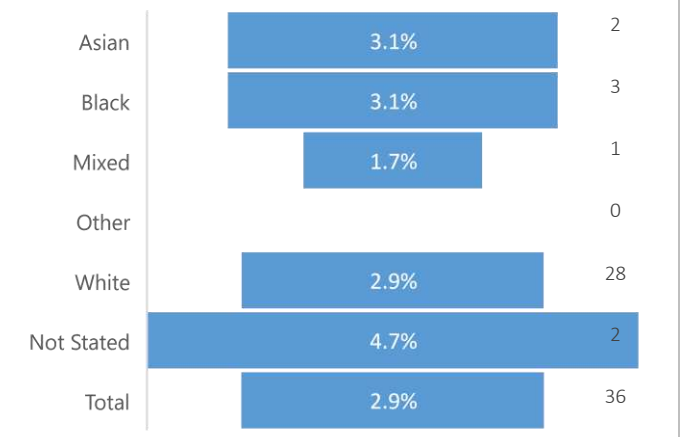
Prevalence by age group.





Prevalence by ethnic group.



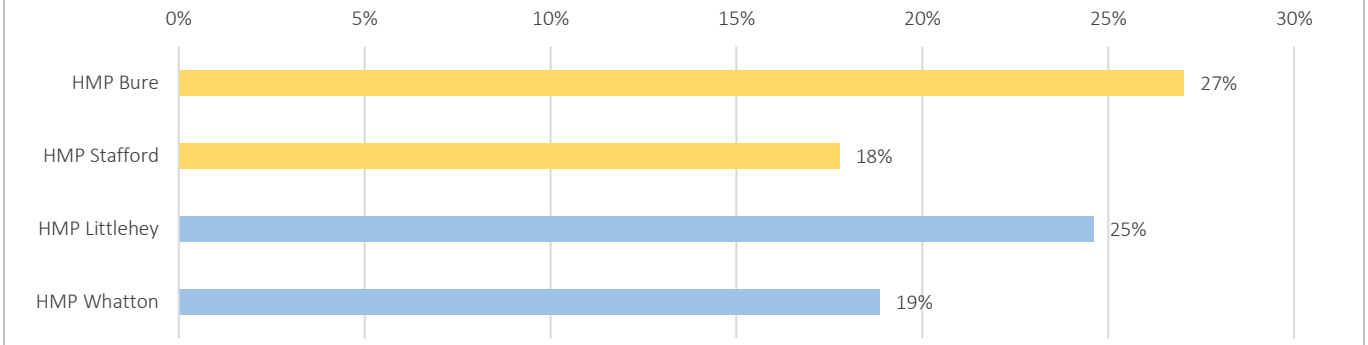


The following table shows an analysis of the QOF depression registers. The rates across the two prisons are similar to each other, however they are greater than the comparator prisons. The analysis by age shows that the 60+ age group reports a comparatively low rate.

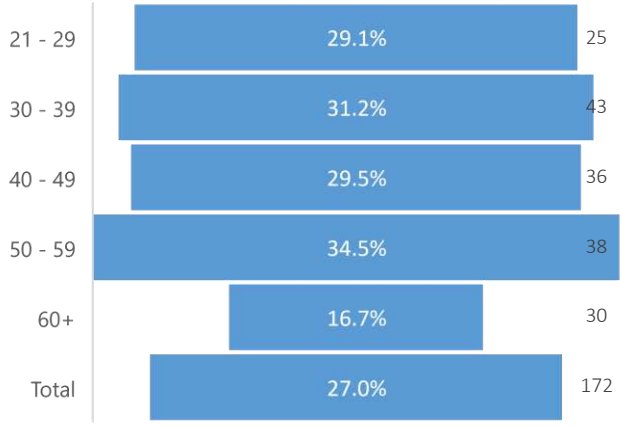
Figure 3.1.5: Analysis of the QOF depression registers.

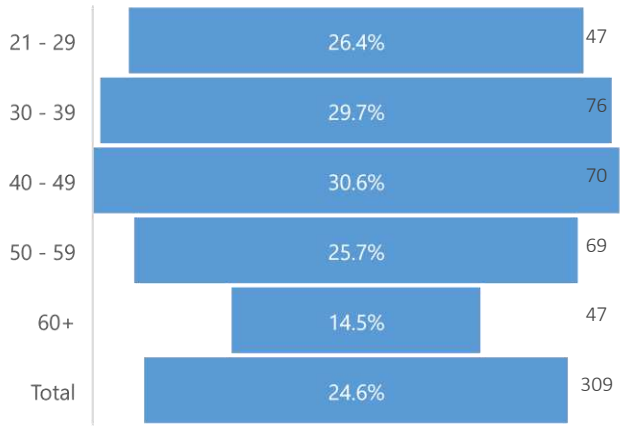
HMP BURE	HMP LITTLEHEY

Comparison of the QOF mental health registers across the two prisons.

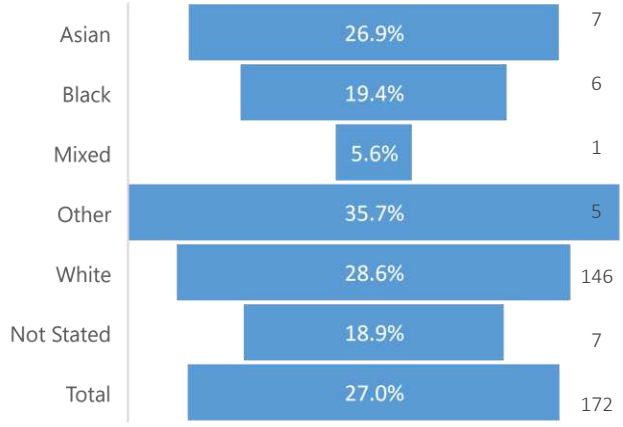


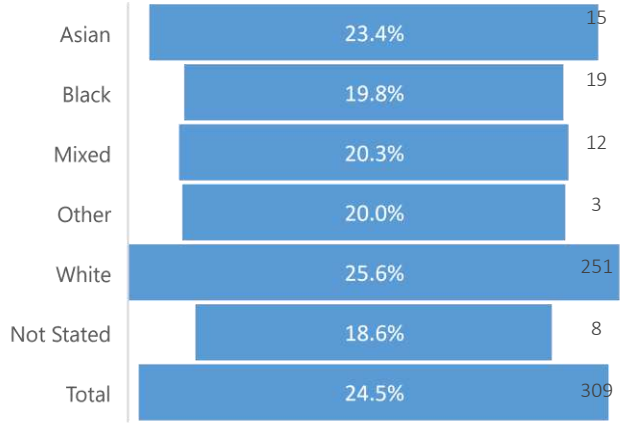
Prevalence by age group.





Prevalence by ethnic group.

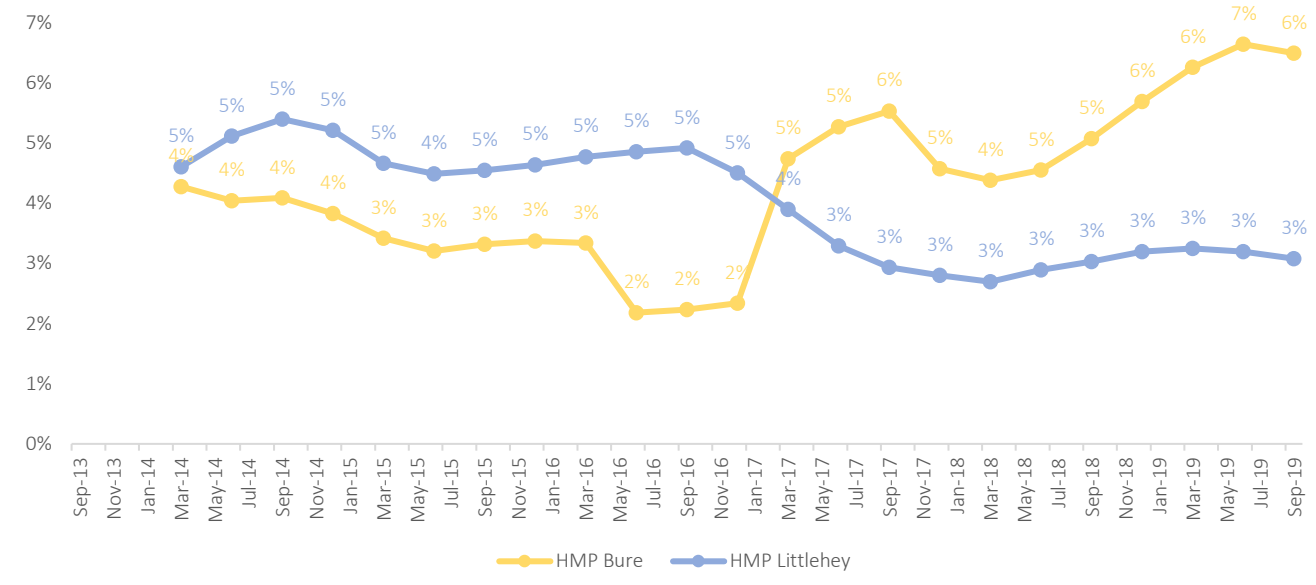




LONG-TERM TREND

The analysis of the long-term trend of the mental health QOF register shows a contrasting pattern. Since 2016, HMP Bure has seen an increase in the rate of those on the register, whereas HMP Littlehey has seen a decrease.

Figure 3.1.6: Long-term trend analysis of the mental health QOF register; rolling 3 month average.



CURRENT PROVISION

HMP BURE
Mental health services in HMP Bure are provided by Care UK. The team are an integrated primary and secondary care mental health team. Care UK began providing a service in the prison in April 2019. IAPT services are provided by Norfolk and Suffolk NHS Foundation Trust. The Mental Health Team is an integrated primary and secondary mental health service. There is a weekly multi-disciplinary team meeting that is attended by mental health team staff including the psychiatrist, the Wellbeing Service (IAPT), and the Psychosocial Service. The hours of operation for the Mental Health Team are: Monday to Friday: 8.00am – 6.00pm Weekends and Bank Holidays: 8.00am – 5.30pm

Figure 3.1.7: HMP Bure Mental Health Service.

Job Title	Number
Band 7 Mental Health Lead	1
Band 6 Registered Mental Health Nurses	2
Band 3 Mental Health Support Worker	1

	HMP BURE
NEED	
PROVISION	Patients with a functional psychosis are likely to be held on the secondary mental health caseload. Patients can see the psychiatrist as clinically necessary and agreed. Mental health practitioners organise health checks for patients in receipt of anti-psychotics for those on their

	HMP BURE
	caseloads. Healthcare assistants run clinics to conduct the monitoring. In HMP Bure, 8% of the population (as of August 2019) were prescribed antipsychotic medication.
NEED	
PROVISION	Depending on how patients present and any co-morbidities, patients with a personality disorder may be managed on the caseload of the Mental Health Team.
NEED	
PROVISION	Mild to moderate mental health issues, including depression, anxiety, low-level PTSD, and mood management are managed on the primary mental health case load. Patients can be held on this caseload if they are waiting for an intervention from the Wellbeing Team, who offer IAPT therapies.
NEED	
PROVISION	There is no counselling provision within the Mental Health Team.
NEED	
PROVISION	Mental health practitioners work with Phoenix Futures regarding patients who are on the caseload of both services.
NEED	
PROVISION	At the time of this HSCNA, there were 21 Listeners in the prison, which is higher than the recommended 13.
NEED	
PROVISION	There are two days a week of psychiatry provision in the prison. The Mental Health Team can also access the psychiatrist one day a week, when they are based in another prison.
NEED	

	HMP BURE
PROVISION	The Mental Health Team practice a CBT approach to self-help, although practitioners are not trained in CBT. The service does not offer an in-depth treatment for trauma. The Wellbeing Service offer some trauma focussed interventions. There are no practitioners trained in EMDR.
NEED	
PROVISION	There was no training provided to prison staff at the time of this assessment.
NEED	
PROVISION	There is no psychology provision in the prison.
NEED	
PROVISION	The Mental Health Team had to manage four sections at once. The Mental Health Team believed that the increase in transfers to secure mental health units was related to drug induced psychosis in prisons. The Mental Health Team have introduced a checklist for staff to follow, when completing a Section 47/ 49 referral.
NEED	
PROVISION	Patients with suspected dementia are able to receive an initial assessment by the GP. Patients who require further assessments can be referred to the Julian Hospital in Norwich. Patients have to travel to the hospital to receive an assessment. The assessment can require a number of appointments and includes a CT scan.

	HMP BURE
	Healthcare can complete blood tests and ECGs in the prison. Prison officers receive training from staff from the Forget-me-not charity. The charity run dementia groups in the prison. At the time of this assessment there was one patient diagnosed with dementia in the prison.
NEED	
PROVISION	The Mental Health Team said that there were not many patients with an ADHD diagnosis being identified in the prison. It was described as difficult to get an ADHD diagnosis for a patient, with long waits in place for specialists from the Norfolk and Norwich Hospital. At the time of this assessment, there was one patient in receipt of ADHD medication.

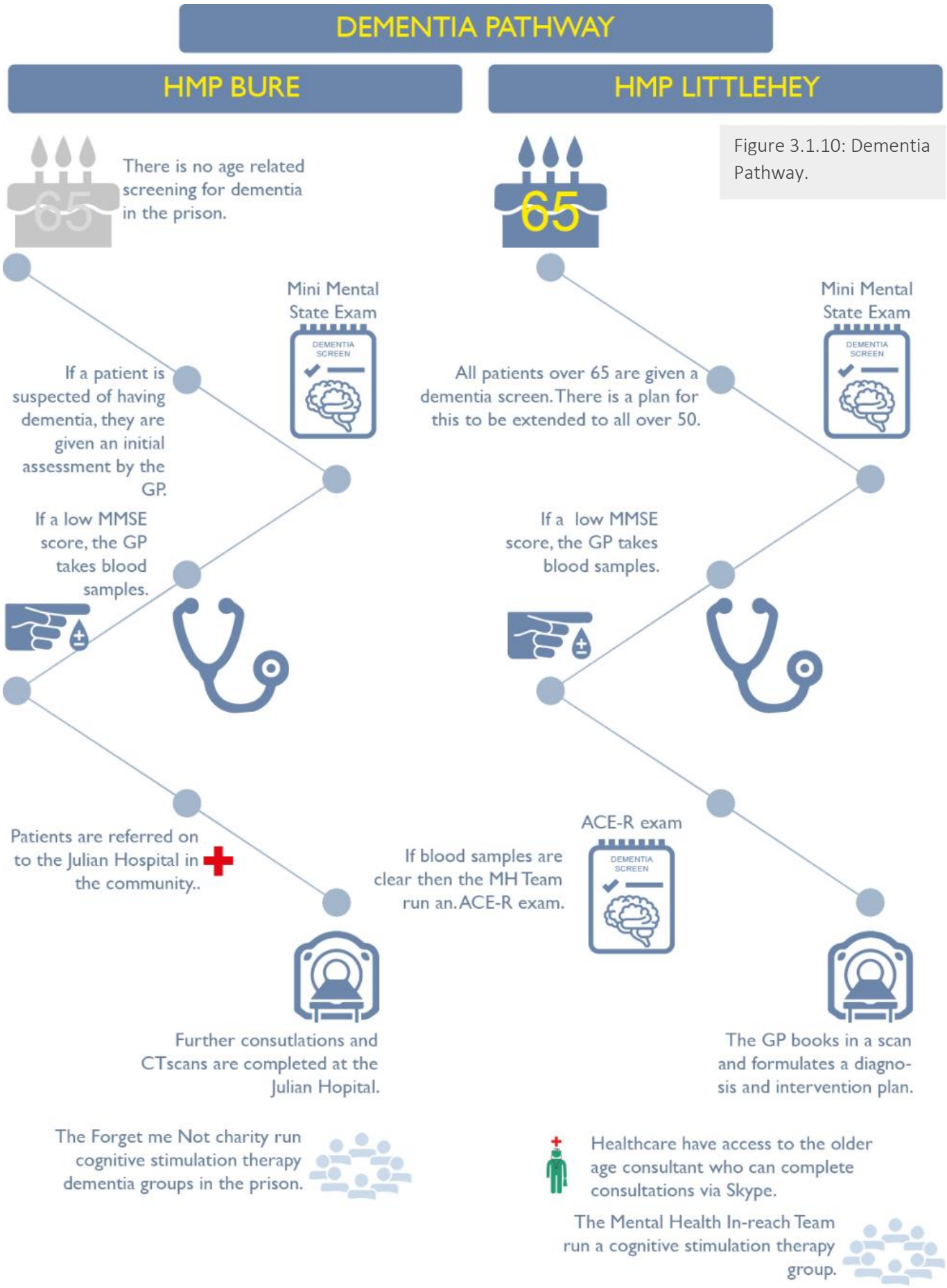


Figure 3.1.10: Dementia Pathway.

In March 2017, NICE released guidance for the treatment of adults with mental health problems in contact with the criminal justice system.[47] The document does not give specific recommendations for interventions, but instead refers practitioners to existing NICE guidance. The new guidance makes the point that there is a need 'to modify the delivery of psychological interventions in the criminal justice system' and 'to ensure continuity of the psychological intervention (for example, transfer between prison settings or on release from prison)'.[48]

Prevalence figures indicate that there is a high need in prison relating to all mental health disorders (see page 92). The table below is taken from NICE guidelines and shows the stepped care model for people with common mental health disorders, including the recommended interventions. The table also includes a column showing how the provisions are met in the two prisons.

Figure: 3.1.11: Local provision against NICE guidelines.

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

[47] NICE (2017), *Mental health of adults in contact with the criminal justice system* [NG66].
[48] NICE (2017), *Mental health of adults*.

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

			group work interventions.	assistant psychologist.
	PTSD: Trauma-focused CBT or EMDR.	Trauma-focused CBT	The IAPT run interventions for patients with trauma issues.	Group work is offered by the assistant psychologist.
		EMDR	This is not offered in the prison.	
	All disorders: Support groups, educational and employment support services; referral for further assessment and interventions.	Support groups	The IAPT services run some limited group work interventions.	Group work is offered by the assistant psychologist.
Step 1: All disorders – known and suspected presentations of common mental health disorders.	**All disorders:** Identification, assessment, psychoeducation, active monitoring; referral for further assessment and interventions.	In both prisons, patients on step 1 of the stepped care model are managed by the GP.		

* Discuss with the person the uncertainty of the effectiveness of counselling and psychodynamic psychotherapy in treating depression.

** For people with depression and a chronic physical health problem.

† For women during pregnancy or the postnatal period.

CBT, cognitive behavioural therapy; ERP, exposure and response prevention; EMDR, eye movement desensitisation and reprocessing; GAD, generalised anxiety disorder; OCD, obsessive compulsive disorder; IPT, interpersonal therapy; PTSD, post-traumatic stress disorder.

IAPT SERVICES

INTRODUCTION

In HMP Bure there is a separately commissioned IAPT service. IAPT services are provided by Norfolk and Suffolk NHS Foundation Trust.

The IAPT service provide interventions to those on Step 2 and Step 3 on the mental health stepped care model. The IAPT Team predominantly offer one-to-one interventions.

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

There are no IAPT services in HMP Littlehey, however the assistant psychologist runs CBT based groups.

STAFFING

Figure 3.1.12: HMP Bure IAPT Service staffing.

Job Title	Number
Psychological Therapist	1
Practitioner	2

REFERRALS

Referrals can be received from any source including self-referrals. In HMP Bure prisoners can self-refer using paper referral forms.

[REFERRAL INFORMATION TO BE SUPPLIED]

Assessments are aimed to be completed within 28 days. If there are high numbers of referrals, this time frame can be breached.

INTERVENTIONS

The IAPT service provide interventions to those on Step 2 and Step 3 on the mental health stepped care model. The IAPT Team predominantly offer one-to-one interventions.

The group work provision is in the process of being updated. The same groups will be offered between the three Norfolk prisons to aid continuity of care.

At the time of this assessment, a self-esteem group is run. Patients in HMP Bure are more stable which allows them to commit to a longer programme of groupwork.

There are 9 workbooks that are used in one-to-one interventions:

- First steps to your wellbeing
- Get active feel good
- Anxiety workbook
- Developing skills to meet your needs
- Worry workbook

- Learning to relax
- New to prison
- Adjustment – leaving prison
- Problem solving

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

There are no joint groups with the Psychosocial Team, however this is being considered by the Wellbeing Team.

EMDR is not offered in the prison.

TREATMENT PATHWAY

Figure 3.1.13: Mental health pathway in the prisons.

MENTAL HEALTH SERVICES

HMP BURE

PROVIDER: care UK

REFERRALS

A MH practitioner sees all new prisoners at reception.
The team have an open referral process, including self-referrals.

ASSESSMENTS

Urgent referrals are assessed within: 4 hours
Routine referals are assessed within: 48 hours

CASELOAD

Primary Care Caseload 30
Secondary Care Caseload 19

INTERVENTION

The Mental Health Team offer 1-2-1 interventions to patients on their caseload. There are no groupwork sessions offered by the team.

The IAPT service run some limited groupwork interventions.

HMP LITTLEHEY

PROVIDER: Northamptonshire Healthcare NHS Foundation Trust

REFERRALS

A MH practitioner sees all new prisoners on the day following their arrival in the prison
The team also run a weekly drop-in session where they can speak to patients with a mental heatlh need

ASSESSMENTS

Routine referals are assessed within: 5 days

CASELOAD

Primary Care Caseload 38
Secondary Care Caseload 5

INTERVENTION

The Mental Health Team offer 1-2-1 interventions and a number of groupwork interventions including trauma, anxiety, and low mood groups.

HMP BURE
A member of the Mental Health Team sees all new arrivals to the prison at reception. From here, a patient can be referred to the Mental Health Team, Wellbeing service, or the Drug and Alcohol Team. Potential patients are discussed at the tri-team meeting between the Psychosocial Team, the Wellbeing service, and the Mental Health Team. The team can also receive referrals from other sources, including the ACCT review process, entering the prison with the CPA initiated, or identified need through the multi-disciplinary team meeting.
New routine referrals at HMP Bure will be screened and assessed by the IMHT within two working days. Referrals via the ACCT process will be screened and assessed within six hours during the normal working day or, if out of hours, within six hours of the next working day but as soon as practicably possible. Urgent referrals will be screened and assessed within four hours or, if out of hours, as soon as practicable on the next working day but within four hours.
At the time of this assessment, there were 30 patients on the caseload of the Primary Care Team and 19 patients on the caseload of the Secondary Mental Health Team. The Mental Health Team were exploring offering Recovery College interventions with support from local NHS mental health forensic services.[49]

[49] A recovery college takes an educational rather than a clinical or rehabilitation approach to improving mental health. As far as possible the distinction between service users and professionals is avoided and there is an emphasis on co-production, co-delivery and co-participation in the learning. An individual with experiences of mental health problems can be engaged in designing and delivering courses and not all of those participating in those courses will have a psychiatric diagnosis. (https://www.open.edu/openlearn/health-sports-psychology/health/health-studies/mental-health/five-things-you-might-know-about-recovery-colleges)

MENTAL HEALTH TRANSFERS

Below shows the number of mental health secure assessments[50] for the 12 months to June 2019 in comparison with the 12 months to June 2018, taken from the HJIPs. The number of assessments in HMP Bure has decreased from 3 to 0 over the two periods. HMP Littlehey has also seen a decrease over the 2 periods from 7 to 4 assessments.

As a snapshot for June 2019, there were no patients awaiting second assessment[51] or awaiting transfer[52] in HMP Bure. In HMP Littlehey, there was 1 patient awaiting second assessment and 1 patient awaiting transfer.

Figure 3.1.14: Number of mental health secure assessments.

	HMP Bure			
Key Performance Indicator/Information Measure	YT June 2018	YT June 2019		
Mental Health Secure Assessment	3	0		

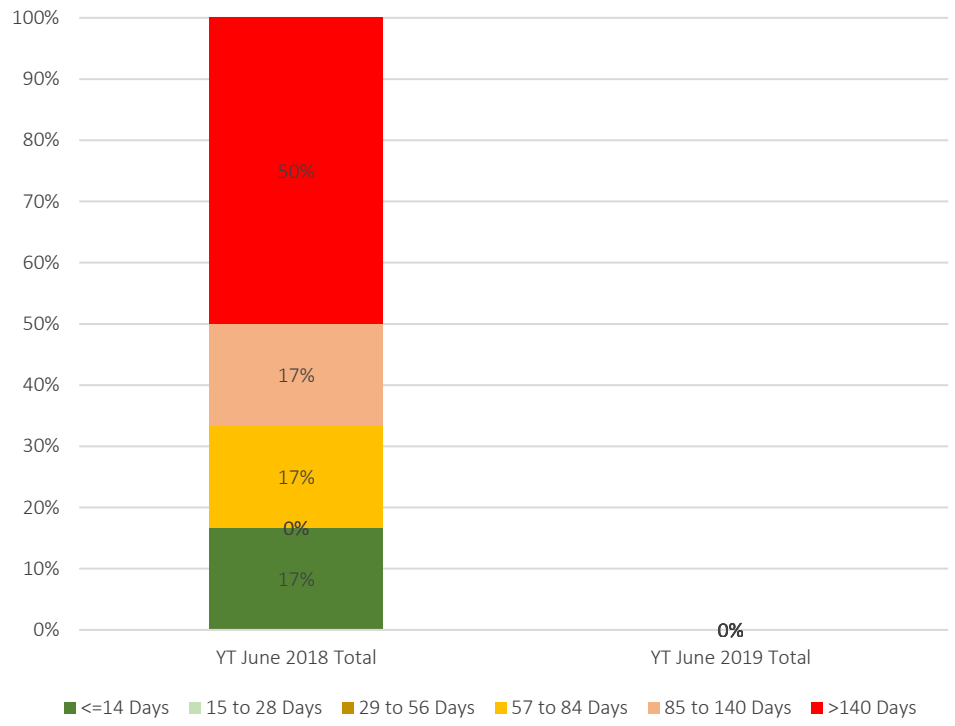
Figures 3.1.15 and figure 3.1.16 show the number of mental health transfers for the 12 months to June 2019, compared with the 12 months to June 2018, broken down by waiting time from first identification as suitable for transfer under the Mental Health Act (initial assessment), to actual transfer.

In HMP Bure there were no transfers for the 12 months to June 2019, compared with 6 for the previous period. Of the 6 transfers for the 12 months to June 2018, only 1 was completed within the recommended 14 days.

Mirroring the decrease in mental health secure assessments, the number of transfers has seen a decrease in HMP Littlehey. In terms of transfer times, the number of transfers within the recommended 14 days has seen a notable decrease. For the 12 months to June 2018, 5 (71%) of the 7 transfers were within 14 days, compared with only 1 (25%) of the 4 transfers for the 12 months to June 2019.

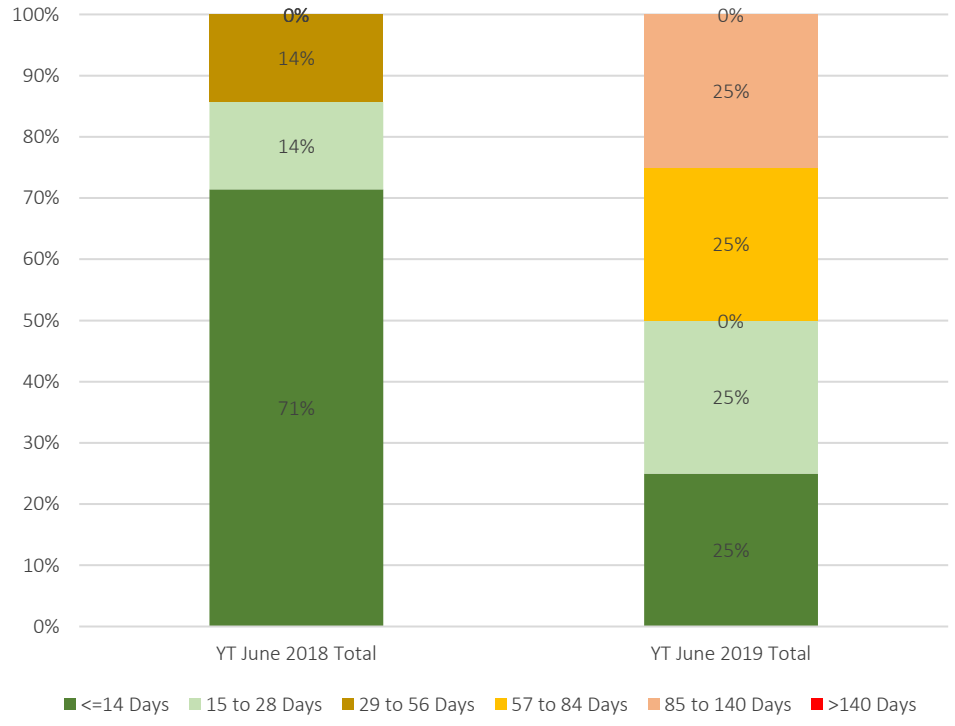
[50] Number of prisoners who received an initial psychiatric assessment, where transfer was deemed appropriate, under the terms of the Mental Health Act. NB. This refers to the number of initial assessments where a decision to create a formal referral was reached. Initial assessment is defined as that occurring in the originating location, prior to any referral decision.
[51] The number of patients awaiting 2nd assessment, where referral has been made, after being deemed suitable by prison assessment.
[52] Number awaiting MH transfer, deemed as appropriate following 2nd assessment.

Figure 3.1.15: Mental health transfers from HMP Bure.



Transfer Days	YT June 18 Total	YT June 19 Total
<=14 days	1	0
15 to 28 days	0	0
29 to 56 days	0	0
57 to 84 days	1	0
85 to 140 days	1	0
> 140 days	3	0
Total	6	0

Figure 3.1.16: Mental health transfers from HMP Littlehey.



Transfer Days	YT June 18 Total	YT June 19 Total
<=14 days	5	1
15 to 28 days	1	1
29 to 56 days	1	0
57 to 84 days	0	1
85 to 140 days	0	1
> 140 days	0	0
Total	7	4

SELF-HARM

HMP BURE	
GENERAL	
In both prisons, the Safer Custody Team worked with Healthcare to maximise attendance at ACCT reviews.	
INCIDENTS	
A range of indicators suggests that self-harm is more of an issue in HMP Littlehey than in HMP Bure. In 2016, there were on average 9 self-harm incidents per month in HMP Bure. For 2018, this reduced to 6 per month, and for Qtr-1 of 2019, this further reduced to 5 a month, which equates to a 44% decrease. In 2016, there were on average 22 self-harm incidents per month in HMP Littlehey. For 2018, this increased to 45 per month, and for Qtr-1 of 2019, this has remained at 45 per month, equating to a 105% increase. The 2018-19 annual performance ratings gives a rate of 481 self-harm incidents per 1000 prisoners[53] for HMP for Littlehey compared to 104 in HMP Bure. The rate in HMP Littlehey far exceeds the set target resulting in a poor performance rating. In contrast, HMP Bure was well within the target resulting in a top performance rating. Across a range of self-harm related READ codes, the rates are higher in HMP Littlehey, although codes relating to thoughts and history of attempted suicide are higher in HMP Bure. This may be linked to the higher rates of self-harm incidents in HMP Bure that required hospital attendance.	
Up until March 2019, there were relatively few self-harm incidents in the prison. The safer custody lead confirmed that since March, there have been 3 new prisoners transferred into the prison who have had multiple self-harm incidents. It was reported that in July, there were 46 self-harm incidents.	
AN UP-TO-DATE POLICY IS IN PLACE	
There are up to date self-harm documents in both prisons.	
ACCT	
At the time of this assessment, there were 5 open ACCT documents. The Safer Custody Team have a good relationship with the Mental Health Team in the prison and they attend all ACCT reviews.	

[53] See Annual Performance Ratings for full definition.

INTRODUCTION

The incidence of self-harm in prison is rising across the prison estate, particularly among older adult males.[54] A 2018 HMPPS rapid evidence assessment[55] on self-harm by adult men in prison was completed in order to understand:

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

The report reiterated a number of risk factors for men who self-harm in prison. It also found that there is "very little evidence on protective factors and limited research exploring the relationships between risk and protective factors."[56] Risk factors for men who self-harm include:

Socio-demographic factors:

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

Custodial/prison-related factors:

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

Psychological/psychiatric factors:

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

In December 2013, the results of the largest ever study of self-harm and suicide in prison was published by *The Lancet*.[57] The report found that in England and Wales, standardised mortality ratios for suicide are five times higher in male prisoners than in the general population.

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

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

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

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

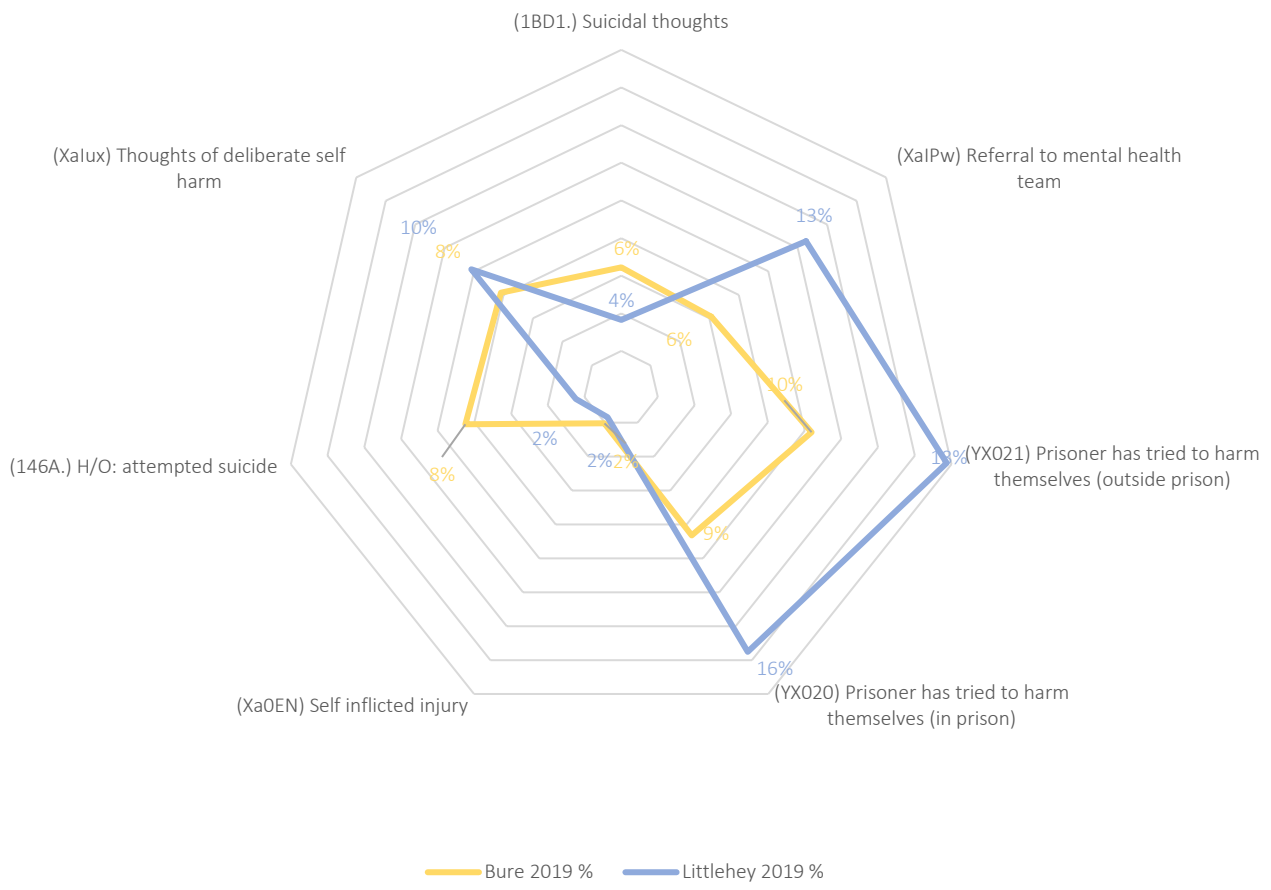
RECEPTION SCREEN

As part of the reception process, questions relating to self-harm are included in the reception screening template. Below shows the prevalence for the current population as of September 2019.

Page 2 – Section B:

- The rates are for the current population.
- There are a number of codes which are higher in HMP Littlehey compared with HMP Bure.
- The higher prevalence reflects the higher rate of self-harm incidents in HMP Littlehey.

Figure 3.2.1: Prevalence for the current population; READ codes collected at reception screen. Page 2 – Section B.



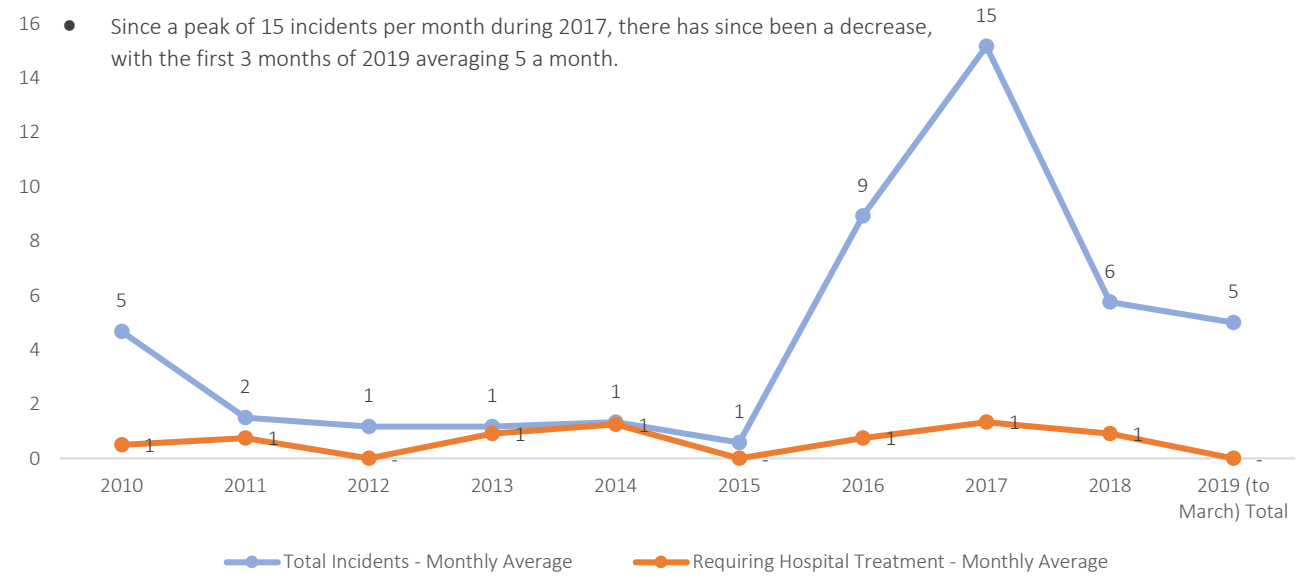
Read code	Bure 2019 #
(1BD1.) Suicidal thoughts	41
(Xalux) Thoughts of deliberate self harm	52
(146A.) H/O: attempted suicide	54
(Xa0EN) Self inflicted injury	13
(YX020) Prisoner has tried to harm themselves (in prison)	55
(YX021) Prisoner has tried to harm themselves (outside prison)	66
(XaIPw) Referral to mental health team	39

Safety in Custody quarterly: update to March 2019

These figures are part of the Ministry of Justice Safety in Custody Statistical bulletin[58]. The analysis covers January 2004 to March 2019, and shows the number of incidents and the number of incidents that required hospital treatment. Incidents under 5 are supressed which means a monthly analysis is not possible. The analysis therefore is based on the monthly average using the year total.

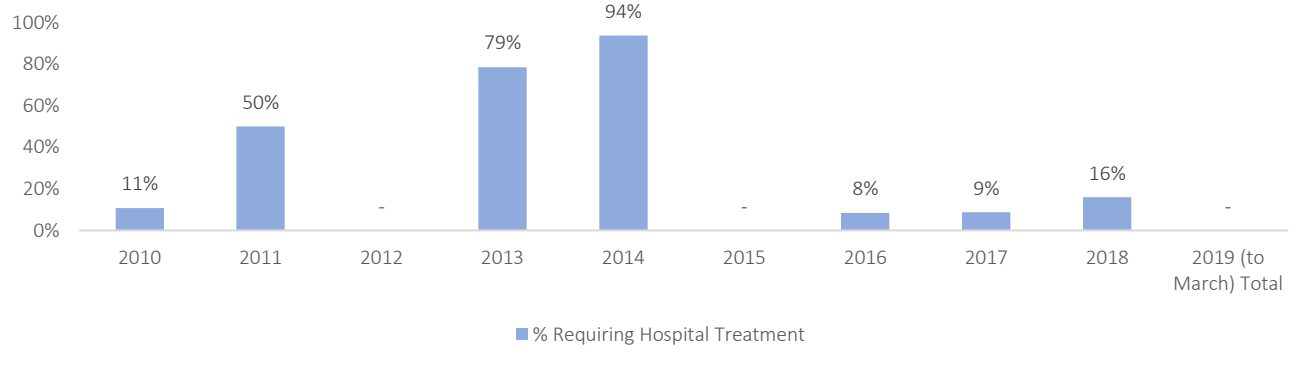
HMP BURE

Figure 3.2.2: Self-harm incidents; total number of incidents, and the total number of incidents requiring hospital treatment; monthly average (chart) and yearly total (table)[59].



Bure	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019 (to March) Total
Total Incidents	56	18	14	14	16	7	107	182	69	15
Requiring Hospital Treatment	6	9	-	11	15	-	9	16	11	-

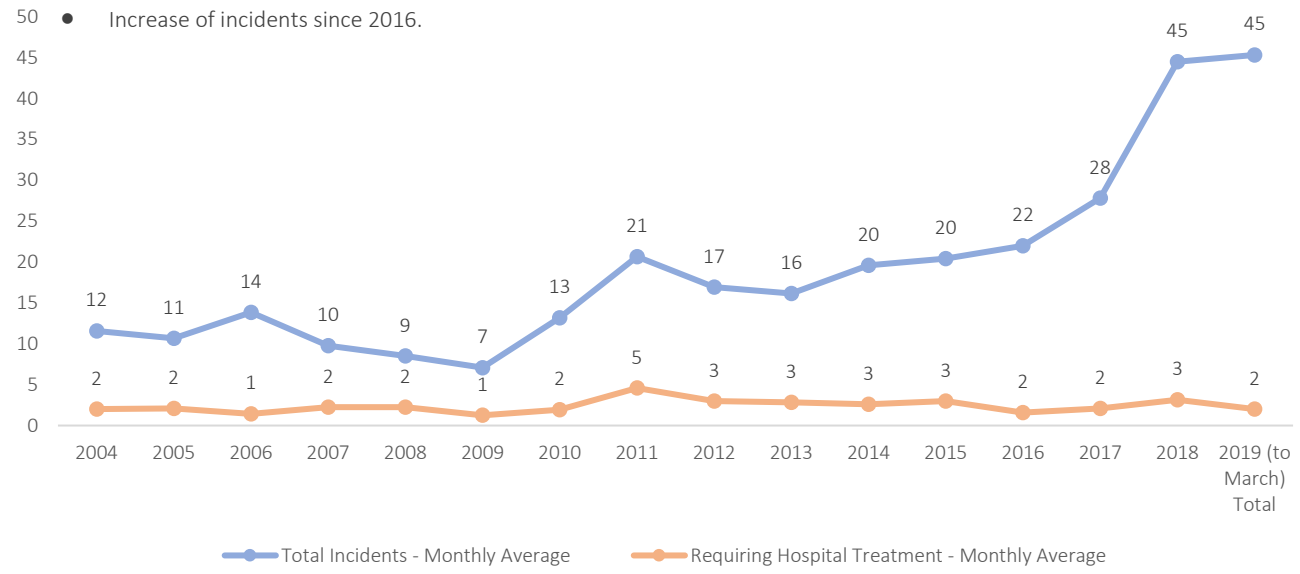
Figure 3.2.3: The percentage of self-harm incidents requiring hospital treatment.



[58] https://www.gov.uk/government/collections/safety-in-custody-statistics
[59] (-) figures of 5 or less and therefore been suppressed.

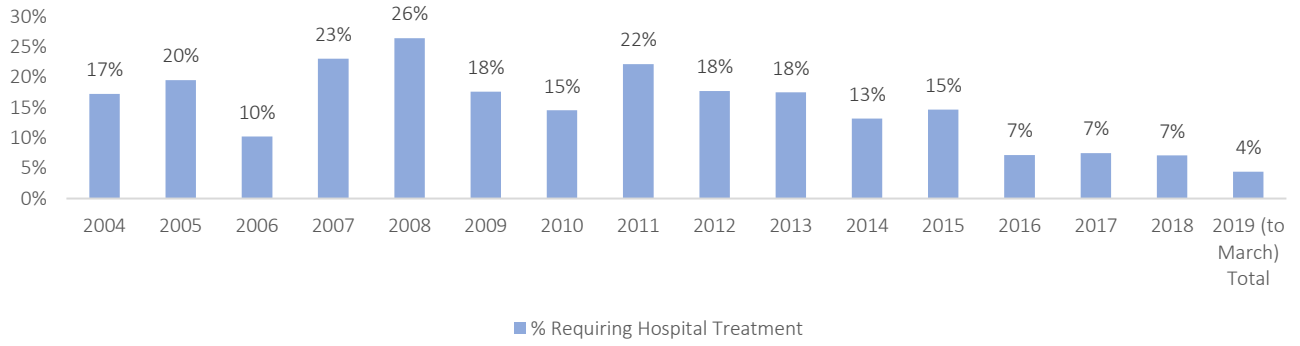
HMP LITTLEHEY

Figure 3.2.4: Self-harm incidents; total number of incidents, and the total number of incidents requiring hospital treatment; monthly average (chart) and yearly total (table)[60].



Littlehey	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019 (to March) Total
Total Incidents	139	128	166	117	102	85	158	248	203	194	235	245	264	334	534	136
Requiring Hospital Treatment	24	25	17	27	27	15	23	55	36	34	31	36	19	25	38	6

Figure 3.2.5: The percentage of self-harm incidents requiring hospital treatment.



[60] (-) figures of 5 or less and therefore been suppressed.

Annual Prison Performance Ratings[61]

The Annual Prison Performance Ratings are derived from the Prison Performance Tool (PPT), which was introduced in April 2018 for the 2018/19 reporting year, replacing the Custodial Performance Tool used in 2017/18. All prison performance ratings reflect performance between 1st April 2018 and 31st March 2019.

The performance measure is based on self-harm incidents reported as a rate per 1,000 prisoners. Self-harm is defined as any act where a prisoner deliberately harms or injures themselves.[62] The target is locally set with the ratings based on a 1-4 scale as summarised below.

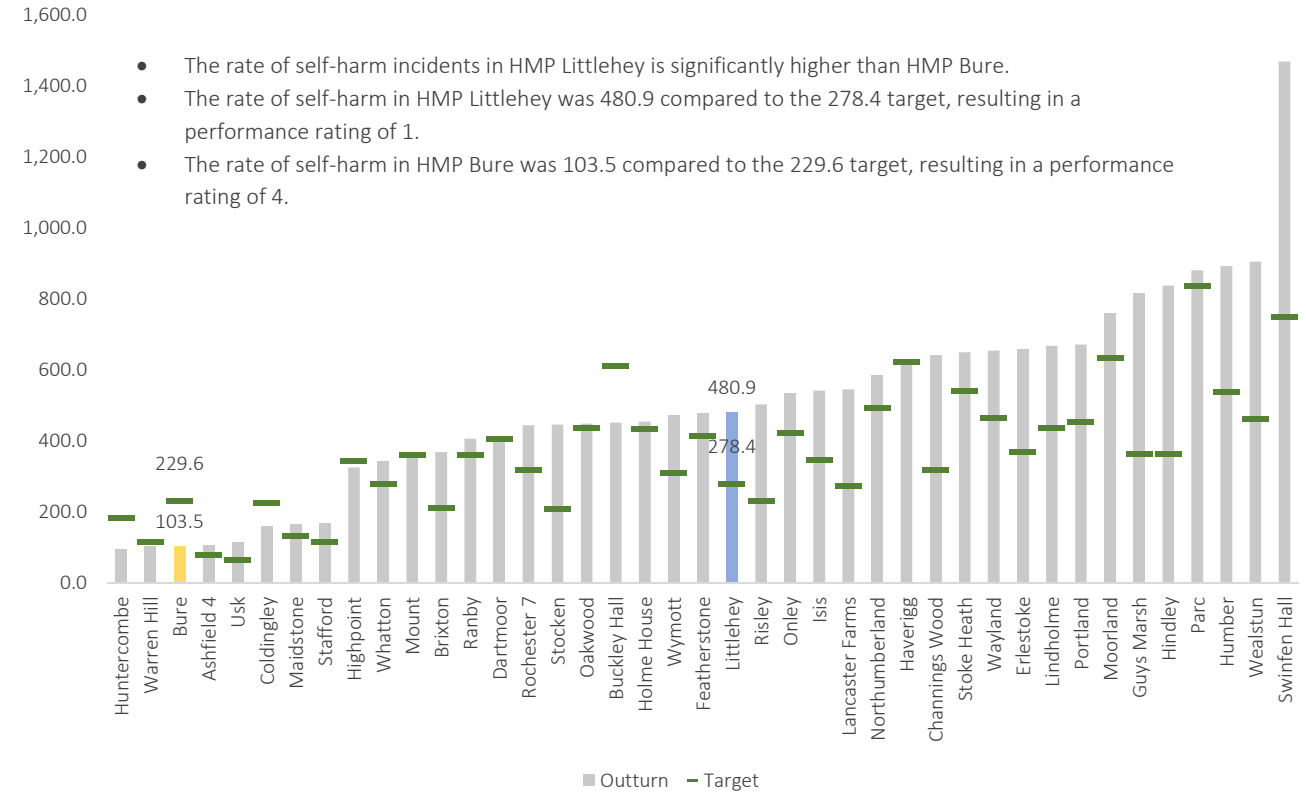
Performance Measure	Measure Rating			
	1	2	3	4
Self-harm incidents – rate per 1,000 prisoners	Greater than 125% of target	Greater than 100% and less than or equal to 125% of target	Less than the target and greater than 75% of target.	Less than or equal to 75% of target
Key	Performance is of serious concern.	Performance is of concern.	Performance is acceptable.	Performance is exceptional.

The 2018/19 comparator groups of prisons can be found below. A statistical methodology is used to calculate the comparator groups. A number of contextual variables are used to determine a statistical score for each prison. HMP Bure and HMP Littlehey share five out of the eight comparator prisons as highlighted in green.

Prison	Comparator Prison							
	1	2	3	4	5	6	7	8
Bure	Usk	Ashfield	Stafford	Dartmoor	Whatton	Littlehey	Channings Wood	Huntercombe
Littlehey	Whatton	Wymott	Bure	Stafford	Moorland	Usk	Ashfield	Northumberland

[61] https://www.gov.uk/government/statistics/prison-performance-ratings-2018-to-2019
[62] Data source = prison NOMIS.

Figure 3.2.6: Self-harm performance taken from the Annual Prison Performance Ratings; 2018-19. Table shows performance against comparator prisons.



Prison	Comparator Prison							
	1	2	3	4	5	6	7	8
Bure	Usk	Ashfield	Stafford	Dartmoor	Whatton	Littlehey	Channings Wood	Huntercombe
Littlehey	Whatton	Wymott	Bure	Stafford	Moorland	Usk	Ashfield	Northumberland

This is a subset of records reviewed as part of the Incident Reporting System Audit, looking specifically at self-harm incidents. If a prison does not meet the target of 85% of self-harm incidents correctly recorded, the maximum rating they can achieve for the self-harm rate performance measure is 2. Both prisons score the maximum of 4.

Figure 3.2.7: Self-harm checks.

Performance Measure	Description	Prison	Target	Outturn
Incident Reporting System – self-harm checks	Percentage of self-harm incidents checked in the Incident Reporting System Data Quality Audit recorded on Prison-NOMIS.	HMP Bure	National: 85%	94.1%
		HMP Littlehey	National: 85%	92.3%

SELF-INFLICTED DEATHS

There have been no incidents of self-inflicted deaths in HMP Bure. In HMP Littlehey, the last self-inflicted death was in October 2018, with the prior incident occurring in August 2012.

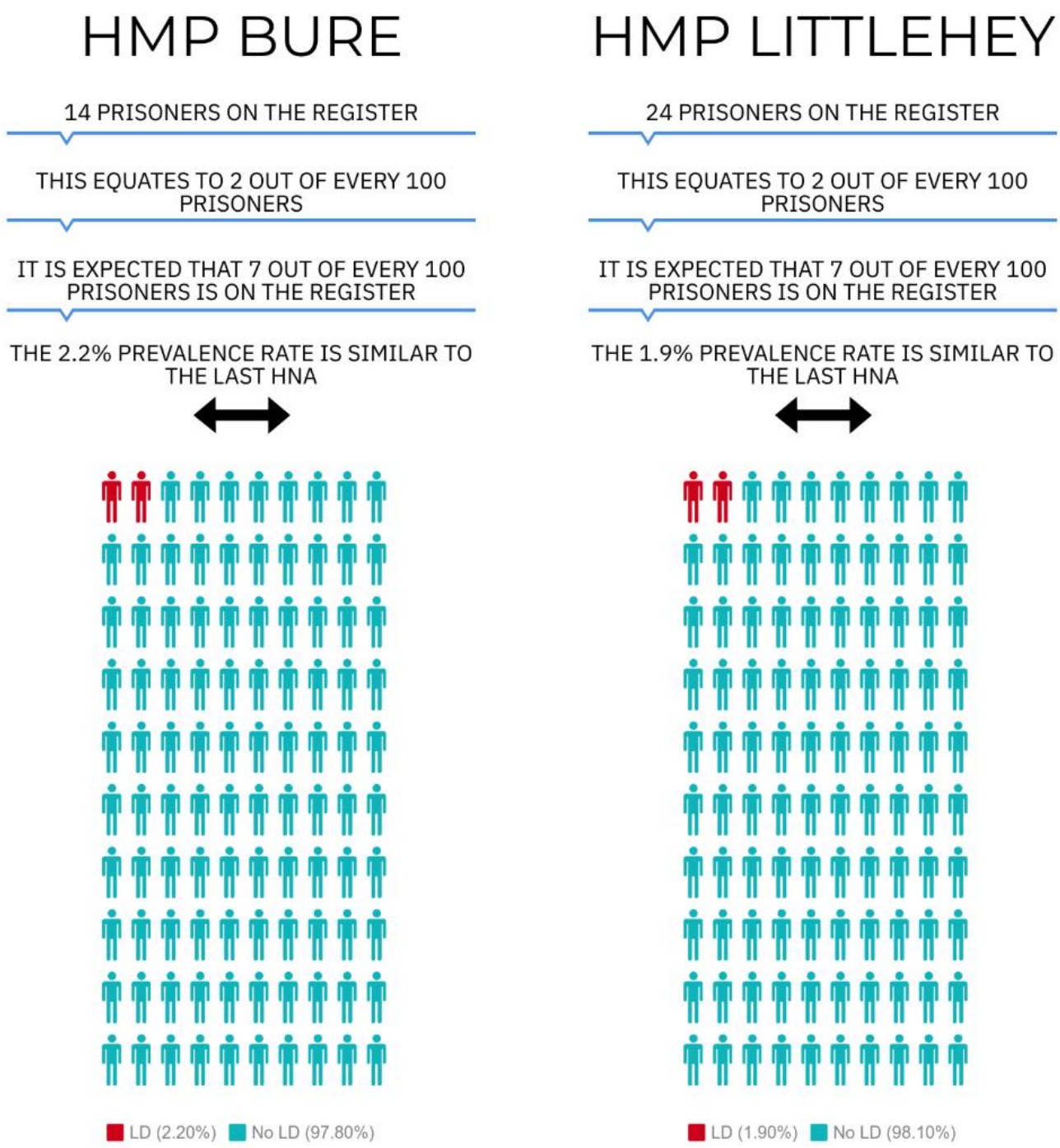
LISTENERS

HMP BURE
At the time of this assessment, there were 21 Listeners in the prison. The training of Listeners is managed by the Samaritans. The Samaritans attend all Safer Custody meetings. Consultations normally take place in cells, but there is also a Listener suite available. There is a Samaritans phone available on all wings.

LEARNING DISABILITIES

HMP BURE
Patients with a learning disability are managed on the caseload of the Mental Health Team. Patients with learning disabilities are normally picked up via the healthcare reception screen. Referrals can also be made from other sources, such as the Wellbeing Team. There are no specialist learning disability or neurodevelopmental practitioners within the Mental Health Team. Mental health practitioners organise health checks for patients with learning disabilities.

Figure 3.3.1: Overview of learning disabilities.



SOCIAL CARE

INTRODUCTION

THE CARE ACT

RESPONSIBILITY

The Care Act sets out new responsibilities for local authorities for arranging and funding services to meet the care and support needs of adults who are detained in prison, or who are resident in approved premises. The Care Act addresses the existing social care provision in prisons, which has been described as "variable, sparse and non-existent".[63]

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

"Social care services are important for people in the criminal justice system who have care and support needs. It supports their rehabilitation and may positively impact on the likelihood of reoffending and the person's ability to rebuild their lives on release".[64]

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

ELIGIBILITY CRITERIA

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

CONTINUITY OF CARE

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

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

DIFFERENCES FOR PRISONERS

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

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

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

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

PRISON SERVICE INSTRUCTIONS

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

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

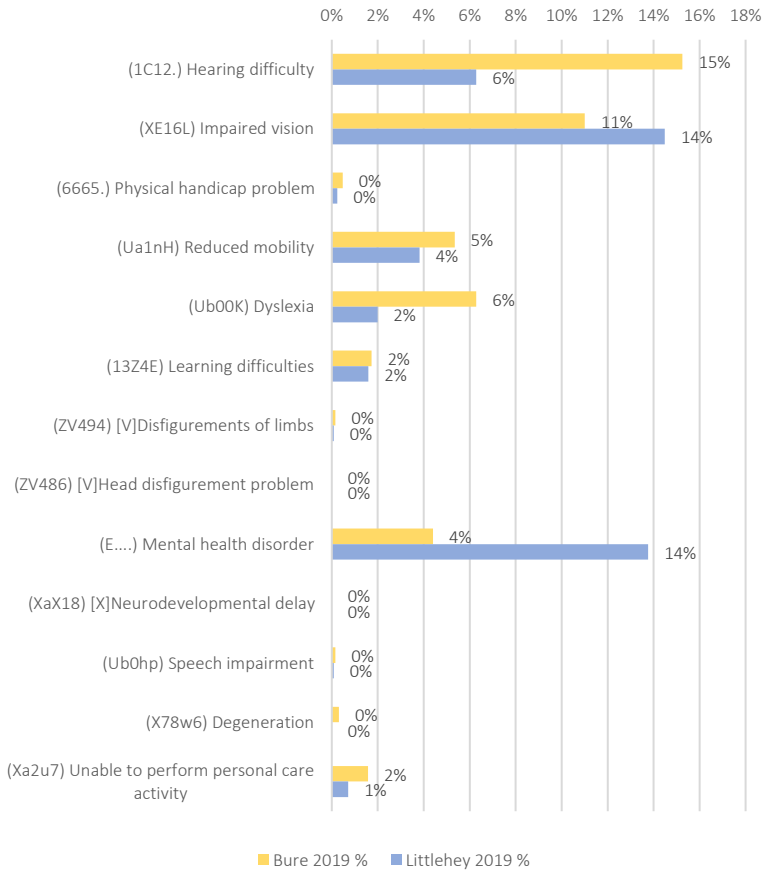
HMP BURE
In HMP Bure, social care assessments and care provision is the responsibility of Norfolk County Council. Two Memorandum of Understanding have been drafted. One covers the relationship between Norfolk County Council and Care UK, and the other covers the relationship between Norfolk County Council and the prison. The Memorandum of Understanding covers the three prisons in the Norfolk Cluster. The lead commissioner for Norfolk County Council stated that there has been good engagement from Care UK regarding social care in the three Norfolk prisons. Norfolk County Council have a remit to increase awareness about social care in the prison. Social care practitioners remind prison staff about the complaints system, and are exploring running TV adverts and sharing a guide to social care in prisons. It was highlighted that there was possibly an emerging need relating to patients with learning disabilities and autism. There is a possible opportunity for there to be a social care and healthcare approach.
Social care assessments are carried out by social care staff. A number of social care specialists have been vetted and security cleared for access to the prison. These staff have various specialities including learning disabilities, mental health and the sensory impairment team.
In addition to completing social care assessments, social care practitioners support prison staff regarding managing the behaviour of prisoners. The goal of the social care practitioners is to ensure that a patient with social care needs is able to manage in prison the best that they can. When a patient is assessed as needing social care interventions, care packages are provided by the healthcare provider.

As part of the reception screen, there is a section which covers 'disabilities'. The following chart shows the rate for the READ codes associated with this area for the current population.

The rate of prisoners recorded with '(E....) Mental health disorder' is significantly higher in HMP Littlehey than HMP Bure, despite a lower rate of prisoners on the mental health register in HMP Littlehey.

Issues relating to hearing difficulty and impaired vision are two of the more prevalent social care related READ codes used. The rate of prisoners recorded with reduced mobility is similar across the two prisons at 4-5%.

Figure 3.4.1: Prevalence of READ codes associated with the disabilities section of the reception screen.



Read code	Bure 2019 #
(1C12.) Hearing difficulty	97
(XE16L) Impaired vision	70
(6665.) Physical handicap problem	3
(Ua1nH) Reduced mobility	34
(Ub00K) Dyslexia	40
(13Z4E) Learning difficulties	11
(ZV494) [V]Disfigurements of limbs	1
(ZV486) [V]Head disfigurement problem	0
(E....) Mental health disorder	28
(XaX18) [X]Neurodevelopmental delay	0
(Ub0hp) Speech impairment	1
(X78w6) Degeneration	2
(Xa2u7) Unable to perform personal care activity	10

HEARING DIFFICULTIES

Both prisons had a significant number of patients with a hearing difficulty. There was no visiting audiology service in either prison. This meant that patients were waiting a long time for an appointment. In HMP Littlehey, the researchers met a patient who had been waiting for an audiology appointment for a year and a half.

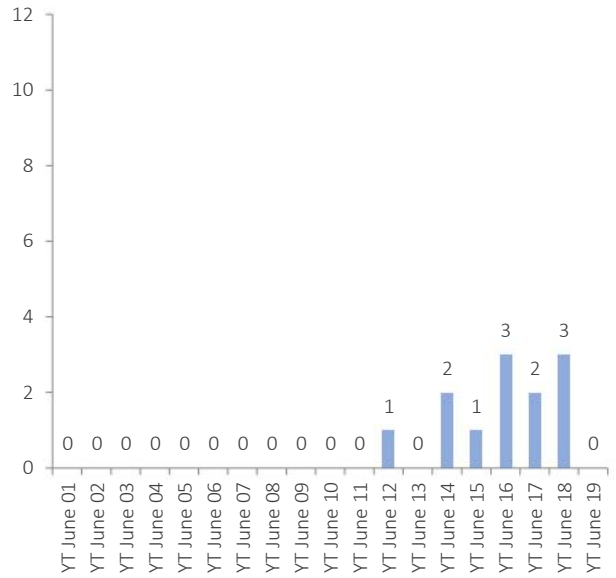
In HMP Littlehey, healthcare trainers had been given training in the servicing and cleaning of hearing aids.

In HMP Bure, the prison was in the process of completing an audit of all patients who had a hearing aid.

DEATHS BY NATURAL CAUSES

Below shows the number of deaths by natural causes.[65] HMP Littlehey is almost twice the size in terms of population as HMP Bure, however the number of deaths over the last few years is comparatively higher.

Figure 3.4.2: The number of deaths by natural causes in HMP Bure.



[65] https://www.gov.uk/government/collections/safety-in-custody-statistics

SUBSTANCE MISUSE

INTRODUCTION

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

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

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

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

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

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

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

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

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

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

BEST PRACTICE

NALOXONE

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

PSYCHOACTIVE SUBSTANCES (PS)

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

ALCOHOL

The Government recommends including an alcohol risk assessment in the NHS health check for adults aged 40 to 75.

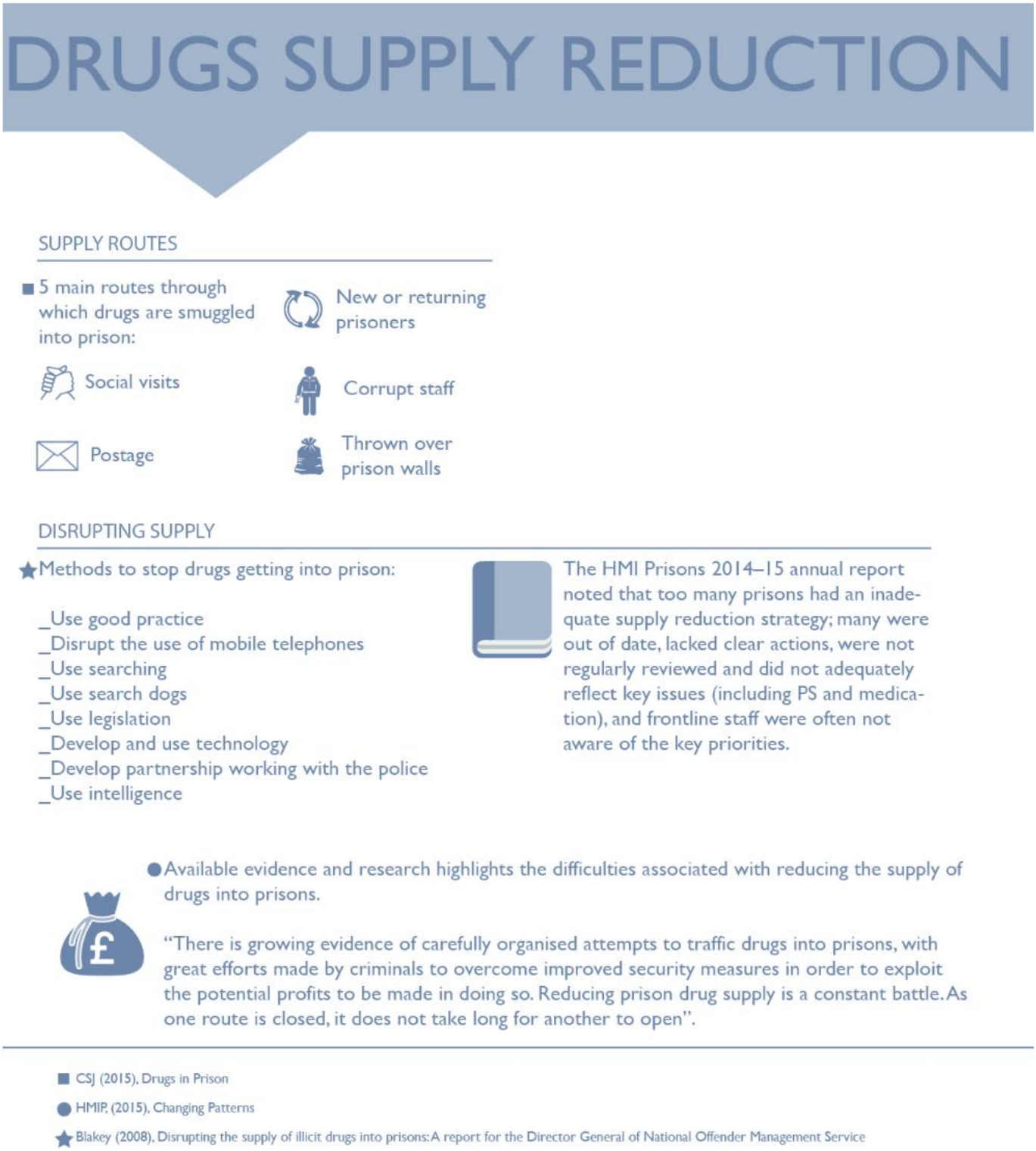
PHE TOOLKIT

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

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

Figure 3.5.1: General overview of drugs in prison.

Figure 3.5.2: General overview of drugs in prison.



DRUG DETECTION DOGS

Best Practice / Recommendation

- Drug dogs are a solution to reduce the amount of drugs being smuggled into prisons.[72] The CSJ report suggests that 'The MoJ should invest more in drug dogs. They are very effective at detecting drugs (including PS) yet, between 2010 and 2014, the number of drug dogs in prison in England and Wales fell by 27 per cent to 328'.
- Dogs trained to detect the smell of various substances, including drugs and mobile telephones, are deployed in some prisons and can be useful both in increasing finds and acting as a deterrent to use. Some staff interviewed for this thematic inspection said that drug dogs were a valuable resource, but there were not enough of them and they were not trained to detect new drugs such as Spice or other PS. Currently, few prisons have access to dogs trained to detect Spice, although more are now being trained (NOMS, 2015b).[73]

Local Practice / Evidence

- HMP LITTLEHEY – The Substance Misuse Strategy mentions the efficient deployment of drug/ mobile phone detection dogs.
- HMP BURE – The Drug and Alcohol Strategy was not available for this report.

SEARCHES

Best Practice / Recommendation

Best Practice / Recommendation	Local Practice / Evidence
Searching, both routine and intelligence- led, is an important supply reduction tool. Searches may be made of prisoners, staff, visitors, prisoner property and the prison itself, and can be random or intelligence led. There are limitations to the effectiveness of manual searches. Manual searches cannot detect substances that have been swallowed or concealed internally.[74]	policy.
The CSJ report recommends that the MoJ consider using body scanners to detect drugs being smuggled into prisons.	
The CSJ report emphasises the need to search all prisoners on their arrival to prison, including those returning from ROTL.	
Staff corruption is another method by which drugs can enter the prison. Targeted and random staff searches should form part of the supply reduction strategy.[75] The CSJ report recommends that a tenth of prison staff	

[72] Centre for Social Justice, (2015), Drugs in Prison
[73] HMIP, (2015), Changing patterns of substance misuse in adult prisons and service responses
[74] HMIP, (2015), Changing patterns of substance misuse in adult prisons and service responses
[75] HMIP, (2015), Changing patterns of substance misuse in adult prisons and service responses

(including contractors) are randomly searched every month.	
The HMIP thematic report repeatedly found that intelligence led searching was either delayed or did not occur, often because of reduced staffing levels. This was repeated in the CSJ report 'staff shortages have led to a reduction in drug searches'.[76]	

INTELLIGENCE GATHERING

Best Practice / Recommendation

- Intelligence forms a key part of any supply reduction strategy. The 2015 HMIP thematic report[77] cites a number of examples where prisons use intelligence reports to build a picture of drug trends within establishments.
- The dissemination of information was important. The report highlights the example of HMP Dovegate where there is 'a weekly intelligence meeting with security and other relevant staff' as well as 'wing managers carrying out detailed briefings on the wings. The prison received good support from the police'.
- Intelligence should be used to inform other parts of the drug reduction process. 'Searching, both routine and intelligence led, is an important supply reduction tool'.
- The report states that 'intelligence-led searching was either very delayed or did not occur, often because of reduced staffing levels'. This may be because there are a high number of intelligence reports submitted, for example, in HMP Stoke Heath, there were over 2,000 intelligence reports in six months.
- The level of drug finds alone does not accurately reflect the level of use as it is unlikely that all illicit drugs will be found; however, in combination with other measures, including MDT rates, levels of violence and intelligence, it may indicate the effectiveness of supply reduction measures.

Local Practice / Evidence

- HMP LITTLEHEY – The Substance Misuse Strategy does not mention intelligence gathering in detail.

JOINT WORKING WITH THE POLICE

Best Practice / Recommendation

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

Local Practice / Evidence

[76] Centre for Social Justice, (2015), Drugs in Prison
[77] HMIP, (2015), Changing patterns of substance misuse in adult prisons and service responses

- HMP LITTLEHEY – The prison work with local police.

WASTE WATER ANALYSIS

Best Practice / Recommendation

- Effective intelligence gathering is a crucial element of the fight against drug smuggling. Waste Water Analysis (WWA) should be introduced to prisons to provide an intelligence picture of drug use. It should replace the use of random Mandatory Drug Testing (rMDT) for this purpose[78]:
    - WWA analyses waste from prison sewage systems. It can identify not only the type of drugs, but the quantity as well;
    - WWA has been successfully piloted in an Australian prison and is being trialled in a number of other countries, including the United States and Spain. The CSJ heard from researchers that it provides a robust, accurate measure of drug use in prisons.

Local Practice / Evidence

- There are no plans for WWA to be introduced into the prisons.

[78] Drugs in Prison

In both prisons, patients who fail MDTs can get referred to the Psychosocial Team. Phoenix Futures wait until the prisoner has their positive test confirmed by adjudication before they approach the prisoner. In both prisons, misuse of medication is a common reason for a positive test.

In HMP Bure, there were two reports of prisoners who had failed tests for NPS, however these were later dismissed. The figures below show how the two prisons compare against prisons of a similar role for positive tests in 2018-19. The data highlights that the positive test rates are low across both prisons.

Figure 3.5.3: Positive tests; all drugs.

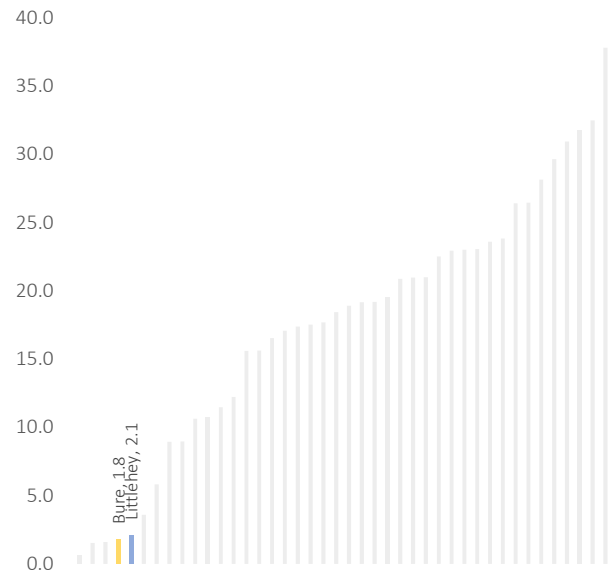


Figure 3.5.4: Positive tests; traditional drugs.

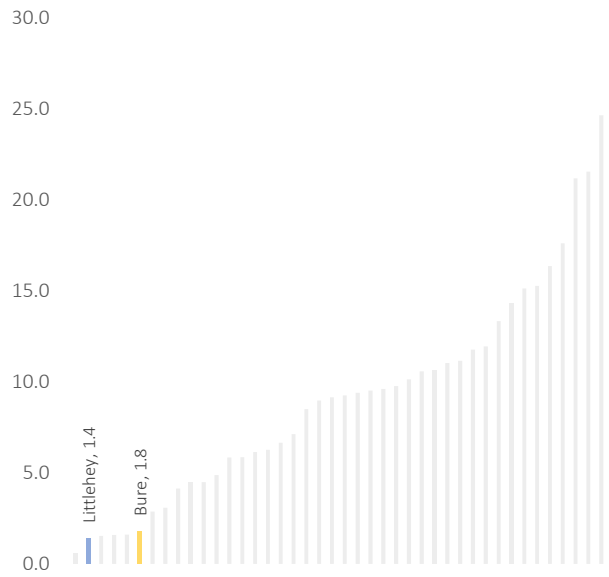


Figure 3.5.5: Positive tests; psychoactive substances.

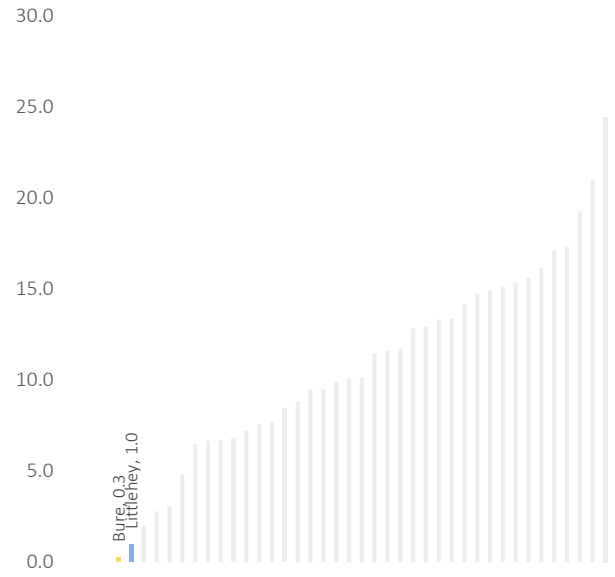


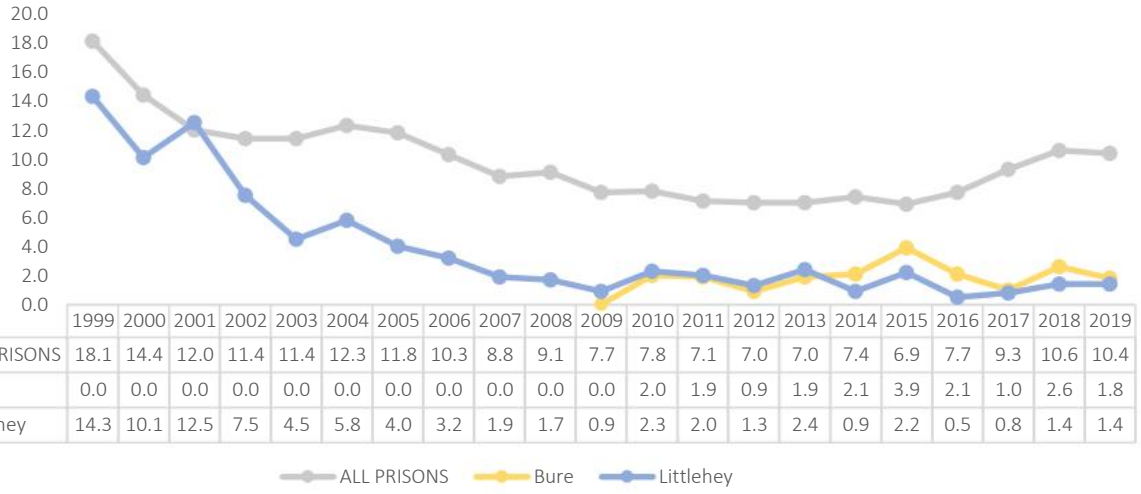
Figure 3.5.6: Positive tests; summary table.

Prison	Bure
Tests attempted	401
Refusals[79]	0
Administrative flaws[80]	7
Flawed samples[81]	0
Tests administered	394
Traditional drugs positive tests	7
Traditional drugs positive tests percentage (%)	1.8
Psychoactive Substances Positive Tests	1
Psychoactive Substances positive tests percentage (%)	0.3
All Positive Tests	7
All positive tests percentage (%)	1.8

[79] Prisoners have the right to refuse to provide a sample for drug testing. This is treated as a disciplinary offence.
[80] This category includes samples that could not be tested because of incorrect or incomplete recording of administrative details.
[81] This category includes samples that could not be tested because of contamination, breakage, or similar reasons.

The following table provides further information around drug testing. Since 2009, the positive test rates across both prisons have remained relatively low and stable, and are comparable to each other. In recent years, the national prison estate has seen an increase, however this is not reflected in HMP Bure and HMP Littlehey.

Figure 3.5.7: The percentage of positive random mandatory drug tests for traditional drugs (excluding psychoactive substances), by prison, 12 months to March 1999 to 12 months to March 2019.[828384]



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
ALL PRISONS	18.1	14.4	12.0	11.4	11.4	12.3	11.8	10.3	8.8	9.1	7.7	7.8	7.1	7.0	7.0	7.4	6.9	7.7	9.3	10.6	10.4
Bure	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0	1.9	0.9	1.9	2.1	3.9	2.1	1.0	2.6	1.8
Littlehey	14.3	10.1	12.5	7.5	4.5	5.8	4.0	3.2	1.9	1.7	0.9	2.3	2.0	1.3	2.4	0.9	2.2	0.5	0.8	1.4	1.4

Figure 3.5.8: Positive random mandatory drug tests, by drug type, by prison, 12 months to March 2017, 2018, 2019; HMP Bure.

Year (Year to March)	Total Tests Administered	Number of Positive Samples[85]								
		Amphetamines	Barbiturates	Benzodiazepines	Buprenorphine	Cannabis	Cocaine	Methadone	Opiates	Psychoactive Substances
2017	390	0	0	0	0	0	0	0	4	-
		0%	0%	0%	0%	0%	0%	0%	1%	-
2018	390	0	0	0	1	0	0	1	9	1
		0%	0%	0%	0%	0%	0%	0%	2%	0%
2019	394	0	1	0	0	1	0	0	5	1
		0%	0%	0%	0%	0%	0%	0%	1%	0%
		0%	0%	0%	0%	0%	0%	0%	1%	1%

MANDATORY DRUG TESTING

The following pages show the number of drug finds[86] by financial year up until March 2019. A summary is provided in the following table.

HMP Bure
• The number of drug finds in HMP Bure has remained low at between 0-2 per year.

[82] The target for Random Mandatory Drug Testing was removed in 2011/12.
[83] From April 2008 the mandatory drug testing regime was extended to include testing for Buprenorphine, following evidence of increasing abuse within prisons. Following a year of shadow reporting, positive tests were included in the published figures for Mandatory Drug Tests from 2009/10 onwards.
[84] Data for psychoactive substances (PS) is excluded from this table.
[85] As each sample may test positive for more than one drug, the positive results by drug type add up to more than the total positive test rate.
[86] https://www.gov.uk/government/statistics/annual-hm-prison-and-probation-service-digest-2017-to-2018

- The last drug find relating to psychoactive substances was in 2016-17.
- The only find in 2018-19 was recorded as ‘unknown’.

The following information was taken from the HMPPS Annual Prison Digest 2018/19. The guidance can be found here: https://www.gov.uk/government/statistics/hmpps-annual-digest-2018-to-2019.

HMP BURE

Figure 3.5.10: Number of drug finds by financial year.

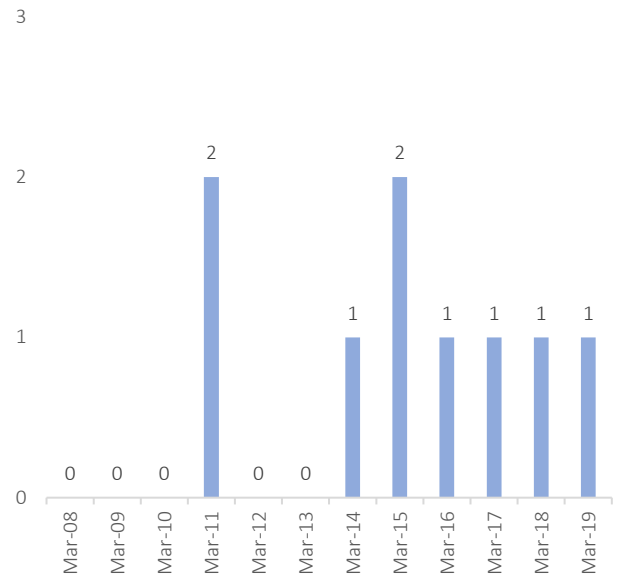


Figure 3.5.11: Long-term trend against 2007-08 baseline; comparison against all prisons.

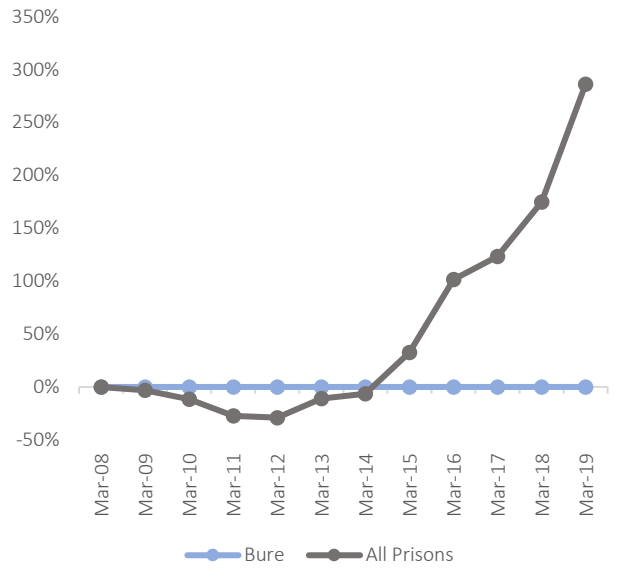


Figure 3.5.12: Number of drug finds by financial year and drug type.

Bure	Mar-15	Mar-16	Mar-17	Mar-18	Mar-19
Amphetamine	0	0	0	0	0
Barbiturates	0	0	0	0	0
Buprenorphine	0	0	0	0	0
Cannabis	0	0	0	1	0
Cocaine	0	0	0	0	0
Diamorphine (Heroin)	0	0	0	0	0
Gabapentin	0	0	0	0	0
LSD	0	0	0	0	0
Methadone	0	0	0	0	0
Other	2	1	0	0	0
Pregabalin	0	0	0	0	0
Psychoactive substances	0	0	1	0	0
Steroids	0	0	0	0	0
Tramadol	0	0	0	0	0
Tranquillisers	0	0	0	0	0
Unknown	0	0	0	0	1
Total	2	1	1	1	1

HMP LITTLEHEY

Figure 3.5.13: Number of drug finds by financial year.

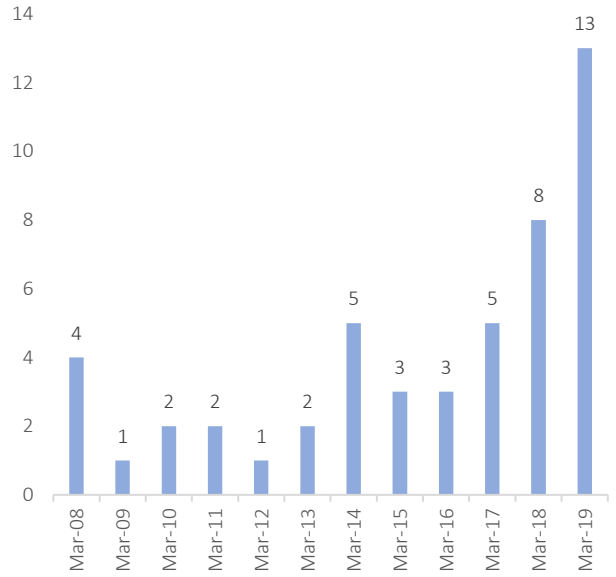


Figure 3.5.14: Long-term trend against 2007-08 baseline; comparison against all prisons.

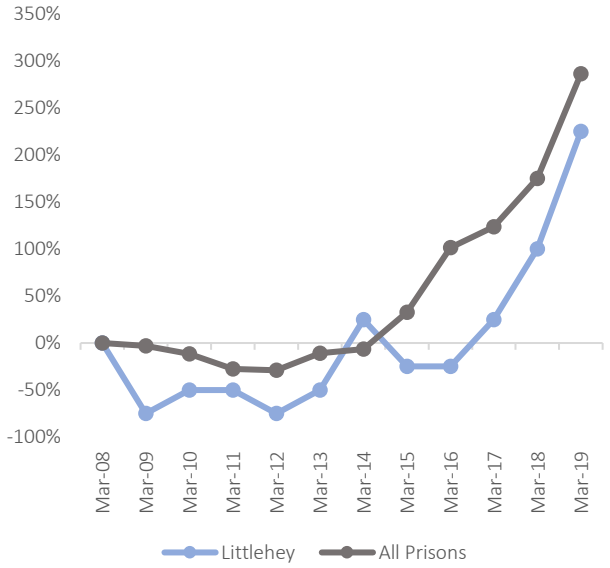


Figure 3.5.15: Number of drug finds by financial year and drug type.

Littlehey	Mar-15	Mar-16	Mar-17	Mar-18	Mar-19
Amphetamine	0	0	0	0	0
Barbiturates	0	0	0	0	0
Buprenorphine	0	0	0	0	0
Cannabis	0	0	0	1	1
Cocaine	0	0	0	0	0
Diamorphine (Heroin)	0	0	0	0	0
Gabapentin	0	0	0	0	0
LSD	0	0	0	0	0
Methadone	0	0	0	0	0
Other	3	1	0	2	1
Pregabalin	0	0	0	1	0
Psychoactive substances	0	0	4	0	7
Steroids	0	0	0	0	1
Tramadol	0	0	0	0	0
Tranquillisers	0	0	0	0	0
Unknown	0	2	1	5	3
Total	3	3	5	9	13

ACCESS TO TREATMENT

HMP BURE

INTRODUCTION

Phoenix Futures provide the Psychosocial Service in both prisons.

In HMP Bure, the Drug Strategy document was being updated at the time of this assessment. The Drug Strategy board meet every two months.

The document in HMP Littlehey was also being updated at the time of this assessment. The Drug Strategy meeting was combined with the prison security meeting.

STAFFING

Figure 3.5.16: HMP Bure Substance Misuse Staffing.

NUMBER	JOB TITLE
CLINICAL	
IDTS prescribing is covered by the Clinical Lead in the Primary Care Team	
PSYCHOSOCIAL	
1	Team Manager
3.4	Case Managers
0.5	Administrator

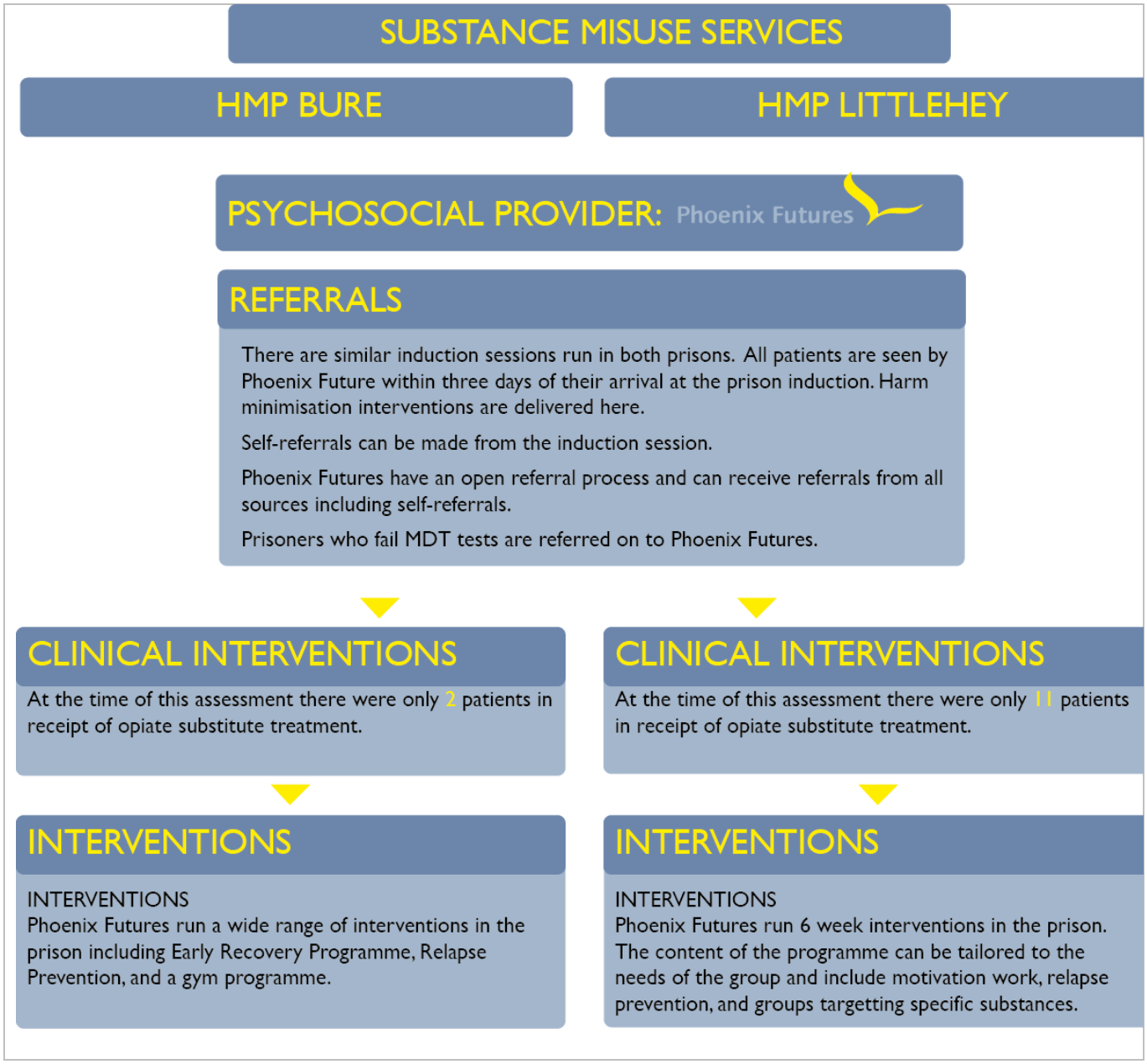
STAFFING RATIO

The table below shows the ratio of various roles in the psychosocial substance misuse teams to the total number of prisoners present in the prison for one year (prison population + new receptions). For comparison, the staffing ratios in HMP Bure and HMP Littlehey are shown against two other category C training prisons.

In category C prison 1, the Mental Health Team and the Substance Misuse Psychosocial Team were merged so patients with mental health issues had access to psychoeducational groups.

Job Title	HMP Bure	Category C Prison 1	Category C Prison 2
Total in year (Population + New Receptions)	1009	618	1260
Practitioners (including senior/ lead practitioners)	3.4 (1:297)	2 (1:618)	2 (1:630)

Figure 3.5.19: Substance misuse pathway in the prisons


SUBSTANCE MISUSE SERVICES
HMP BURE
HMP LITTLEHEY
PSYCHOSOCIAL PROVIDER: Phoenix Futures
REFERRALS
There are similar induction sessions run in both prisons. All patients are seen by Phoenix Future within three days of their arrival at the prison induction. Harm minimisation interventions are delivered here.
Self-referrals can be made from the induction session.
Phoenix Futures have an open referral process and can receive referrals from all sources including self-referrals.
Prisoners who fail MDT tests are referred on to Phoenix Futures.
CLINICAL INTERVENTIONS
At the time of this assessment there were only 2 patients in receipt of opiate substitute treatment.
CLINICAL INTERVENTIONS
At the time of this assessment there were only 11 patients in receipt of opiate substitute treatment.
INTERVENTIONS
INTERVENTIONS
Phoenix Futures run a wide range of interventions in the prison including Early Recovery Programme, Relapse Prevention, and a gym programme.
INTERVENTIONS
INTERVENTIONS
Phoenix Futures run 6 week interventions in the prison. The content of the programme can be tailored to the needs of the group and include motivation work, relapse prevention, and groups targetting specific substances.

CLINICAL INTERVENTIONS

HMP BURE
Nurses within the Primary Care Team work with patients who are in receipt of an opiate substitute prescription.
At the time of this assessment, there were 2 patients in receipt of opiate substitute treatment. The numbers of patients with a clinical substance misuse need is normally low.

PSYCHOSOCIAL INTERVENTIONS

HMP BURE
Phoenix Futures run eight different groups in the prison. The groups are not specific to any substance but are instead focussed on behaviour change. The following groups are run: • Early Recovery Programme • Relapse Prevention Programme • Emotional Management Programme • Healthy Coping and Network of Support • Developing Effective Communication (a group for those prisoners who have been in custody for a long time and have to communicate with other agencies, including the Parole Board) • Moving on Programme (for those who are being released or moving on to an open prison) • Phoenix Recovery Gym Programme (12 sessions, including 9 active gym sessions and work on sleep hygiene, nutrition, and stress management) • Mindfulness programme (run by a trained peer supporter). Any patient with social anxiety who does not feel comfortable in group sessions can have a one-to-one intervention.

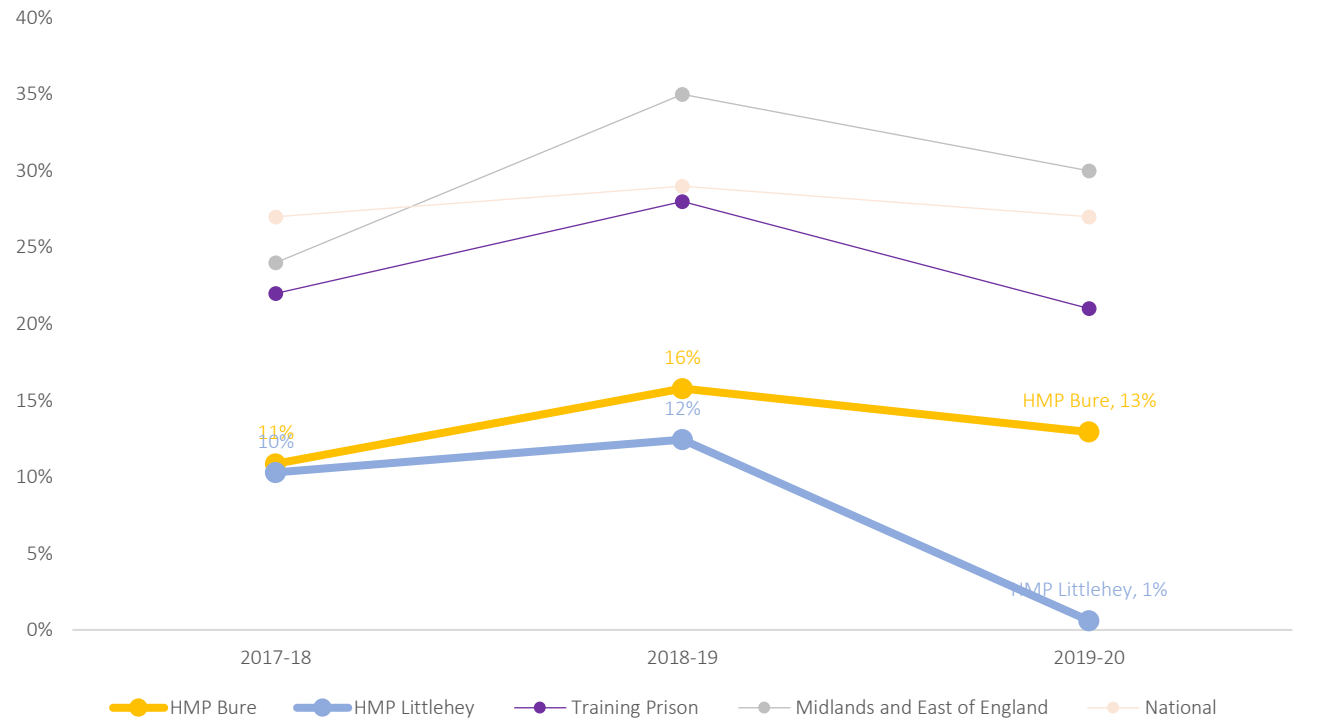
Phoenix Futures work with the Mental Health Team to discuss clients who have a dual diagnosis need.

There are not many prisoners released from HMP Bure. Those who are released with a substance misuse need are managed by Phoenix Futures.

The majority of prisoners are transferred to other prisons. Phoenix Futures do not have a formal link with the receiving prison.

Figure 3.5.20 below shows the percentage of receptions starting a treatment episode. The rate of new receptions in HMP Bure that started a treatment episode in 2017-18, 2018-19, and the first quarter of 2019-20 has remained around 11-16%. This is low in comparison with prisons of a similar role. HMP Littlehey exhibited a similar rate, however Qtr-1 of 2019-20 appears to have data issues.

Figure 3.5.20: The percentage of receptions starting a treatment episode



Prison	HMP Bure			HMP Littlehey		
Year	2017-18	2018-19	2019-20	2017-18	2018-19	2019-20
New Receptions	442	393	85	690	386	165
Starting Episode	48	62	11	71	48	1
%	11%	16%	13%	10%	12%	1%

DRUG TYPES

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

- Both prisons exhibit a similar drug in-treatment profile.
- Alcohol is the most prevalent substance in both prisons, with around three quarters of those in-treatment listing it as a drug type.
- Cannabis and cocaine are the next most prevalent drugs across the two prisons.

Figure 3.5.22: In-treatment profile by drug type; HMP Bure.

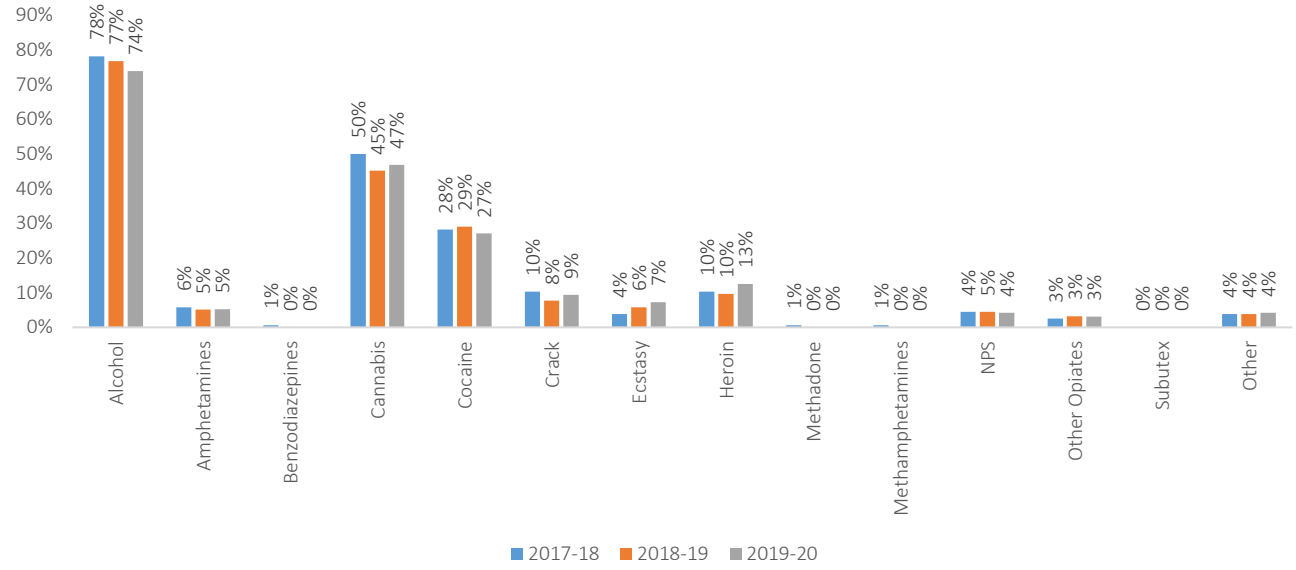
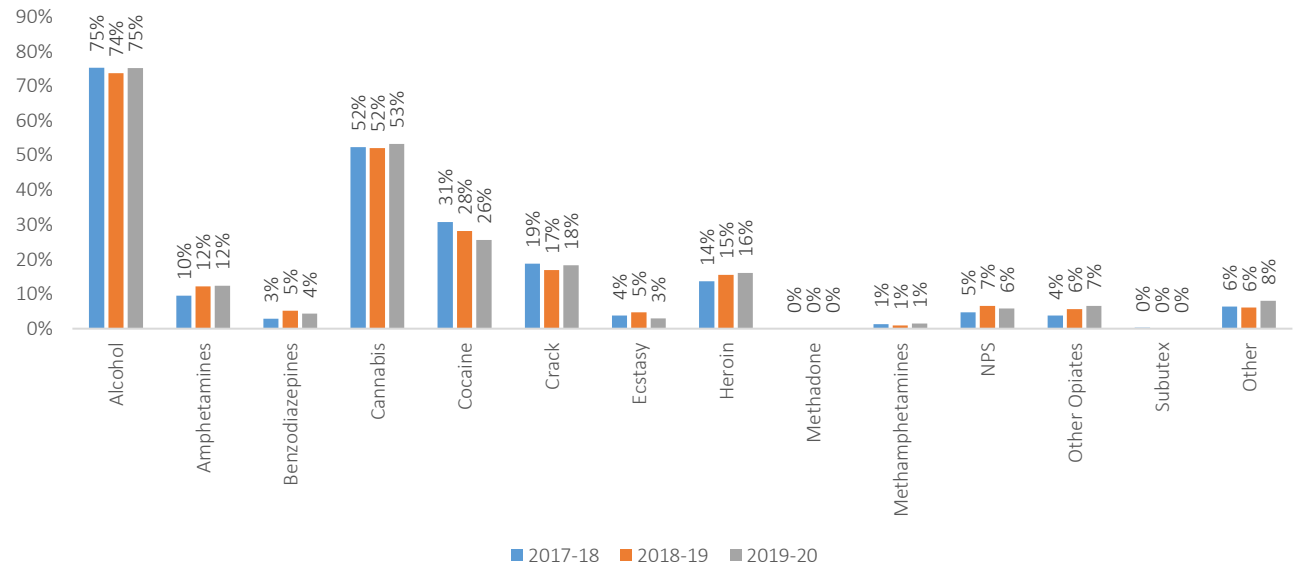


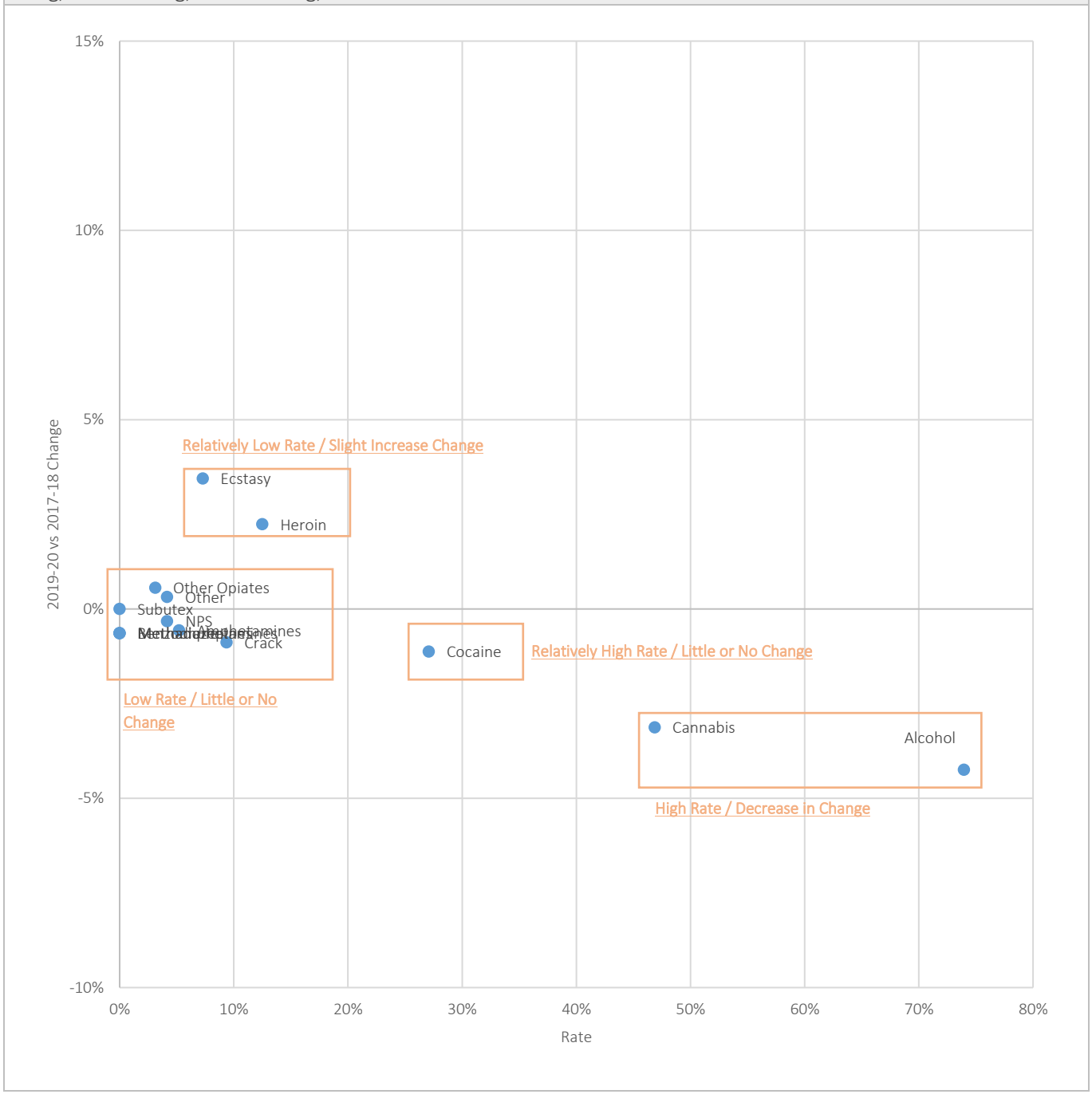
Figure 3.5.23: In-treatment profile by drug type; HMP Littlehey.



The following two charts show how the drug rates compare when taking into account both the prevalence for the in-treatment population in 2019-20[87] and the change against the 2017-18 data.

Alcohol and cannabis are the two most prevalent drug types in HMP Bure, however there has been a decrease in the rate of those in-treatment listing them as a drug. Ecstasy and heroin have seen a slight increase.

Figure 3.5.24: In-treatment profile based on whether prisoners recorded any of the listed drugs as the main drug, second drug, or third drug; HMP Bure.

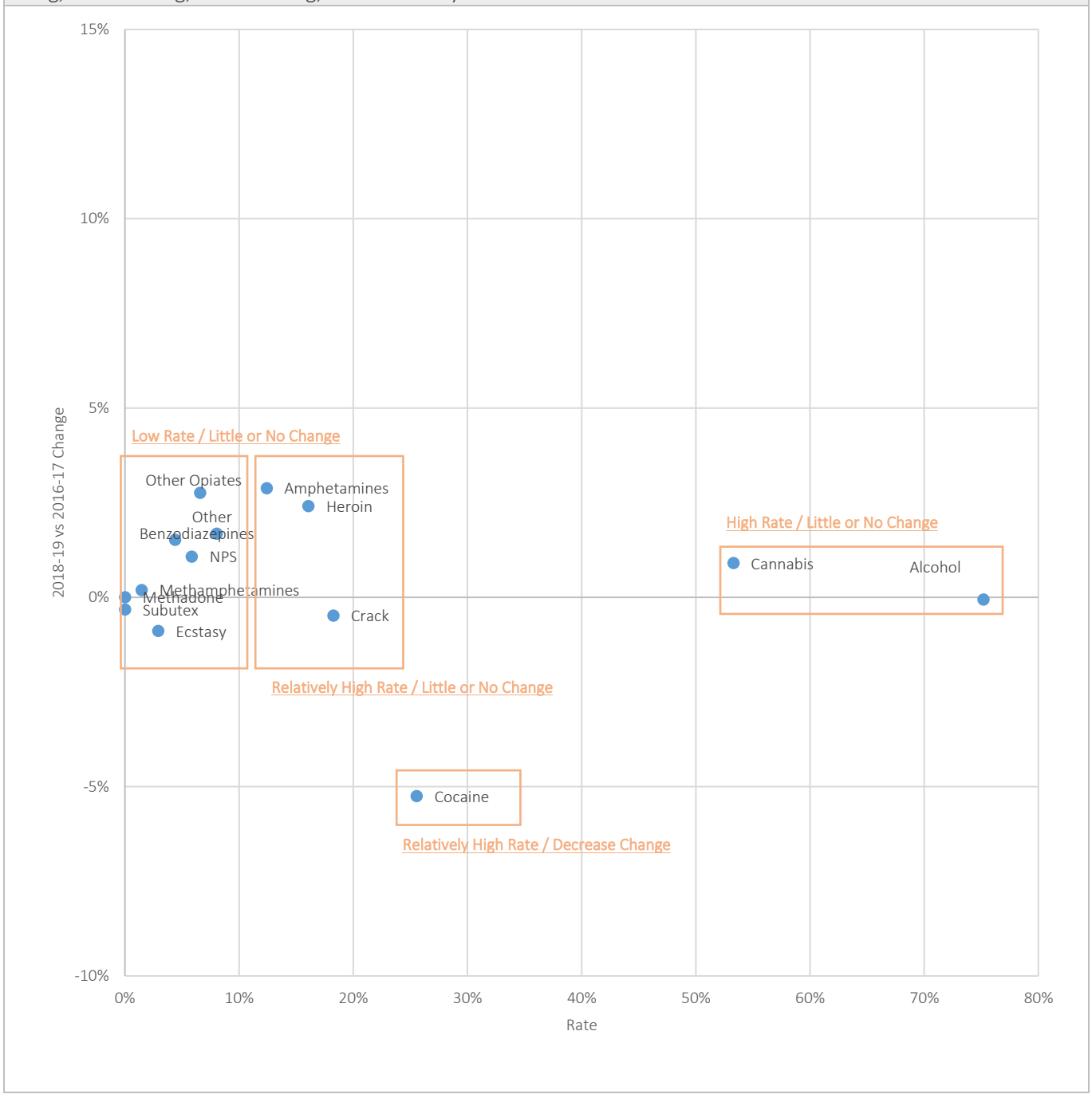


[87] First Quarter.

Similar to HMP Bure, alcohol and cannabis are the two most prevalent drug types in HMP Littlehey, however unlike HMP Bure there has not been a decrease in the rate of those in-treatment listing them as a drug. Ecstasy and heroin have seen a slight increase.

Cocaine shows a relatively high rate, however there has been a decrease in the rate of those in-treatment listing this as a drug. The remaining drug types have seen little change.

Figure 3.5.25: In-treatment profile based on whether prisoners recorded any of the listed drugs as the main drug, second drug, or third drug; HMP Littlehey.



CONTINUITY OF CARE

The figures below show the transfers to community[88] based on NDTMS data.

In HMP Bure, there were 22 transfers to the community during the analysed time period, of which only 2 (9%) were recorded as commencing treatment. This is low when compared to prisons of a similar role which stands at 45%, and nationally at 34%.

In HMP Littlehey, there were only 4 transfers to the community, with all of them recorded as commencing treatment.

Figure 3.5.26: Transfers to community; HMP Bure.

Partnership Referred To	Referred	Commenced Treatment	% Commenced Treatment
Peterborough	3	1	33%
Lambeth	2	0	0%
Southwark	2	0	0%
Kent	2	0	0%
Lincolnshire	1	0	0%
Cambridgeshire	1	0	0%
Essex	1	0	0%
Hertfordshire	1	0	0%
Norfolk	1	0	0%
Suffolk	1	0	0%
Bromley	1	0	0%
Croydon	1	0	0%
Merton	1	0	0%
Newham	1	1	100%
Wandsworth	1	0	0%
West Sussex	1	0	0%
Bristol	1	0	0%
HMP Bure	22	2	9%
Role	3716	1688	45%
Region	8292	2837	34%
National	23545	8050	34%

[88] Shows total number released and discharged from treatment as 'Transferred - Not in Custody' between 1 April 2018 and 31 March 2019, and total number commencing a treatment episode in the community within 3 weeks of release.

The figures below show the transfers to prison[89] based on NDTMS data.

In HMP Bure, there were 25 transfers to another prison during the analysed time period, of which only 4 (16%) were recorded as commencing treatment. This is low when compared to prisons of a similar role which stands at 41%, and nationally at 55%.

In HMP Littlehey, there were only 12 transfers to another prison, with 4 (33%) of them recorded as commencing treatment.

Figure 3.5.28: Transfers to prison; HMP Bure.

Prison Transferred To	Referred	Commenced Treatment	% Commenced Treatment
HMP North Sea Camp-Addaction	4	0	0%
HMP Brixton (Care UK/Forward Trust)	4	0	0%
HMP Littlehey - NHFT/Phoenix Futures	3	0	0%
HMP Leyhill	2	1	50%
HMP Ashfield	2	0	0%
HMP Hull	1	0	0%
HMP Oakwood (Care UK)	1	0	0%
HMP Whatton	1	0	0%
HMP Peterborough (Male)	1	0	0%
HMP Pentonville (Care UK/Phoenix Futures)	1	1	100%
HMP Grendon (Care UK/Inclusion)	1	1	100%
HMP Dartmoor	1	1	100%
The Verne IRC	1	0	0%
HMP Thameside (Oxleas/Turning Point)	1	0	0%
HMP Warren Hill	1	0	0%
HMP Bure	25	4	16%
Role	3214	1310	41%
Region	5005	2323	46%
National	15911	8055	51%

[89] Shows the total number transferred to another establishment and discharged as 'Transferred - In Custody' between 1 April 2018 and 31 March 2019, and the total number commencing treatment in the new establishment within 3 weeks of transfer.

PRIMARY CARE AND LONG-TERM CONDITIONS

HMP BURE

There are plans for long-term conditions to be nurse led. Nursing staff were in the process of being trained to lead on the various conditions at the time of this needs assessment.

There were plans for an audiologist to visit the prison as there is need amongst patients for hearing tests. As of September 2019, Healthcare advised that the audiologists will not be visiting the prison due to funding issues.

Figure 4.1.1: HMP Bure primary care staffing.

Number	Job Title
1	Head of Healthcare
1	Clinical Lead
1	Nurse Practitioner
6	RGN (1 post vacant)

The clinical lead is currently going through nurse practitioner training.

The gym run some targeted sessions for the older population. A bowls session is run for older patients, and there is an over 50's gym session.

The gym also run weight loss clinics and a specialist session for patients with a substance misuse issue.

There has been a limited amount of joined up work between the gym and Healthcare. A wellbeing day has been run and another one is planned for early 2020.

There are a group of healthcare representatives who are supervised by the lead pharmacy technician. The healthcare representatives have a bi-monthly meeting.

ASTHMA

HMP BURE

There is a plan in place for a nurse to lead on the care of patients with asthma.

A respiratory study day is planned for September 2019.

There is an asthma Standard Operating Procedure in place.

It is intended that clinics will be run by nursing staff when they complete training in respiratory conditions.

	Expected Prevalence	Actual Prevalence
Receptions (YT Aug 2019)	39	51
QOF (Sep 19)	63	82

Medication is held in-possession following a risk assessment.

There are two health care assistants trained in the delivery of spirometry.

There is no smoking cessation offered in the prison unless the patient had not finished a course of treatment started in a previous prison.

NICE Quality Statement 5: 'People with asthma receive a structured review at least annually'.[90]

Condition reviews are led by the GP, but there are plans for them to be led by the nurse with a special interest in respiratory conditions.

[90] https://www.nice.org.uk/guidance/qs25/chapter/Quality-statement-5-Review#data-source-5

ASTHMA

NICE

NICE guideline [NG80] Asthma: diagnosis, monitoring and chronic asthma management

SELECTED RECOMMENDATIONS ■

INITIAL CLINICAL ASSESSMENT - Take a structured clinical history

DIAGNOSIS - Objective tests for diagnosing, including "spirometry to adults, young people and children aged 5 and over if a diagnosis of asthma is being considered."

SELF-MANAGEMENT - Offer an asthma self-management programme, comprising a written personalised action plan and education, to adults, young people and children aged 5 and over with a diagnosis of asthma (and their families or carers if appropriate).

MONITORING - Asthma Quality Measures indicate that patients with asthma should have had a review within the past 12 months.
Reviews should include a review of inhaler technique, and confirmation of adherence to prescribed treatment.

Public Health England

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

Key points from condition related research

Key points from prison related research

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

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

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

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

RECEPTION HEALTH SCREEN

IDENTIFICATION - 1st Screen: Current Health Conditions: Asthma
2nd Screen: Family History: Asthma

■ Due to space restrictions, only selected recommendations are included here. Full recommendations can be found here NICE guideline [NG80]

● http://www.asthma.org.uk/asthma-facts-and-statistics

★ Gopalakrishnan, N., 'Ethnic variations in incidence of asthma episodes in England & Wales: National study of 502,482 patients in primary care', Respiratory Research, 6:120, (2005).

● Marshall, T., Simpson, S. & Stevens, A., Toolkit for health care needs assessment in prisons, (Department of Public Health & Epidemiology, University of Birmingham, 2000).

PREVALENCE

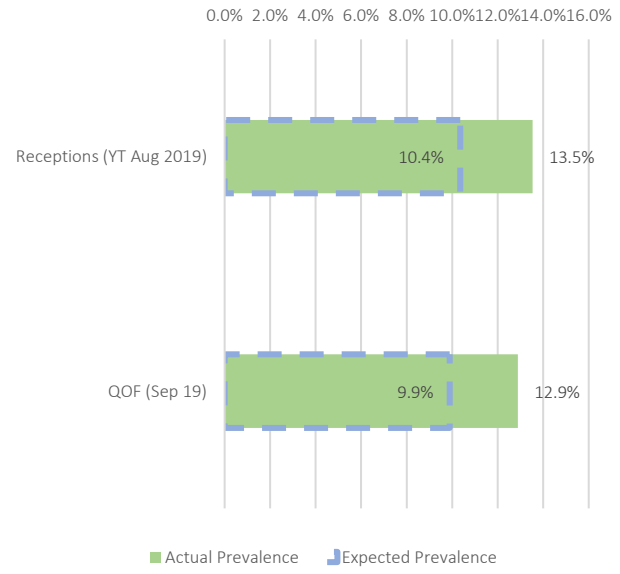
The expected prevalence is calculated using the PHE Toolkit, and is based on age. This means other factors that affect asthma prevalence such as smoking, ethnicity, and exercise were not included in the calculation.

Both the expected and the actual prevalence across both prisons are similar. Both prisons report higher actual prevalence at both the reception screen and the snapshot population.

Figure 4.2.1: Expected asthma prevalence taken from the PHE Toolkit.

Age Group	Expected Prevalence
16-24	19%
25-34	12%
35-44	11%
45-64	8%
65+	

Figure 4.2.2: Expected and actual prevalence of asthma in HMP Bure.



	Expected Prevalence	Actual Prevalence
Receptions (YT Aug 2019)	39	51
QOF (Sep 19)	63	82

CANCER

HMP BURE
There were no patients undergoing cancer treatment at the time of this assessment. A patient underwent radiotherapy last year. There are patients under the care of Norfolk and Norwich Hospital who have a diagnosis of cancer, but they are being monitored by the respective teams within the hospital.
There is a cancer Standard Operating Procedure in place.
Patients who require a two-week hospital appointment for a specialist cancer check-up are facilitated by the prison.
As at September 2019, there were 19 (2.9%) patients on the QOF cancer register, compared to 24 (3.7%) for the 2016 HSCNA.
There is an end-of-life care pathway in place. If a patient is moving into the end-of-life stage, Healthcare in HMP Bure liaises with the local hospice, the Priscilla Bacon Lodge, or the Norfolk and Norwich Hospital. HMP Bure did have the National Gold Standard Framework in place previously, however, due to staff changes this has lapsed. Training was planned for the Gold Standard Framework, to ensure that it was in place in the prison. Patients who have been identified as likely to need end-of-life care are involved in advanced care planning, which allows them to make decisions about their care before their condition deteriorates too greatly. Previously there was a support group for patients with cancer, however this was not running at the time of the assessment. There is no 24-hour healthcare in HMP Bure.
In addition to sustaining a cancer register, QOF requires that qualifying patients have a review within 6 months of diagnosis. There were 4 patients that qualified and 2 had received a review. Staff are currently receiving training on how to offer reviews for cancer care. Care has been led by the GP

due to a lack of full-time nursing staff and a high number of agency staff.

CANCER

NICE

There are 17 cancer related guidance documents published by NICE ■

SELECTED RECOMMENDATIONS

SUSPECTED CANCER: RECOGNITION AND REFERRAL - Suspected cancer pathway referral. The patient is seen within the national target for cancer referrals (2 weeks at the time of publication of this guideline). ●

Public Health England

PHE TOOLKIT - As outlined in the PHE Toolkit, all people in prison should have access to all cancer screening programmes for which they are eligible. Male prisoners aged 60 to 69 should have a bowel cancer screening every 2 years; the programme is being expanded to include people up to the age of 75 years.
The PHE Toolkit does not provide prevalence rates for the prison population.

IDENTIFICATION - 1st Screen: Current Health Conditions: Malignant tumour
2nd Screen: Family history of cancer

Key points from prison related research

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

- Tobacco use. It is estimated that 80 to 85% of the prison population smoke or have smoked. 90% of lung cancer cases in the UK are caused by tobacco smoking.
- Excessive consumption of alcohol. It is estimated that 58% of remand and 63% of sentenced prisoners are drinking at hazardous levels.
- Research shows that the 2 risk factors of smoking and excess alcohol combined increases the chance of developing mouth cancer by up to 30 times.
- Poor diet and lack of physical activity. Research has shown that poor diet and not being active are 2 key factors that can increase a person's cancer risk.
- Lack of awareness. Research shows that difference in socioeconomic status has a significant impact on the awareness and knowledge of cancer.

■ Due to space restrictions only selected recommendations are included here. Full recommendations can be found here https://www.nice.org.uk/guidance/conditions-and-diseases/-cancer

● NICE guideline [NG12]

CARDIOVASCULAR DISEASE

HMP BURE
There was a nurse specialist identified for the management of cardiovascular disease, including hypertension There is no cardio rehabilitation offered in the prison. Patients tend to be referred to the Norfolk and Norwich Hospital if they require cardio rehabilitation.
There are a range of Standard Operating Procedures covering various CVDs in place.
Patients have their medication managed by the GP.
The gym staff run remedial gym sessions.
At the time of this assessment, reviews were completed by the GP. There were plans for nursing staff to take over the completing of condition reviews.
HMP Bure shows generally good performance across a range of QOF indicators relating to cardiovascular disease.

CARDIOVASCULAR DISEASE

NICE

There are a large number of NICE guidelines related to hypertenison and CVD. The following recommendations come from Cardiovascular disease: risk assessment and reduction, including lipid modification Clinical Guidance [CG18]

SELF-MANAGEMENT - NICE guidance makes recommendations on individual level behaviour change interventions, aimed at changing the behaviours that can damage people's health. Interventions that help people change have considerable potential for improving health and wellbeing and helping people to:

- improve their diet and become more physically active;
- lose weight if they are over weight or obese;
- stop smoking; and
- reduce their alcohol intake.

MONITORING - People with existing CVD should be identified at the reception screen and require an annual comprehensive review of cardiovascular disease risk factors (NICE quality standard [QS28])■

Public Health England

PHE TOOLKIT - One third of deaths in custody (35%) are due to cardiovascular causes and the 2012-13 report from the Prison and Probation Ombudsman highlights the problems caused when heart attacks are confused with epileptic fits and the delays occur in contacting staff who are trained in CPR when prisoners are found unconscious.

Key points from condition related research

Key points from prison related research

There are a number of risk factors for cardiovascular disease (CVD)●. Risk factors can be broken down into those that can be controlled or influenced and those that cannot:

CONTROLLABLE - High-blood pressure, smoking, high-blood cholesterol, diabetes, lack of exercise, being overweight, diet, alcohol, stress.

UNCONTROLLABLE - Family history of heart disease, ethnic background, age.

Prisoners have some influence over their own cardiovascular risk through their choice of diet, smoking behaviour, and exercise, although diet and exercise are largely controlled by the institution. By offering a diet low in saturated fat and salt, but high in polyunsaturated fat, fruit, and vegetables, prisons can influence cholesterol levels, blood pressure, and the risk of heart disease.⬣

RECEPTION HEALTH SCREEN

IDENTIFICATION - 1st Screen: Essential hypertension; Ischaemic heart disease.
2nd Screen: FH: Cardiovascular disease; FH: Hypertension; FH: Myocardial infarction; FH: Ischaemic heart disease at greater than 60 years; FH: Ischaemic heart disease at less than 60 years.

■ Due to space restrictions, only selected recommendations are included here. Full recommendations can be found here Hypertension in adults Quality standard [QS28]

● http://www.asthma.org.uk/asthma-facts-and-statistics

⬣ Marshall, T., Simpson, S. & Stevens, A., Toolkit for health care needs assessment in prisons, (Department of Public Health & Epidemiology, University of Birmingham, 2000).

Figure 4.4.1 shows the prevalence of the CVD related QOF registers as at September 2019. The chart shows that the rates for these registers across the two prisons are similar. Of note is that around a quarter of the population in both prisons are listed on the hypertension register, compared with 14% nationally. 9% of the population are listed with coronary heart disease compared to 3% nationally.

Figure 4.4.2 and figure 4.4.3 show the percentage point change of those on the CVD related QOF register since the last HNA. The analysis shows a mixed picture, notably an increase for hypertension and coronary heart disease, and a decrease for the rate of those on the cardiovascular disease register.

Figure 4.4.1: Prevalence of the QOF registers associated with cardiovascular disease.

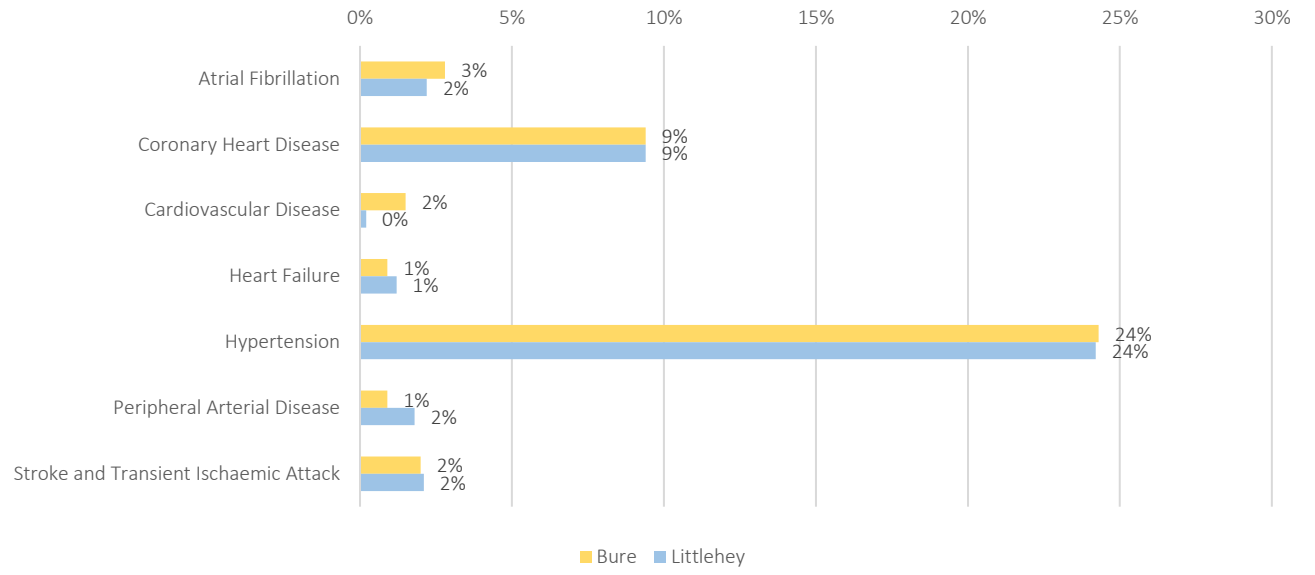


Figure 4.4.2: % point change since the 2016 HSCNA; HMP Bure.

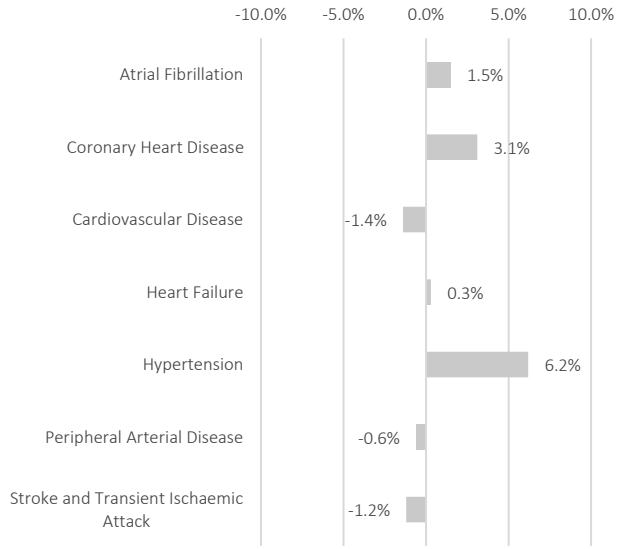
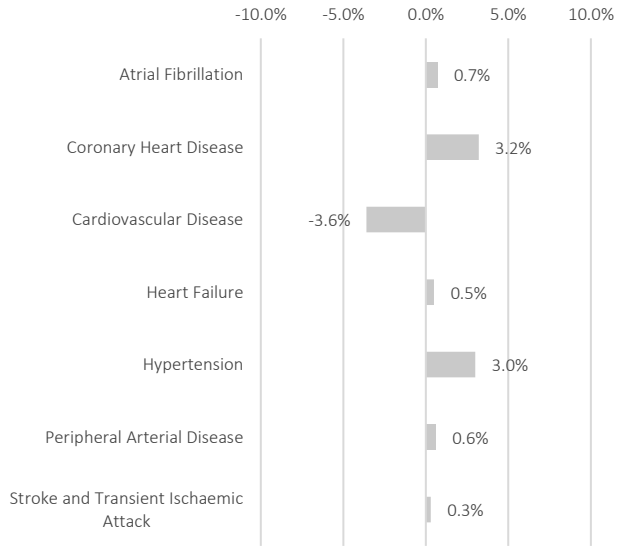


Figure 4.4.3: % point change since the 2016 HSCNA; HMP Littlehey.



COPD

HMP BURE
There are plans in place for a nurse to lead on the management of COPD and asthma. A respiratory condition study day is planned for September 2019. While nursing staff are being upskilled, the condition is managed by the GP. There is no pulmonary rehabilitation run in the prison.
Modelled estimates from the community for the prevalence of COPD ranges from 3.7% (using the England average) to 6.4% (using the maximum prevalence rate in England) when applied to the age profile of HMP Bure; however, the prison prevalence is expected to be higher. At the time of this HSCNA, there were 33 (5.1%) prisoners on the QOF register. This is similar to the 5.5% recorded for the 2016 HSCNA.

COPD

NICE

There are a number of NICE guidelines related to COPD. The following recommendations come from Chronic obstructive pulmonary disease in over 16s: diagnosis and management (NG115)

SELECTED RECOMMENDATIONS

DIAGNOSIS - The diagnosis of chronic obstructive pulmonary disease (COPD) depends on it being investigated as a cause of breathlessness or cough. The diagnosis is suspected on the basis of symptoms and signs, and is supported by spirometry.

SELF-MANAGEMENT - At every opportunity, advise and encourage every person with COPD who is still smoking (regardless of their age) to stop, and offer them help to do so.

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

Public Health England

PHE TOOLKIT - COPD coverage is limited in the PHE Toolkit.

Key points from condition related research

Key points from prison related research

In the UK, COPD is one of the most common respiratory diseases. COPD usually affects people over the age of 35, although most are not diagnosed until they are in their 50s. The main cause of COPD is smoking.●

The rate in prison is expected to be higher due to the high rate of smokers. It is estimated that 80% of prisoners smoke, with COPD present in 18% of male smokers in the UK. In addition, a survey of the physical health of prisoners in 1994 found that major illnesses in many organ systems, such as COPD, were much more common in prisoners than in the general population.★

RECEPTION HEALTH SCREEN

IDENTIFICATION - 1st Screen: Chronic obstructive lung disease 2nd Screen: Family History: Family history of chronic obstructive lung disease

■ Due to space restrictions, only selected recommendations are included here. Full recommendations can be found here Chronic obstructive pulmonary disease in adults Quality standard [QS10]

● NHS (2014), Chronic Obstructive Pulmonary Disease - Causes.

DIABETES

HMP BURE
Patients with diabetes are monitored by the GP. Healthcare have a plan in place for the condition to be led by a nurse with a special interest in diabetes, however training for staff had not taken place at the time of this assessment. There is plan in place for staff to attend a diabetes course. There is no visiting specialist from the Norfolk and Norwich Hospital.
There is a diabetes Standard Operating Procedure in place.
Patients can be referred to a dietician if required.
The prison run a remedial gym which Healthcare can refer patients to.
The podiatrist undertakes diabetic foot checks with patients. The podiatrist is completing some teaching with the healthcare assistants so that they can monitor patients for signs of deterioration.
There is no structured education in place in the prison. Advice to patients is limited to diet and lifestyle advice. Healthcare have tried to arrange diabetic education, however diabetic specialist nurses from Norfolk and Norwich Hospital will not provide a service in the prison.
Medication is held in-possession following an in-possession risk assessment.
At the time of this assessment, reviews were completed by the GP. There were plans for nursing staff to take over the completing of condition reviews.

DIABETES

NICE

There are a number of NICE guidelines covering diabetes. The diagnosis and management of Type 1 diabetes is covered in NG17. The management of Type 2 diabetes is covered in NG28.

MONITORING - Clinical best practice is covered by NICE quality standard 6.
Quality standards include:

- People with diabetes and/or their carers receive a structured educational programme.
- People with diabetes receive personalised advice on nutrition and physical activity.
- People with diabetes are assessed for psychological problems.

Public Health England

PHE TOOLKIT - In his 2012-13 annual report, the Prison and Probation Ombudsman highlighted poor assessment and care planning of diabetes as contributory causes in a number of deaths. This included not measuring blood sugar (via HbA1c measurements) every 3-6 months for those with insulin-nondependent diabetes and not actively following up when organ damage was identified, such as diabetic retinopathy or renal disease. Diabetes UK has identified 9 key care processes, which are outlined here: http://www.diabetes.org.uk/documents/reports/state-of-the-nation-2012.pdf.

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

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

Key points from condition related research

Key points from prison related research

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

The prison environment can provide the opportunity to address the health needs of a "hard to reach" sector of society with diabetes. ★

RECEPTION HEALTH SCREEN

IDENTIFICATION - 1st Screen: Diabetes mellitus
2nd Screen: Family History: FH: Diabetes mellitus

■ Due to space restrictions, only selected recommendations are included here. r

● Diabetes UK (2012), Diabetes in the UK 2012.

★ Booles, K., Survey on the quality of diabetes care in prison settings across the UK, (2011)

PREVALENCE

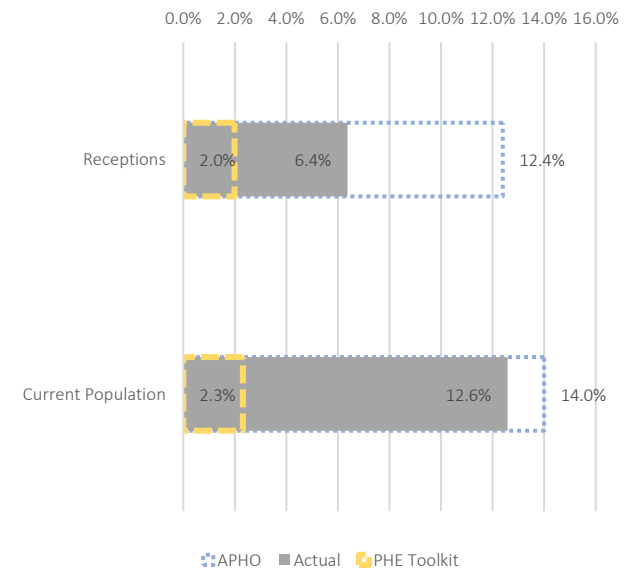
Prevalence rates relating to diabetes can be found in the PHE Toolkit. It is understood that the true prevalence is higher, as the expected prevalence was based on community data for 1996, and the UK rate has increased since then.

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

The following charts include the expected prevalence rates calculated from both the PHE Toolkit and the APHO model. The key points from the analysis are:

- The expected prevalence calculated from the APHO model is significantly higher than the PHE Toolkit.
- The expected prevalence across the two prisons is similar.
- The expected prevalence of the current populations are slightly higher than those coming through reception, which is due to the difference in the age profiles and turnover rates.
- The actual prevalence in both prisons show a higher rate for the current populations compared to those coming through reception. This could indicate that those with diabetes are not being identified at reception or are developing diabetes once they are in prison.
- The actual prevalence on the QOF register is slightly lower than the expected prevalence.

Figure 4.6.1: Expected and actual prevalence of diabetes in HMP Bure.



	Expected Prevalence (PHE)	Expected Prevalence (APHO)	Actual Prevalence
Receptions (YT Aug 2019)	7	47	24
QOF (Sep 19)	15	89	80

EPILEPSY

HMP BURE
The GP leads on the care of patients with epilepsy in the prison. There are plans for nursing staff to be offered training in the care of patients with epilepsy.
There is an epilepsy Standard Operating Procedure in place.
Looking at the actual prevalence in HMP Bure, both those identified at reception and those on the QOF register are slightly higher, at 2.4-2.5%, than the expected rate of 2.0%.
Where possible, following a risk assessment, the majority of patients are encouraged to have their medication in-possession. Healthcare complete compliance checks with patients, which includes the checking of cells for medication.
Reviews are completed by the GP.

EPILEPSY

NICE

Clinical guideline 137 covers Epilepsies: diagnosis and management

Key points from condition related research

Key points from prison related research

SELECTED RECOMMENDATIONS ■

DIAGNOSIS - The diagnosis of epilepsy in adults should be established by a specialist medical practitioner with training and expertise in epilepsy.

SELF-MANAGEMENT - Adults should receive appropriate information and education about all aspects of epilepsy. This may be best achieved and maintained through structured self-management plans.

MONITORING - Children, young people and adults with epilepsy should have a regular structured review and be registered with a general medical practice.
For adults, the maximum interval between reviews should be 1 year but the frequency of review will be determined by the person's epilepsy and their wishes.

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

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

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

Public Health England

PHE TOOLKIT - The PHE toolkit has limited information on epilepsy.

IDENTIFICATION - 1st Screen: Current Health Conditions: Epilepsy
2nd Screen: Family History: FH: Epilepsy

■ Due to space restrictions, only selected recommendations are included here.

● 2017-18 QOF

⬣ Mersey Region Epilepsy Association, Epilepsy in Prison

PREVALENCE

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

Figure 4.7.1 shows a study by Seena Fazel, Evangelos Vassos and John Danesh in the BMJ (2007). A finding from the study is that '...this synthesis of seven surveys involving more than 3000 participants in general prison populations indicates that only about 1% reported a history of chronic epilepsy.'

Figure 4.7.3 and figure 4.7.4 have used the higher estimate of 2% as stated in the PHE Toolkit. The 2% rate is for those newly sentenced; however, due to the nature of the condition, it was considered valid for this data exercise.

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

There is evidence that the incidence of epilepsy is now higher in elderly people than children.' Figure 4.7.2 shows the incidence of epilepsy in the UK per 100,000 of the population, taken from the Joint Epilepsy Council of the UK and Ireland.[91]

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

Figure 4.7.1: Expected epilepsy prevalence in prisons.[92]

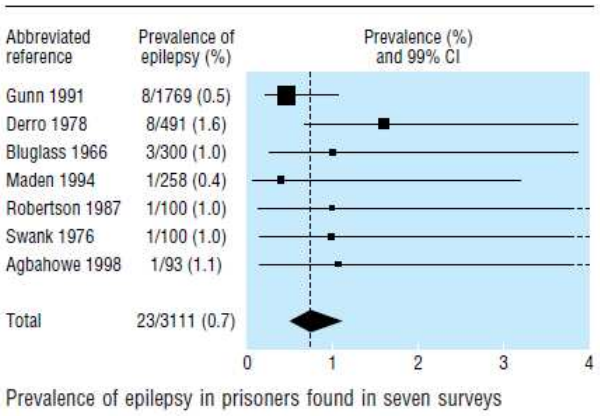
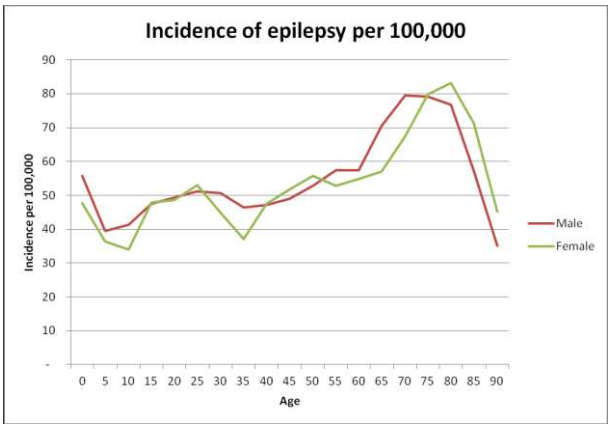


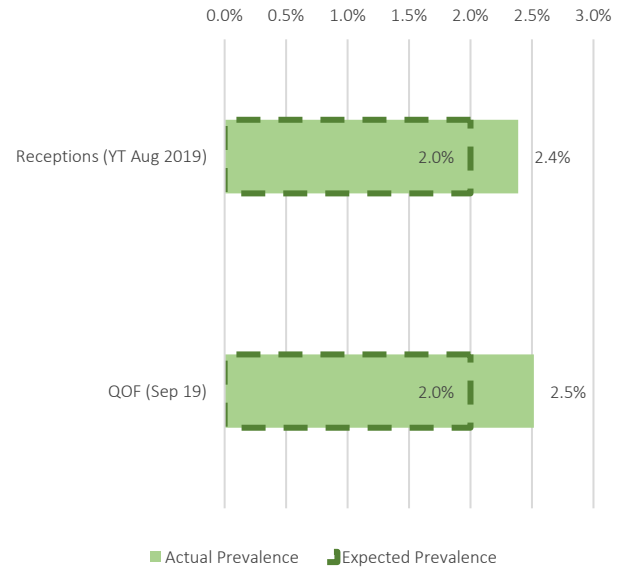
Figure 4.7.2: Incidence of epilepsy by age. [93]



[91] http://www.epilepsyscotland.org.uk/pdf/Joint_Epilepsy_Council_Prevalence_and_Incidence_September_11_%283%29.pdf
[92] Seena Fazel, Evangelos Vassos and John Danesh
[93] http://www.epilepsyscotland.org.uk/pdf/Joint_Epilepsy_Council_Prevalence_and_Incidence_September_11_%283%29.pdf

The expected prevalence for both prisons is 2.0%. Looking at the actual prevalence in HMP Bure, both those identified at reception and those on the QOF register at 2.4-2.5% are slightly higher than the expected 2.0% rate. In HMP Littlehey, the actual prevalence at both the reception and QOF register is slightly lower than the expected rate.

Figure 4.7.3: Expected and actual prevalence of epilepsy in HMP Bure.



	Expected Prevalence	Actual Prevalence
Receptions (YT Aug 2019)	8	9
QOF (Sep 19)	13	16

OBESITY

HMP BURE
Healthcare do not run any health clinics in the prison. There are number of patients in receipt of orlistat.
The gym run weight loss sessions, however places on these are limited.

OBESITY

NICE

There are a number of NICE guidelines relating to obesity. The following recommendations come from Obesity: identification, assessment and management Clinical guideline [CG189]

DIAGNOSIS - Use clinical judgement to decide when to measure a person's height and weight. Opportunities include registration with a general practice, consultation for related conditions (such as type 2 diabetes and cardiovascular disease) and other routine health checks.

SELF-MANAGEMENT - Multicomponent interventions are the treatment of choice. Ensure weight management programmes include behaviour change strategies (see recommendations 1.5.1–1.5.3) to increase people's physical activity levels or decrease inactivity, improve eating behaviour and the quality of the person's diet, and reduce energy intake.

IDENTIFICATION - 1st Screen: Basic Observations: BMI
2nd Screen: Basic Observations: BMI

Key points from condition related research

Key points from prison related research

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

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

Public Health England

PHE TOOLKIT - Key points taken from the PHE Toolkit are:

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

■ Due to space restrictions, only selected recommendations are included here. Full recommendations can be found here NICE guideline [NG80]

● HSCIC (2015), Statistics on Obesity, Physical Activity and Diet.

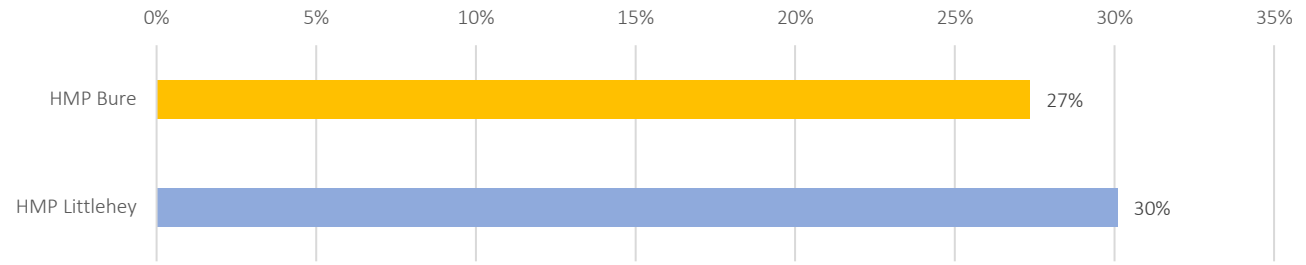
PREVALENCE

Of the 636 current prisoners in HMP Bure, 602 (95%) had a BMI recorded after their arrival at the prison. This is a much higher rate than the last HNA where only 360 (56%) of the 645 prisoners had a BMI recorded. This is reflected in the low rates on the obesity register. In HMP Littlehey, 1065 (85%) of the 1257 had a BMI recorded after their arrival at the prison. This is higher than the 837 (65%) of the 1282 for the last HNA.

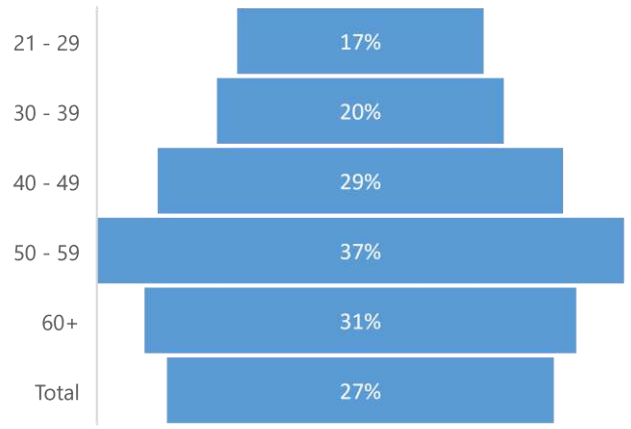
Figure 4.8.1: Analysis of the QOF Obesity Register.

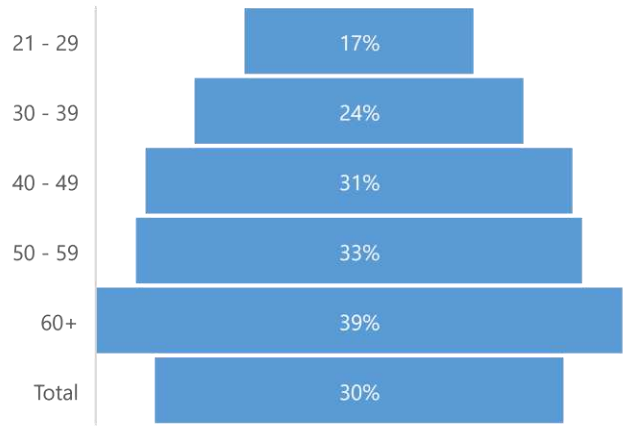
HMP BURE	HMP LITTLEHEY

Comparison of the QOF Obesity register across the two prisons.

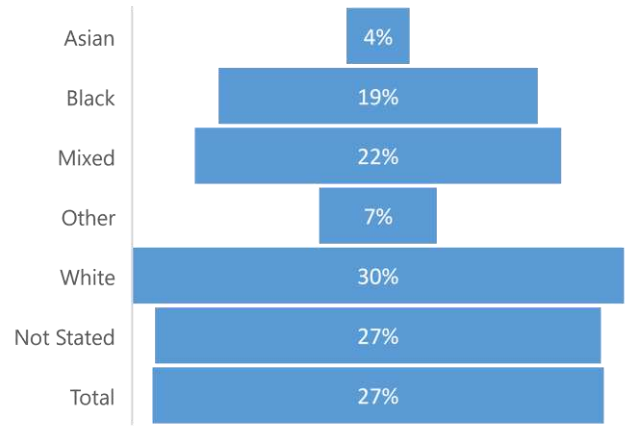


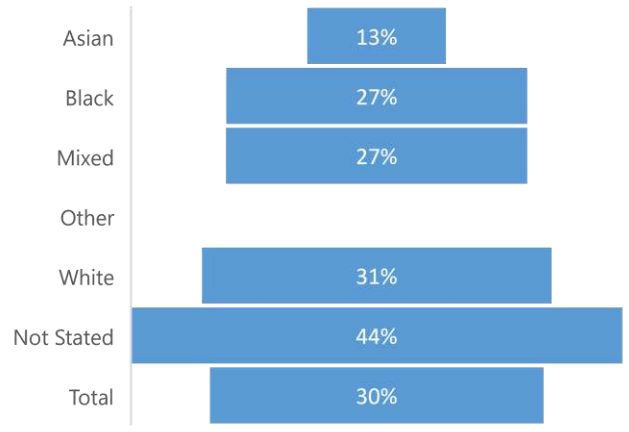
Prevalence by age group.





Prevalence by ethnic group.

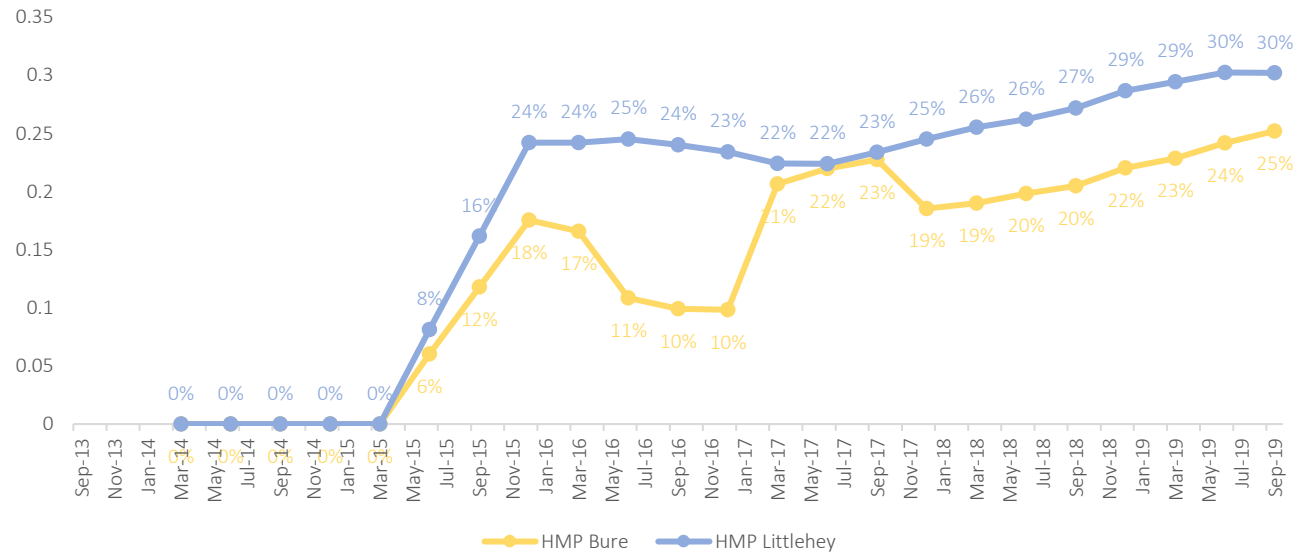




LONG-TERM TREND

Below shows the long-term trend analysis of the obesity QOF register. It can be observed that the rate of obesity has seen a steady increase over the last 18 months. As highlighted on the previous page, the increase in better recording of the BMI for prisoners may be a reason for the increase on the OQF register.

Figure 4.8.2: Long-term trend analysis of the obesity QOF register; rolling 3 month average.



OTHER SERVICES

PHARMACY

INTRODUCTION

There are various models that support pharmaceutical service delivery in prisons. The 2012 National Prescribing Centre report, *Safe Management and Use of Controlled Drugs in Prison Health in England*[94] agreed on the requirements of a full pharmaceutical service to a prison, regardless of the service model. The requirements were:

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

BEST PRACTICE

The Royal College of General Practitioners document, *Safer Prescribing in Prisons: Guidance for clinicians*[95] highlighted that many prisoners, though not all, are accustomed to using illicit and prescribed drugs to ameliorate or treat symptoms and perceived wants and needs.

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

PHE TOOLKIT

The PHE Toolkit states that pharmacy data "provides information about use of drugs. 44% of the prison population reported in 2013 to be taking medication (HoC Justice Committee); 73% in women prisoners (Plugge E. Health of women prisoners 2006)".[96]

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

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

CURRENT PROVISION

HMP BURE

There is no dispensing pharmacy in HMP Bure. Instead, medication is dispensed by a private provider, Sigma Pharmaceuticals. Medication is delivered Monday to Saturday, and the cut off for next day delivery is 2pm.

Pharmacy staff see patients when medication is being administered. Staff field queries regarding medications and also questions about appointment times.

Occasionally patients arrive in the prison without their critical medication. Healthcare have a stock of critical medications in the prison that they can dispense.

FP10 forms can also be used to request medications from local pharmacies.

Care UK have an online formulary that is available on SystmOne.

Figure 5.1.1: HMP Bure primary care staffing.

Job Title	Number
1	Lead Pharmacy Technician
4.5	Pharmacy Technicians

There is a minor ailment scheme in the prison.

A pharmacy shop was explored, however patients get their medication free of charge.

There are no pharmacy led clinics in the prison, however technicians can meet with patients to discuss the side effects of medications.

The GP and nurse practitioner run medicine use review clinics.

A complex case MDT meeting is attended by the pharmacy and the GP. Patients discuss reducing doses with the GP.

There is a standard Care UK In-possession policy in place. The in-possession risk assessment is completed by nursing staff at the reception screen.

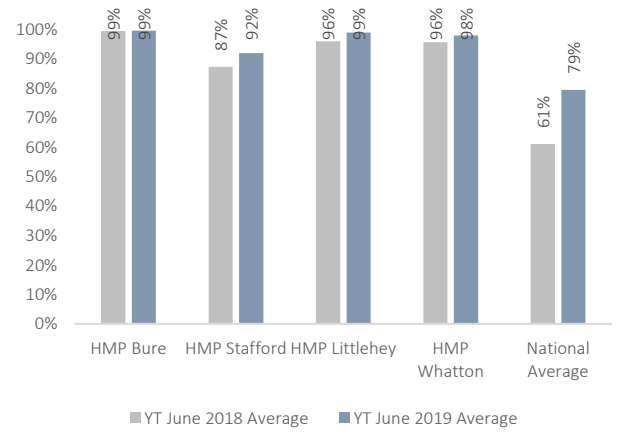
The Pharmacy Team monitor patient's compliance with medications. Pharmacy technicians complete cell visits with prison officers. Patients were roughly 70% compliant. Healthcare aim for 10 compliance checks per week.

HJIPS

The following information covers the 12 months to June 2019. The HJIPs show that:

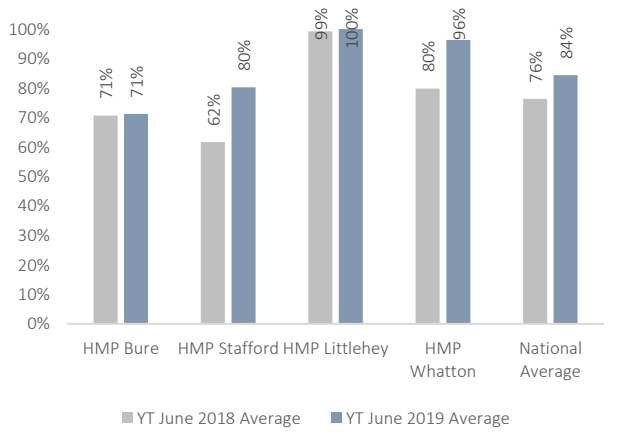
- Nearly all patients arrive in HMP Littlehey with a documented in-possession status. 71% of patients in HMP Bure arrive with in-possession status.
- The data from HMP Littlehey shows that 0 patients have arrived at the prison with a minimum of 7 days' supply of medicine. In addition, 0 patients are discharged with a minimum of 7 days' medication. In HMP Littlehey, this data does not reflect activity. The pharmacy confirmed that they will review this information. The pharmacy confirmed that all discharges are sent with a minimum of 7 days' supply of medication.

Figure 5.1.3: In-Possession Medication (Arrivals)
The % of newly arrived patients who have been assessed to hold medication in-possession



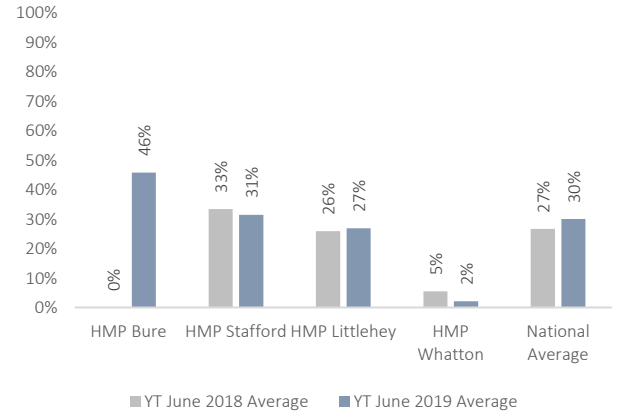
Total	HMP Bure		HMP Littlehey	
	YT June 2018	YT June 2019	YT June 2018	YT June 2019
Denominator	446	371	670	632
Numerator	443	369	642	624

Figure 5.1.4: In-Possession Medication (Pre-existing population)
The % of pre-existing patients who have a documented in-possession status



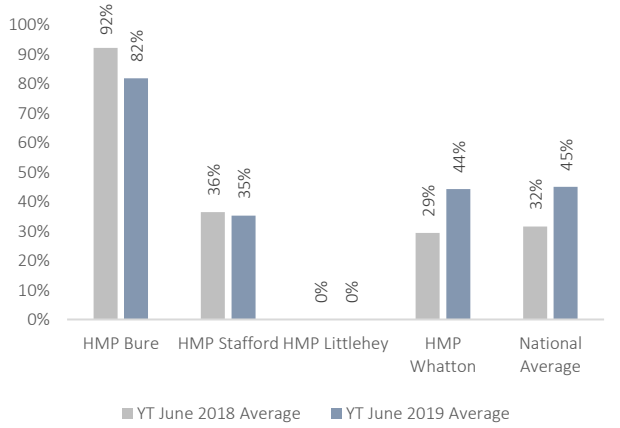
Total	HMP Bure		HMP Littlehey	
	YT June 2018	YT June 2019	YT June 2018	YT June 2019
Denominator	7361	7369	14373	14093
Numerator	5197	5245	14255	14079

Figure 5.1.5: Receipt of Medication
The percentage of patients prescribed supervised medication, who miss doses of the same drug (excluding PRN medication) on 3 consecutive days



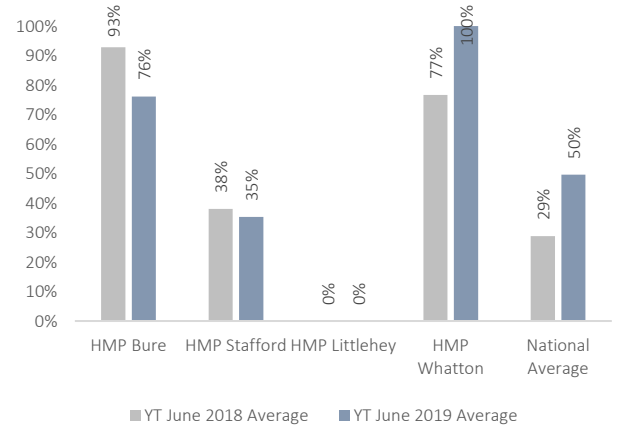
Total	HMP Bure		HMP Littlehey	
	YT June 2018	YT June 2019	YT June 2018	YT June 2019
Denominator	4154	361	541	651
Numerator	0	165	140	175

Figure 5.1.6: Supply on Transfer
The % of all transfers received with a minimum of 7 days' supply of medicine



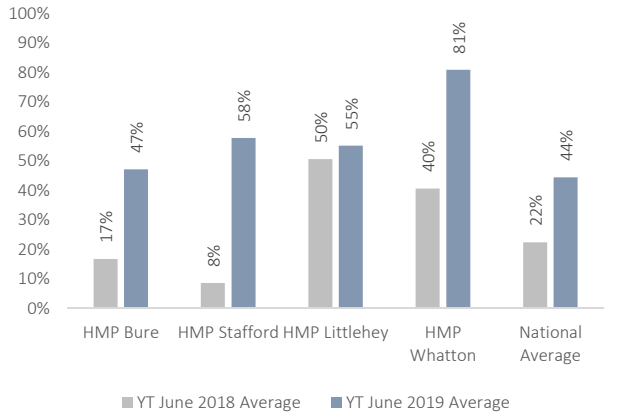
Total	HMP Bure		HMP Littlehey	
	YT June 2018	YT June 2019	YT June 2018	YT June 2019
Denominator	289	242	607	331
Numerator	266	198	0	0

Figure 5.1.7: Supply on Discharge
The % of all discharges with a minimum of 7 days' supply or FP10/FP10MDA



Total	HMP Bure		HMP Littlehey	
	YT June 2018	YT June 2019	YT June 2018	YT June 2019
Denominator	140	155	563	307
Numerator	130	118	0	0

Figure 5.1.8: Medicines Reconciliation
Medicines reconciliation recorded within 72 hours of reception



Total	HMP Bure		HMP Littlehey	
	YT June 2018	YT June 2019	YT June 2018	YT June 2019
Denominator	427	372	670	634
Numerator	71	175	338	349

ESCORTS AND BEDWATCHES

HMP BURE

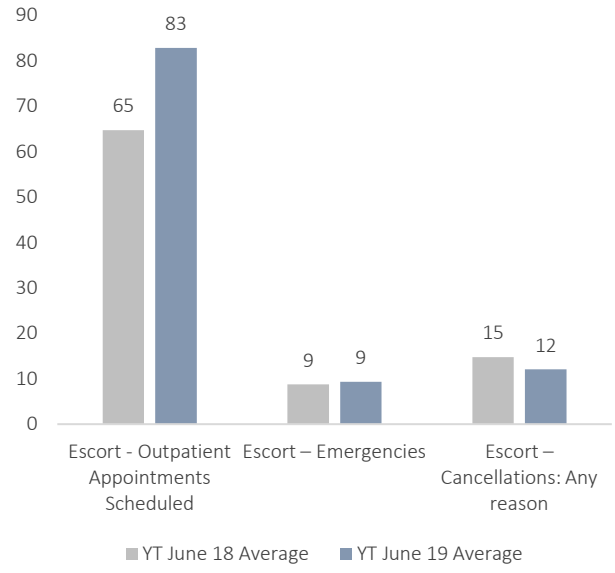
In HMP Bure there were 4 planned escorts per day. Healthcare and the prison work closely to ensure that escorts are kept. An example was given of the prison arranging extra staff to facilitate an escort to take place on a Saturday.

To try and reduce the number of escorts, Healthcare can assess chest pain in the prison using in-house ECG machines. These are analysed by an external company directly and a decision can be made about an emergency hospital appointment.

Below shows the escort activity as taken from the HJIPs data. The key points are:

- Both prisons have seen an increase in the number of appointments scheduled, however this trend was more prominent in HMP Bure.
- As a rate of the snapshot population, HMP Bure gives a figure of 131 compared to 156 in HMP Littlehey.
- The monthly average cancellations have seen a decrease in HMP Bure whilst HMP Littlehey has seen an increase. For the rate of appointments scheduled, HMP Bure gives a figure of 14% compared to 31% in HMP Littlehey.

Figure 5.2.1: Average number of escorts per month; HMP Bure.



CLINICS

Clinic	HMP Bure	
	Sessions per week	Waiting Times
Dentist	4	28 days (55 on routine waiting list and 35 on further treatment)
GP	4	8 days
Optician	0.5	29 days (24 on waiting list)
Physiotherapy	1.5	10 days (13 on waiting list)
Podiatry	1.5	7 days (3 on new waiting list and 71 on routine/follow up)

DENTAL SERVICE

LOCAL PROVISION

Dental services in HMP Bure are provided by Community Dental Services.

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

The dental service in HMP Littlehey did not supply information for this assessment.

Questions	HMP Bure
Has a Disability Access Audit been carried out on the dental surgery?	Unknown
Is the dental surgery wheelchair accessible?	Yes
When was the surgery last refurbished?	Unsure, have only commenced with contract April 2019
When was the surgery last redecorated?	As above
What is your role/ job title?	Prison Operations Manager
How long have you worked in this prison?	Since April 2019
What is the total number of clinical sessions worked by all dentists at this prison per week?	4
How long have you worked in prison dentistry?	4 years
Is there a signed Service Level Agreement (SLA) in place?	Yes
To your knowledge, has an oral health needs assessment been carried out at this prison?	No
How many dentists are employed in the prison?	One
How many dental nurses are employed in the prison?	One
Do any of the following work at the prison? *[Hygienist/Dental Therapist/Clinical Technician/Oral Health Promoter/Other]*	Hygienist
Does any of the following equipment need to be updated or replaced? *[Dental chair/Delivery system/X-ray Unit/Cabinetry/Suction/Compressor/Handpieces/Hand Instruments/Autoclave/Disinfection eqpt/Floor covering/Decoration/Surgical Instruments/Other]*	No
Who is responsible for organising the maintenance of equipment?	CDS for non-fixed assets HMP for fixed assets
Who is responsible for payment of the maintenance contracts?	CDS for non-fixed assets HMP for fixed assets
Are maintenance contracts in place for equipment that needs regular certification?	Yes
What items are currently without a maintenance contract? *[Autoclave/Washer- disinfector/X-ray equipment/Compressor/Suction/Other]*	Autoclave
Are there any items of equipment that urgently need replacing or updating?	No
When was the most recent HTM 01-05 audit carried out?	August 2019
What was the result of the HTM 01-05 audit?	No report yet
Has a full CQC inspection (England) or an equivalent inspection (Wales) been carried out?	Unknown
Is SystmOne used in the dental surgery?	Yes
For which of the following do you use SystmOne?	Clinical notes
How many SystmOne training sessions did you attend?	None

Is the dental surgery registered with the Information Commissioner's Office (ICO)?	Unknown
Who manages the dental appointment diary?	Dental Team
Who manages the dental waiting list?	Dental Team
How long is the waiting list for routine examinations?	4 - 7 weeks
After the initial examination, how soon is a follow-up appointment for treatment available?	14 weeks
How many patients, on average, are booked into a clinical session?	Eight
How long do you book for an average new patient exam?	20 mins
How quickly are patients requiring emergency dental treatment (trauma, hemorrhage, etc) seen by the dentist or other appropriately trained staff?	On the same day
How quickly are patients with dental pain normally seen by the dentist or other appropriately trained staff?	As an emergency on the day
On average, how many external dental referrals are arranged each month for specialist dental care outside the prison?	Unknown
Are there any problems with making referrals for specialist dental care in your area or for patients attending these appointments?	No
Escort problems	No
Prison security (lock downs, counts, bad behaviour, etc.)	Unannounced lock downs
Patients being released or transferred without notice	No
Patients unavailable due to court appearances or video links, etc.	No
Patient out of prison due to medical appointments	No
Patient has visitors	No
Patient refuses to attend	No
Please give details of 'Other' reasons that result in DNAs:	No access issues
Do you have an issue with patients being transferred or released before laboratory work is fitted?	Yes, but if they are transferred to another site where CDS are the dental provider then the lab work gets transferred to the new site.
Are DMFTs recorded and collated separately from the dental records for epidemiological or monitoring purposes?	No
Any comments on Training:	No training given in SystmOne
In what ways is OHP delivered?	By dental team at patient's appointment
Is there a specialist smoking cessation team in the prison?	Unknown
Do you offer smoking cessation advice in the surgery?	Yes
Any additional comments on Oral Health Promotion:	Bespoke posters in surgery
How would you rate cooperation and liaison between the dental staff and other healthcare staff?	Very Good
Does the dental team meet regularly with doctors and nursing staff to discuss healthcare issues?	No
How many patient complaints have been received in the last 12 months concerning the dental service?	8 informal complaints since commencement of contract in April 2019
Which of the following have been the subject of complaints?	Applications not being addressed, needing a referral and not

	addressing a previous complaint. Length of time to see dentist.
Is there a patient care pathway in place?	Yes
Is there an effective dental triage pathway in place?	Yes
Is Language Line translation services or an equivalent service available for your use in the surgery?	Unknown
Any additional comments on Communication:	Sometimes we use Google Translate as easier than Language Line.

PERFORMANCE

- HMP Bure has seen an increase in both booked appointments and patients seen.
- The number of booked appointments in HMP Littlehey has remained the same, however the patients seen has decreased. The number of patient cancellations has increased.
- The percentage of patients seen as a rate of booked appointments is similar at 87-90% across the 2 prisons. This is higher than the national average.
- Figure 5.3.6 shows information relating appointments booked and attended in comparison with the population size, and has been included for comparative purposes. The rate is calculated using the snapshot population as at the end of July 2018 + the number of receptions in the 12 months to June 2019 as the denominator.
- Taking into account population size, the rate of appointments booked and attended in HMP Bure is higher than in HMP Littlehey.

Figure 5.3.2: Monthly clinic activity; HMP Bure.

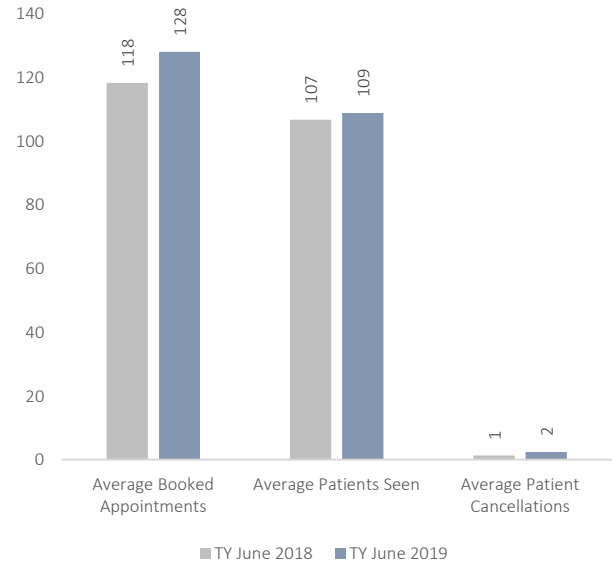


Figure 5.3.3: Monthly clinic activity; HMP Littlehey.

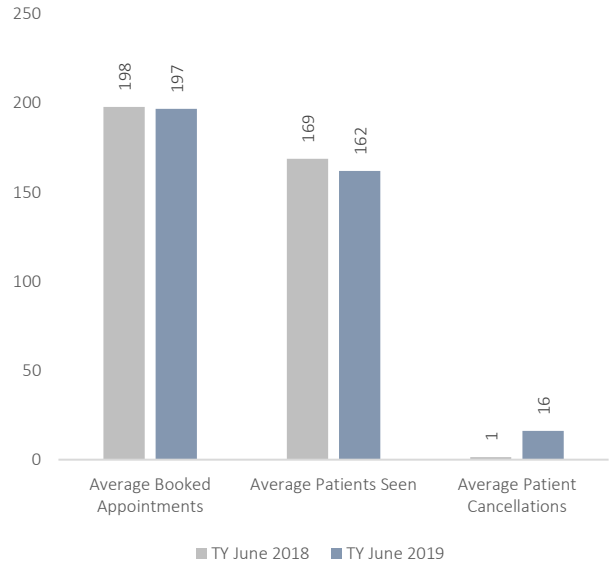


Figure 5.3.4: Percentage of patients seen as rate of appointments booked.[97]

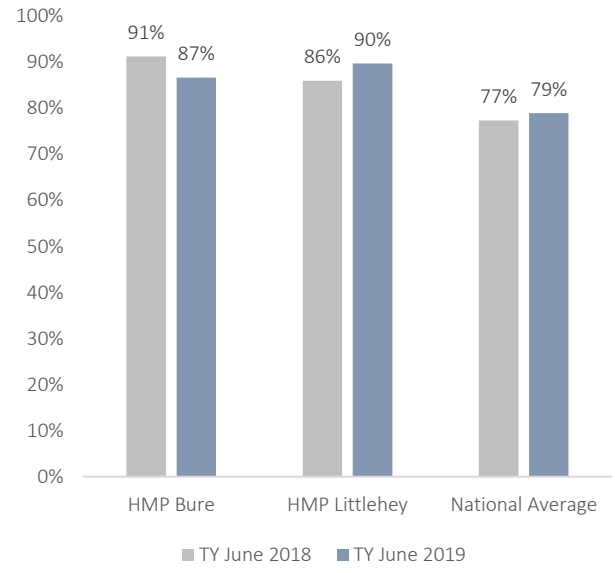
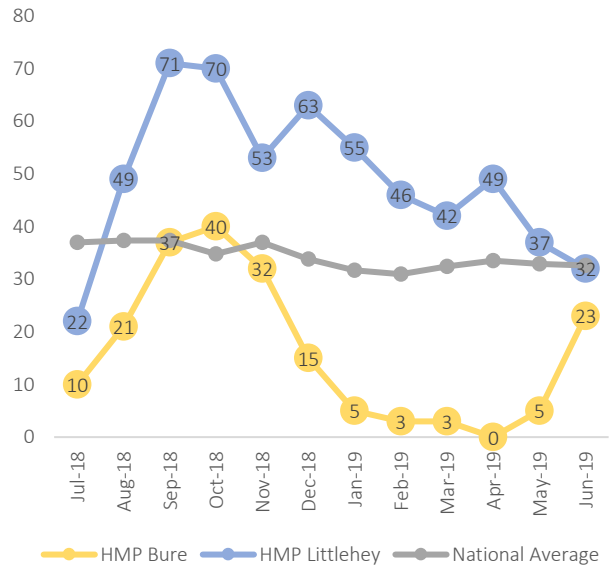


Figure 5.3.5: Waiting time for routine care.



[97] Patients Seen / (Booked Appointments minus Cancellations).

	HMP Bure
Snapshot Population Average (July 2018)	644
Receptions (YT June 2019)	372
Combined (Denominator)	1016
RATE – Booked Appointments	1512
RATE – Attended	1284

GP SERVICE

LOCAL PROVISION

HMP BURE
In HMP Bure there are 4 GP sessions per week. GP services are provided by a private GP provider.

PERFORMANCE

- HMP Bure has seen a slight decrease in both the number of booked appointments and appointments attended when comparing the 12 months to June 2019 against the previous year. The percentage of patients seen as rate of appointments booked has decreased from 93% to 88%.
- HMP Littlehey has also experienced a decrease in both the number of booked appointments and appointments attended when comparing the 12 months to June 2019 against the previous year, however the percentage of patients seen as rate of appointments booked has increased from 93% to 97%. This rate is higher than HMP Bure and the national average.
- Figure 5.5.7 shows information relating appointments booked and attended in comparison to the population size and has been included for comparative purposes. The rate is calculated using the snapshot population as at the end of July 2018 + the number of receptions in the 12 months to June 2019 as the denominator.
- Taking into account population size, the rate of appointments booked and attended in HMP Littlehey is higher than in HMP Bure.
- The waiting time in HMP Bure is generally lower than HMP Littlehey and the national average.

Figure 5.5.7: Monthly clinic activity; HMP Bure.

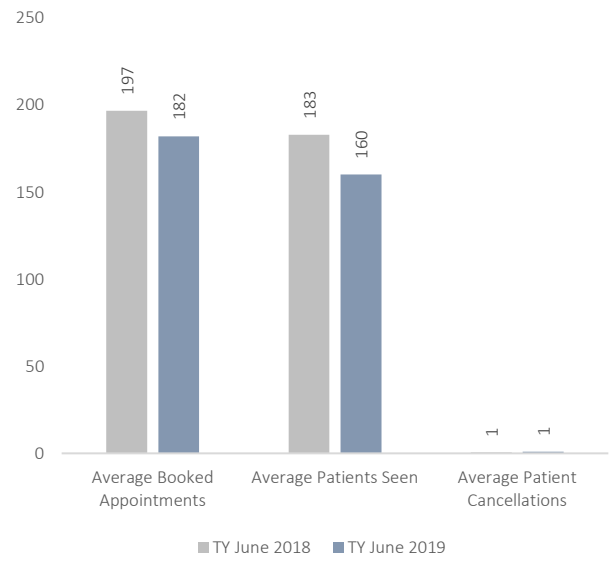


Figure 5.5.8: Monthly clinic activity; HMP Littlehey.

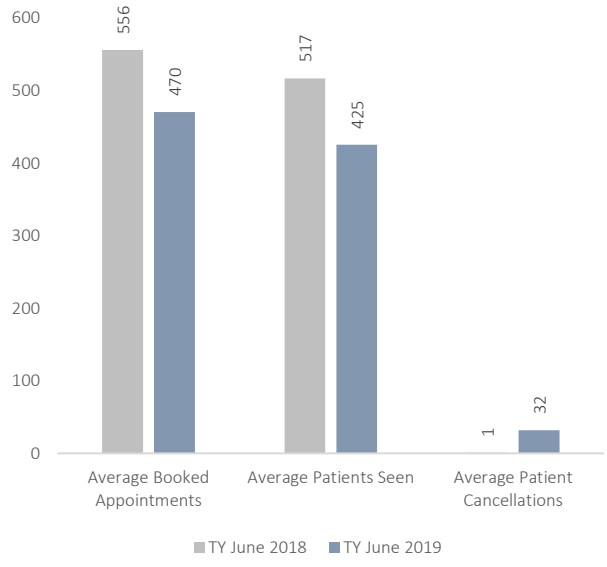


Figure 5.5.9: Percentage of patients seen as rate of appointments booked.[98]

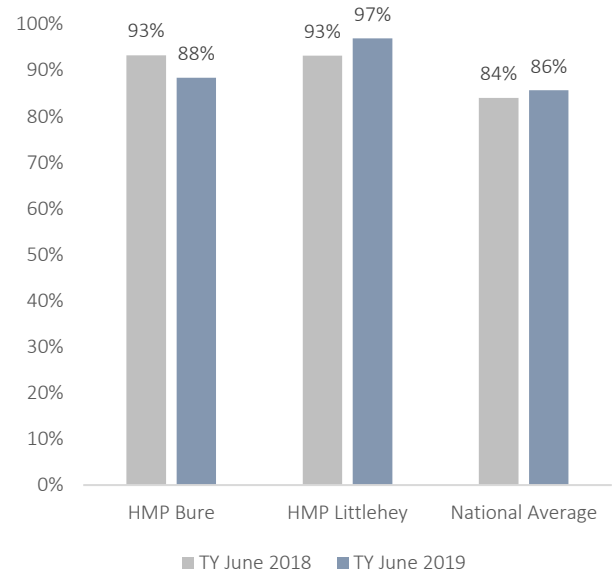
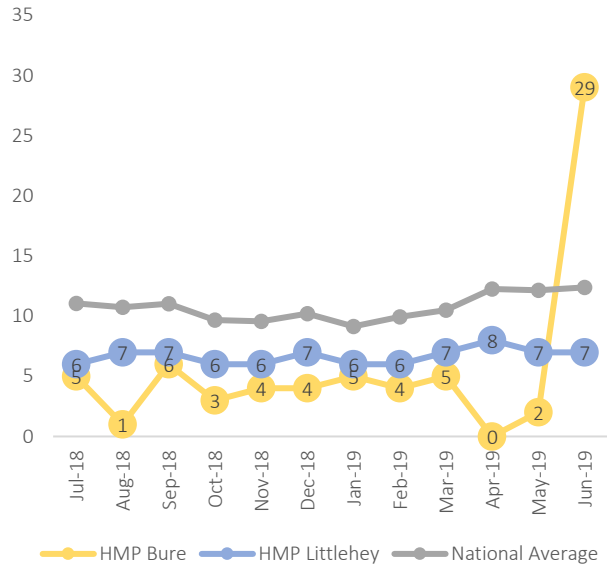


Figure 5.5.10: Waiting time for routine care.



	HMP Bure
Snapshot Population Average (July 2018)	644
Receptions (YT June 2019)	372
Combined (Denominator)	1016
RATE – Booked Appointments	2149
RATE – Attended	1890

[98] Patients Seen / (Booked Appointments minus Cancellations).

OPTICIAN SERVICE

HMP BURE
Optician services are provided by the Pen Optical Trust. The optician visits the prison every other week. At the time of this assessment, the waiting list was approximately 2 weeks.
The space is suitable for delivering an optometry service.

PHYSIOTHERAPY SERVICE

HMP BURE
Physiotherapy provision is provided by Premier Physical Healthcare. The physiotherapist is commissioned as a musculoskeletal service. The physiotherapist provides 6 sessions per month. The service accepts referrals via healthcare professionals and does not accept self-referrals. The physiotherapist said that there was an extremely good relationship with the Healthcare Team in the prison.
There are no issues with the room or equipment.
The physiotherapist does not attend the pain review clinics. This has not been explored in the prison.
The physiotherapist is able to refer patients to the remedial gym sessions. The physiotherapist can make a written referral to the gym describing the programme of exercises a patient should follow.

PODIATRY SERVICE

HMP BURE
Podiatry services are subcontracted to a private provider. There are 6 sessions per month. On the day they attend the prison, the podiatrist attends the daily hand over sessions with other healthcare staff. There is an open referral process. The podiatrist completes foot checks for diabetic patients. Healthcare assistants have received some training relating to diabetic foot checks from the podiatrist. Healthcare assistants do not complete any nail cutting. Patients are given advice on how to self-care for nails, including using emery boards. There are plans for the podiatrist to complete some education work with patients on Residential Unit 7. Some nail surgery can be completed in the prison.
The room and equipment are suitable for practice. There was a doppler machine available for the podiatrist to use to assess the blood flow in feet, which can be used for diabetic complications.

SMOKING CESSATION SERVICE

HMP BURE

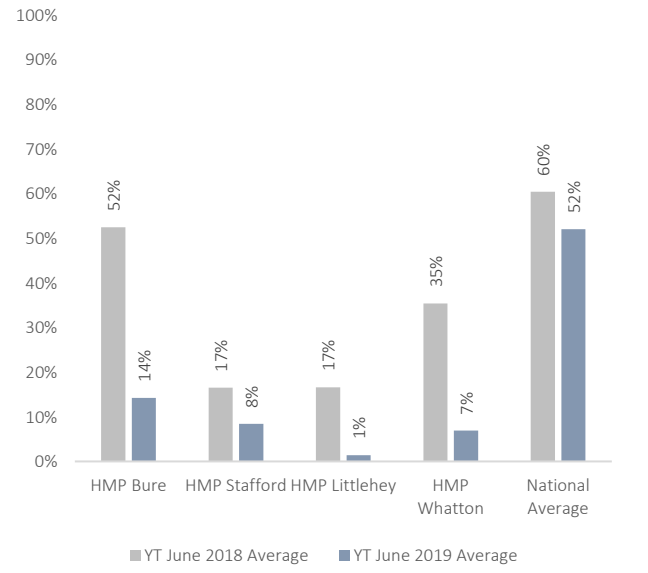
Smoking cessation therapies are only offered to patients who have not finished a course of treatment that was started in a previous prison.

PERFORMANCE

The following information relates to the HJIP indicators associated with smoking:

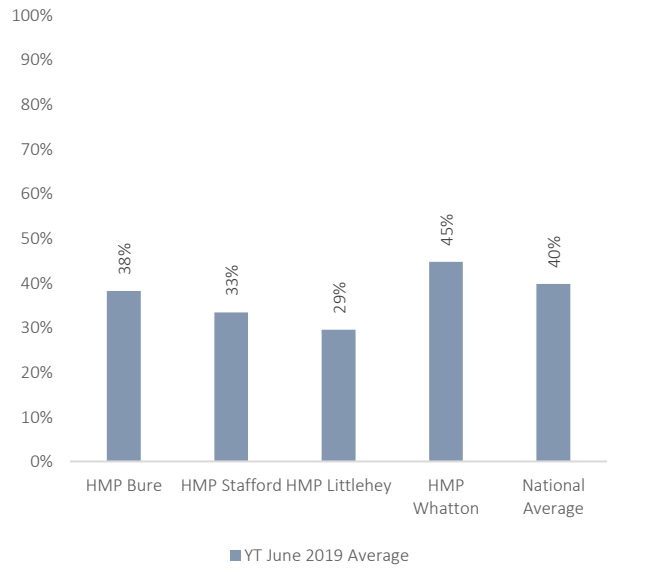
- The percent of patients at arrival who are smokers has seen a decrease, however this is likely to be due to better recording around vaping.
- For the 12 months to June 2019, 14% of new arrivals in HMP Bure were recorded as smokers. This is significantly higher than the 1% in HMP Littlehey.
- The prevalence of e-cigarette users is also higher in HMP Bure than HMP Littlehey.
- The higher prevalence of smokers at reception is reflected in the activity for smoking services.

Figure 5.5.12: Smoking Prevalence
The percentage of patients at arrival who are smokers.



Total	HMP Bure		HMP Littlehey	
	YT June 2018	YT June 2019	YT June 2018	YT June 2019
Denominator	446	372	670	634
Numerator	234	53	111	9

Figure 5.5.13: Vaping Prevalence
The percentage of patients at arrival who are e-cigarette users



Total	HMP Bure		HMP Littlehey	
	YT June 2018	YT June 2019	YT June 2018	YT June 2019
Denominator	-	372	-	634
Numerator	-	142	-	187

Figure 5.5.14: Smoking Cessation Uptake

Figure 5.5.15: Smoking cessation referral to treatment

The percentage of smokers who take part in regular smoking therapies	The percentage of patients able to access smoking cessation treatment within 48 hours of referral (including self-referrals)
In HMP Bure, between April 2019 and June 2019 there were 434 prisoners who identified as a smoker, with 153 (35%) engaging in smoking cessation therapies. During the same period in HMP Littlehey, only 79 prisoners identified as a smoker, with 0 engaging in smoking cessation therapies.	For the 12 months to June 2019, there were 13 prisoners in HMP Littlehey that were referred to stop smoking services, with 7 (54%) being able to access the service within 48 hours. In HMP Littlehey, there was only 1 prisoner referred to stop smoking service, with 0 accessing the service within 48 hours.

COMMUNICABLE DISEASES

HEPATITIS

INTRODUCTION

The prevalence of sexually transmitted infections (STIs) and blood-borne viruses (BBVs) is higher in the prison population than in the general population, due to high risk behaviour such as unprotected sex, multiple partners, and injecting drugs.[99]

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

A report released by the Health Protection Agency in 2011[100] shows that the increase in prison hepatitis B virus (HBV) vaccinations has significantly reduced the HBV rates for injecting drug users (IDU).

PHE TOOLKIT

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

Injecting drug use is the main risk factor in the transmission of BBVs for hepatitis C infection in the UK (over 90% of new infections are acquired this way).[101]

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

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

LOCAL PROVISION

HMP BURE
Patients are tested for hepatitis C at the secondary health screen. Testing can also be offered at phlebotomy clinics. Those who test positive are educated about the risks of hepatitis C and given information on treatment. The Hepatitis C Trust visit the prison to promote treatment to the population.

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

Fibroscanning, ultrasound checks, and blood monitoring are available in the prison.

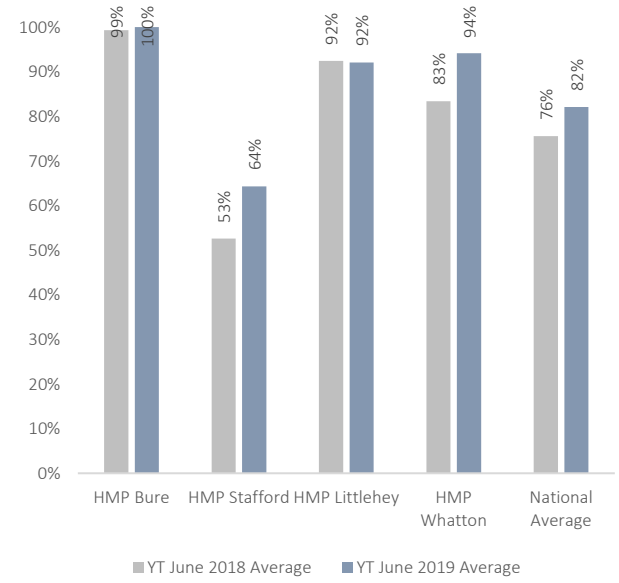
Treatment is managed under a shared care arrangement, with a visiting hepatology nurse completing treatment in the prison.

HJIPS

The following information relates to the HJIP indicators associated with hepatitis.

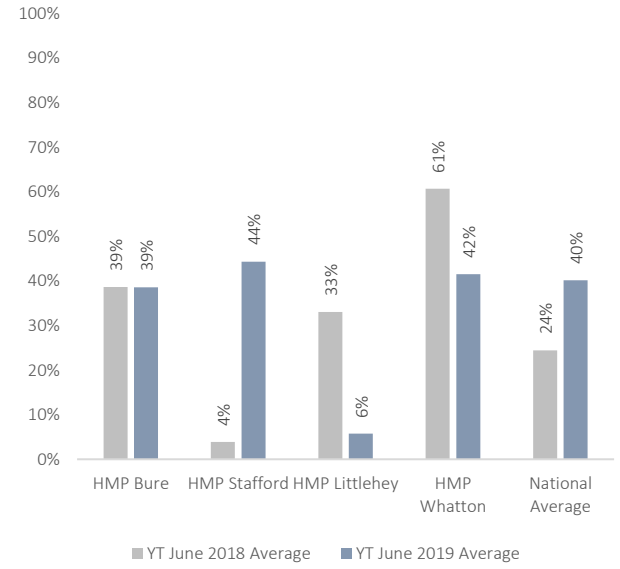
- In HMP Bure, 99-100% of receptions for the 2 years to June 2019 were offered hepatitis B testing compared to 92% in HMP Littlehey.
- In terms of those that underwent testing (HBsAg), the rate of 39% in HMP Bure is higher than that reported for HMP Littlehey.
- The number of those testing positive is low, at around 1 per year.

Figure 6.1.1: Hepatitis B Offered
The % of patients offered hepatitis B testing, within 7 days of reception



Total	HMP Bure		HMP Littlehey	
	YT June 2018	YT June 2019	YT June 2018	YT June 2019
Denominator	279	230	487	402
Numerator	277	230	450	370

Figure 6.1.2: Hepatitis B – HBsAg Uptake
The % of new arrivals that underwent testing (HBsAg) within 4 weeks of arrival of the total patients eligible during the reporting period



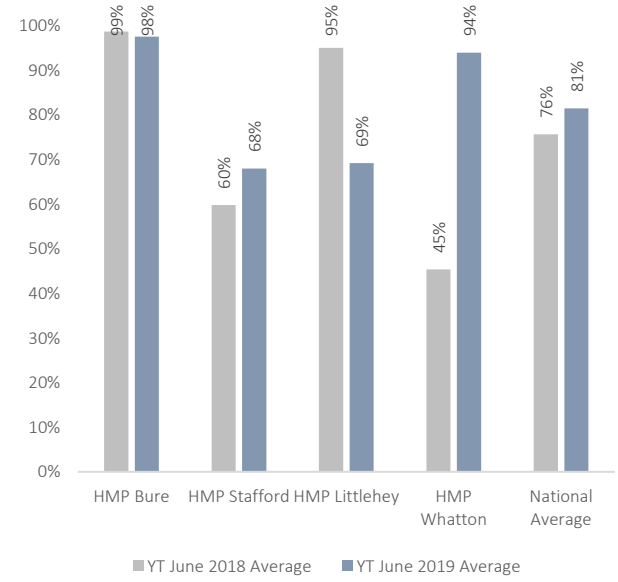
Total	HMP Bure		HMP Littlehey	
	YT June 2018	YT June 2019	YT June 2018	YT June 2019
Denominator	267	231	494	402
Numerator	103	89	163	23

Figure 6.1.3: Hepatitis B – Referral
The % of those testing positive for chronic hepatitis B being referred to a specialist service

Total	HMP Bure		HMP Littlehey	
	YT June 2018	YT June 2019	YT June 2018	YT June 2019
Denominator	0	1	1	1
Numerator	0	0	1	0

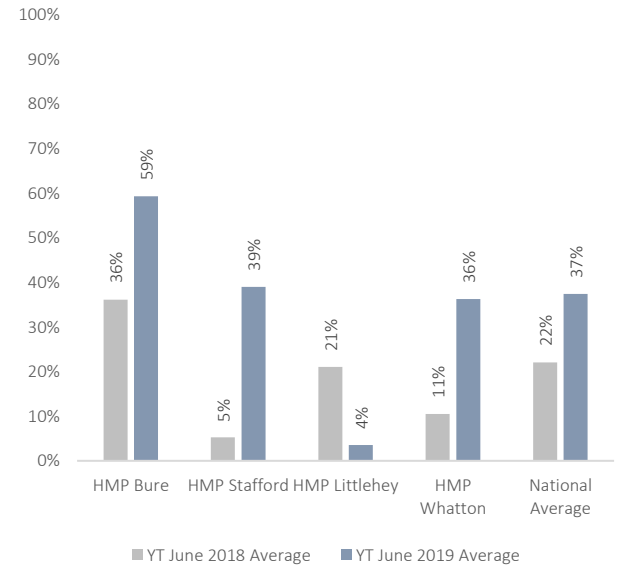
- In HMP Bure, 99-100% of receptions for the 2 years to June 2019 were offered hepatitis B testing compared with 95% in HMP Littlehey for the 12 months to June 2018. Testing for hepatitis B in HMP Littlehey has further reduced to 69% for the 12 months to June 2019.
- In terms of those that underwent hepatitis C Ab test, the rate has increased from 36% to 59% in HMP Bure, and is higher than the comparative prison and national average. For HMP Littlehey, this has reduced from 21% to 4%.
- For the 12 months to June 2019, there were 0 patients identified as hepatitis C Ab positive at reception who underwent hepatitis C PCR testing across both prisons.
- For the 12 months to June 2019, there were 0 patients identified as hepatitis C PCR positive at reception.

Figure 6.1.4: Hepatitis C Offered
The % of patients offered hepatitis C testing, within 7 days of reception



Total	HMP Bure		HMP Littlehey	
	YT June 2018	YT June 2019	YT June 2018	YT June 2019
Denominator	368	324	666	616
Numerator	363	316	633	426

Figure 6.1.5: Hepatitis C - Hepatitis C Ab
The % of eligible patients who have a undertaken a hepatitis C Ab test



Total	HMP Bure		HMP Littlehey	
	YT June 2018	YT June 2019	YT June 2018	YT June 2019
Denominator	368	324	666	616
Numerator	133	192	140	22

Figure 6.1.6: Hepatitis C - Hepatitis C PCR
The % of patients identified as hepatitis C Ab positive at reception who underwent hepatitis C PCR testing.

For the 12 months to June 2019, there were 0 eligible in either HMP Bure or HMP Littlehey.

Figure 6.1.7: Hepatitis C – Referral
The % of those identified as hepatitis C PCR positive at reception being referred to a specialised service within 2 weeks.

For the 12 months to June 2019, there were 0 eligible in either HMP Bure or HMP Littlehey.

SEXUAL HEALTH

INTRODUCTION

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

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

Higher rates of STIs have been reported among the prison population than the general population – 15% of prisoners in the UK have had or have an STI.[102] This is likely due to a large proportion of the prison population engaging in the high-risk behaviours of having unprotected sex with multiple partners, and/or injecting drugs. In 2006, 48% of female prisoners reported having sex without condoms.[103]

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

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

Research carried out by the Prison Reform Trust reported that 55% of those under the age of 24 in prison are expected to have had unprotected sex in the past year with 2 or more partners. In 2012, the Howard League for Penal Reform undertook the first ever review into sex in prisons.

Nick Hardwick, the former Chief Inspector of Prisons, raised a number of concerns while giving evidence to the Howard League for Penal Reform's Commission into Sex in Prisons, including the possibility that inmates could be contracting sexually transmitted diseases because prisons are failing to support them. Nick Hardwick suggested that the Prison Service should implement a uniform approach to providing protection.

In an HM Inspectorate of Prisons survey, 1% of prisoners said that they were being sexually abused, rising to 2-3% among prisoners who considered themselves to be disabled.[104]

In an academic study of 200 ex-prisoners, 91% said they had been coerced sexually, yet only a small number of complaints about sexual issues are officially logged. The Probation and Prison Ombudsman (PPO) logged just 108 such complaints be-tween 2007 and 2012.[105]

LOCAL PROVISION

HMP BURE
There is no visiting sexual health specialist in the prison. Nurses manage sexual health issues and patients with more complex issues can be referred to the iCASH service in Norwich. Condoms are available in the prison.

[102] NHS Commissioning Board (2012), *Public health functions to be exercised by the NHS Commissioning Board*.
[103] Ibid.
[104] Howard League for Penal Reform, (2014), *Commission on Sex in Prison*.
[105] https://www.independent.co.uk/news/uk/home-news/sex-in-prisons-campaigners-warn-of-culture-of-denial-over-sexual-relationships-between-inmates-as-8605109.html

Patients who are HIV positive have their conditions reviewed at the iCASH service in Norwich.

At the time of this assessment, there were 4 patients who were HIV positive. Patients were generally compliant with their medication.

TUBERCULOSIS

INTRODUCTION

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

Some of the key facts taken from the research include:

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

BEST PRACTICE

NICE systematic evidence reviews[106] established that the most effective approach for identifying TB in high-risk groups, such as those in prisons, involves active case finding.[107]Active case finding can be achieved through the use of digital x-ray machines, which have been installed in some prisons across the country. The use of digital x-ray machines can reduce diagnostic delay with cases less likely to be contagious on diagnosis, when compared with passive case detection and symptom screening alone.[108]

In 2017, the Journal of Public Health[109] published an audit of tuberculosis services in prisons and immigration removal centres. 12 healthcare teams within PPD commissioned by NHS England (London Region) were included in the audit. Services were evaluated against the NICE standards for TB best practice.

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

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

PHE TOOLKIT

Coverage of tuberculosis in the PHE Toolkit is limited:

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

LOCAL PROVISION

In both prisons, patients are given a symptomatic screen for tuberculosis as part of the reception healthcare screen. Healthcare in both prisons have links with Public Health England and the local tuberculosis clinics.

HJIPS

The following information covers the 12 months to June 2019:

Tuberculosis (TB) Screening Uptake

- For the 12 months to June 2019, 366 (98%) of the 372 receptions and transfers into HMP Bure underwent a medication check.
- HMP Littlehey reports a similar rate, with 632 (100%) of the 634 receptions and transfers receiving a medication check.

Tuberculosis (TB) Referral

- In HMP Bure, there were 2 prisoners screened positive for symptoms of TB, however 0 were referred to a specialist TB screening service.
- In HMP Littlehey, there have been no prisoners that have screened positive for symptoms of TB.

Tuberculosis (TB) Treatment

- Across both prisons, there have been no prisoners referred to a specialist TB assessment service.

APPENDIX

RELATED POLICIES

SUBSTANCE MISUSE STRATEGY	
HMP BURE	
The embedded files below contain the latest substance misuse policies for the prisons.	
This document was not available in time for this needs assessment.	

SUICIDE AND SELF-HARM POLICY	
HMP BURE	
The embedded files below contain the latest suicide and self-harm policies for the prisons.	
Suicide Prevention Policy 2019-20.doc	

ABBREVIATIONS

ACCT	Assessment Care in Custody and Teamwork
ADHD	Attention Deficit Hyperactivity Disorder
ADHS	Adult Dental Health Survey
AMD	Age-related Macular Degeneration
APHO	Association of Public Health Observatories
BAME	Black, Asian and Minority Ethnic
BBV	Blood-borne virus
BMI	Body Mass Index
BPD	Borderline Personality Disorder
BTS	British Thoracic Society
CBT	Cognitive Behavioural Therapy
CMO	Chief Medical Officer
CNA	Certified Normal Accommodation
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CSJ	Centre for Social Justice
CVD	Cardiovascular Disease
DAFNE	Dose Adjustment For Normal Eating
DASA	Defence Analytical Services Agency
DIP	Drug Interventions Programme
DMFT	Decayed, missing or filled teeth
DNA	Did Not Attend
EMDR	Eye Movement Desensitisation and Reprocessing
ERP	Exposure Response Prevention
FNP	Foreign National Prisoner
GAD	Generalised Anxiety Disorder
GP	General Practitioner
GUMCAD	Genitourinary Medicine Clinic Activity Dataset
HAWC	Health and Wellbeing Champion
HBV	Hepatitis B virus
HCA	Health Care Assistant
HJIP	Health and Justice Indicators of Performance
HMIP	Her Majesty's Inspectorate of Probation

HMP	Her Majesty’s Prison
HMPPS	Her Majesty's Prison and Probation Service
HSCNA	Health and Social Care Needs Assessment
IAPT	Improving Access to Psychological Therapies
ICO	Information Commissioner's Office
IDTS	Integrated Drug Treatment System
IDU	Injecting drug users
IMB	Independent Monitoring Board
IPT	Interpersonal therapy
LD	Learning Disability
MDT	Mandatory Drug Testing
MoJ	Ministry of Justice
NDTMS	National Drug Treatment Monitoring System
NICE	National Institute for Clinical Excellence
NOMIS	National Offender Management Information System
NOMS	National Offender Management Service
OCD	Obsessive Compulsive Disorder
OHRN	Offender Health Research Network
PECS	Prisoner Escort and Custody Services
PEI	Physical Education Instructor
PHE	Public Health Executive
PHiPs	Public Health in Prisons
PHPQI	Prison Health Performance Quality Indicator
PPO	Probation and Prison Ombudsman
PS	Psychoactive substances
PSI	Prison Service Instruction
PSO	Prison Service Order
PTSD	Post Traumatic Stress Disorder
QOF	Quality and Outcomes Framework
RCGP	Royal College of General Practitioners
REA	Rapid Evidence Assessment
rMDT	random Mandatory Drug Testing
RNIB	Royal National Institute of Blind People
SCMH	Sainsbury Centre for Mental Health
SDTP	Substance Dependency Treatment Programme

SIGN	Scottish Intercollegiate Guidelines Network
SOPHID	Survey of Prevalent HIV Infections Diagnosed
SPCR	Surveying Prisoner Crime Reduction
STI	Sexually transmitted infection
WHO	World Health Organisation
WTE	Whole time equivalent
WWA	Waste Water Analysis
YOI	Young Offender Institution
YOT	Youth Offending Team