Health and Well-Being Needs Assessment

HMYOI Werrington

Acknowledgements

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

Thanks are extended to Staffordshire & Shropshire Local Area Team, the HNA Steering group, to all at HMYOI Werrington (Healthcare, DARS, In Reach, CAMHS, Primary Mental Health, contracted service providers, HMPS and NOMS colleagues) and to the young people who participated in focus groups and completed questionnaires.

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

Maggie Wood M.A, R.N

OHNA Ltd

Foreword

This Health & Well-Being Needs Assessment (HWBNA) has been commissioned by NHS England Health & Justice Staffordshire & Shropshire Local Area Team.

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

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

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

The Health and Well-Being Needs Assessment for HMYOI Werrington is distinct and separate from the adult Health Needs Assessments and has been undertaken using the Public Health England Child and Maternal Health Intelligence Network (ChiMat) template provided within the Youth Justice Health and Well-Being Needs Assessment Toolkit[1], developed by the Department of Health as part of the Healthy Children Safer Communities cross government strategy.

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

[1] http://www.chimat.org.uk/yj/na/template

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ACCT	Assessment, Care, and Custody Teamwork
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autistic Spectrum Disorder
BME	Black Minority Ethnic
BMI	Body Mass Index
CAMHS	Child & Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CHAT	Comprehensive Health Assessment Tool
ChiMat	Child and Maternal Health Intelligence Network
CQC	Care Quality Commission
DBT	Dyadic Behavioural Therapy
DDP	Dialectical Development Psychotherapy
DNA	Did Not Attend
EMDR	Eye Movement Desensitization and Reprocessing
GP	General Practitioner
HMIP	Her Majesty's Inspectorate of Prisons
HMPS	Her Majesty's Prison Service
HNA	Health Needs Assessment
HONOSCA	Health of a Nation Outcome Scales
HWBNA	Health and Well-Being Needs Assessment
IPC	Infection Prevention and Control
MASH	Multi Agency Safeguarding Hub
MAYSI-2	Massachusetts Youth Screening Instrument – Second Version
MMR	Measles Mumps and Rubella
NHS	National Health Service
NICE	National Institute for Care and Health Excellence
NPS	New Psychoactive Substances
PALS	Patient Advice and Liaison Service
PHE	Public Health England
QOF	Quality Outcomes Framework
RGN	Registered General Nurse
RMN	Registered Mental Health Nurse
SCU	Separation and Care Unit
SSOPT	Staffordshire and Stoke-on-Trent Partnership NHS Trust
STC	Secure Training Centre
STI	Sexually Transmitted Infection
TAG	Threshold Assessment Grid
TYC	Transforming Youth Custody
WHO	World Health Organisation
YPDASS	Young Persons Drug and Alcohol Support Service
YJB	Youth Justice Board
YJS	Youth Justice System
YOI	Youth Offender Institution
YOS	Youth Offending Service

Executive Summary

HMYOI Werrington is a Young Offender Institution located in Stoke-on-Trent. The prison population consists of male young people aged 15 to 18 who have been sentenced or are on remand. The establishment has an operational capacity of 160.

There are two accommodation blocks: Denby and Doulton.

Denby/C Wing houses the Rehabilitation and Support Unit with 6 single beds and two 'safer' rooms.

Doulton is split into two wings: A (38 single and 14 double cells) and B (26 single and 18 double cells).

Within HMYOI Werrington, there is a purpose built gymnasium and Healthcare Unit. In recent years, a new reception has been built. There is also an exterior football pitch.

At the time of undertaking this Health and Well-Being Needs Assessment there were 113 young people in the establishment.

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

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

Population & Demography

- The population at HMYOI Werrington remains one of young males aged between 15 and 18 years of age. The population of 113 is similar to that recorded on June 30th 2013.
- There has been an increase in the remand population from 17% on June 30th 2013 to 23.89% on 31st December 2014.
- The percentage of foreign nationals at HMYOI Werrington (11%) is lower than the current national prison average of 13%.
- The percentage of young people of black or black British ethnicity had risen from 13.7% in June 2013 to 17% in December 2014.
- The percentage of those of Asian or Asian British ethnicities has also risen, accounting for 13.3% of the population in December 2014.
- The national over-representation of young people from BME groups in the secure estate is reflected in the population of HMYOI Werrington.
- With the closure of juvenile places at HMYOI Hindley, it is expected that the population at HMYOI Werrington may increase slightly over the next year, and that there may be some changes in presenting healthcare.

- The governments `Transforming Youth Custody' agenda will mean that healthcare departments will need to maximise the efficiency of the available time in which to access young people and find innovative ways of working to deliver key health messages.
- The majority of young people are serving detention and training order sentences of 12 months or more giving healthcare services an opportunity for engagement, intervention and promotion of good health choices.

Physical Health & Well-Being Needs

- The Comprehensive Health Assessment Tool (CHAT) is utilised to undertake comprehensive health screening of all young people received in to the establishment.
- The prevalence of asthma (8% from SystmOne data) is higher than the national prevalence of 5.9% and also higher than the prevalence estimates in the Birmingham toolkit (7%).
- There are no young people with diabetes or epilepsy.
- The World Health Organization (WHO) regards childhood obesity as one of the most serious global public health challenges for the 21st century.
- Nationally in England and Wales, the prevalence of overweight and obesity is lowest in the 16-24 age group where 24.3% males are overweight and 12.1% obese.
- Levels of obesity amongst the current population at HMYOI Werrington are below the national average.
- There is a commitment to national vaccination programmes; however, significant numbers of young people decline vaccinations.
- Of the 79 young people received into HMYOI Werrington during the period April 2013-March 2014, 24% were already vaccinated against Hepatitis B and a further 35.4% declined vaccination.
- Of the remaining 32 young men, 31 received Hepatitis B vaccination within a month of coming into the establishment.
- Between October 1st 2013 and September 30th 2014, 63.75% of eligible young people declined the MMR vaccination.
- There is a communicable disease policy developed in liaison with Public Health England and an Infection Control Policy and plan.
- There is an up to date and completed outbreak plan.
- There have been no infectious/acquired infections (MRSA, Clostridium Difficile, E Coli, Norovirus).
- Levels of physical disability are very low.

Physical Health - Met Needs

- Access to the G.P is good – there is no waiting list and young people can be seen within a few days for routine appointment and on the same day for more urgent needs.
- Access to nurse is excellent.
- Hospital appointments for secondary care are facilitated when required.
- Dental and optician waiting lists are well managed.
- All services are at least comparable to those that would be received in the community and young people are very positive about services received.

Physical Health- Unmet Needs

- The number of young people declining vaccinations is high.
- It is suggested that the healthcare team source or develop age appropriate, innovative and appealing materials to encourage vaccination uptake.
- The prevalence of type I diabetes and epilepsy is very low and there have been no young people presenting with these conditions in recent years.
- Should a young person be received into the establishment who has epilepsy or diabetes, staff will require refresher training to ensure employment of up to date evidence based practice and care, and knowledge and understanding of current medication regimes and approaches.

Emotional and Mental Health Needs

- Young males in custodial settings are 18 times more likely than those in the general population to take their own lives[2].
- There have been 16 deaths of young people in secure care since 2000[3]. The death rate for this group is higher than in equivalent age groups who have a diagnosis of schizophrenia or eating disorder[4].
- Drug use, suicide, and non-intentional injury are the leading causes of death among young offenders.
- Nearly three quarters of young people in custody have been assessed as having some form of speech, language or communication need[5].
- Initial studies looking at rates of traumatic brain injury in young offenders also suggest higher incidence in this population[6].
- Between April 2013 and March 2014 there were 144 ACCTS opened (mean average of 12 per month) at HMYOI Werrington.
- A total of 521 ACCT reviews were undertaken.
- The Primary Care Mental Health Team undertook assessments.
- The CAMHS case load averages 20 – 25 young people at any one time.

[2] Fazell, D. (2008) 'Mental disorders among adolescents in juvenile detention and correction facilities: a systematic review and metaregression analysis of 25 surveys', *Journal of the American Academy of Child and Adolescent Psychiatry*, 47(9): 1010-19.
[3] Youth Justice Board (2014) *Youth Justice Statistics 2012/2013 England and Wales*. London: Youth Justice Board.
[4] Coffey, C.F. Veit, F. Wolfe, R. Cini, E. and Patton, G.C. (2003) 'Mortality in young offenders: retrospective cohort study', *British Medical Journal*, 326: 1064-7.
[5] Bryan, K., Freer, J. and Furlong, C. (2007) 'Language and communication difficulties in juvenile offenders', *International Journal of Language and Communication Disorders*, 42: 505-20.
[6] Williams, W.H., Cordan, G., Mewse, A., Tonks, J. and Burgess, C.N. (2010) 'Self-reported traumatic brain injury in male young offenders: A risk factor for re-offending, poor mental health and violence?', *Neuropsychological Rehabilitation*, 20(6): 801-12.

- Medium secure adolescent Mental Health Inpatient Beds have been found difficult to access with only one referred young person being accepted in four years.
- On average one or two referrals to medium secure beds are declined per year.

Emotional and Mental Health - Met Needs

- Young people receive good levels of support from Primary Mental Health and CAMHS teams.
- Links with the prison are good with weekly Multi Agency Meetings held to discuss vulnerable young people.
- Although a small multi-disciplinary team, CAMHS provide a broad range of evidence based interventions appropriate to the age and complexity of the client group.

Emotional and Mental Health - Unmet Needs

- It is recommended that a programme of child focussed skills and knowledge training is developed to include a wide range of physical and mental & emotional health training from CAMHS, Looked After Children's Team, Paediatric Nurse Specialists and Specialist Children's Charities.
- Interventions do not include Speech and Language Therapy or Occupational Therapy as recommended in the Healthcare Standards.
- There is no capacity to provide group work approaches and this is an area for development.
- A constant watch protocol should be jointly agreed between the healthcare department and prison colleagues.

Substance Misuse Needs

- Over the 5 months for which figures are recorded there were 95 new referrals to the service of which 9 were transfers in to the establishment and 2 were re-referrals/ relapses.
- This provides a mean average of 19 new referrals per month - an estimate of approximately 228 new referrals per annum.
- One of the referrals to the service required clinical / pharmacological interventions.
- 97 received psychosocial interventions.
- Cannabis was the most popular primary substance of choice, with alcohol being second.
- No young people cited heroin or benzodiazepines as primary substances.
- A small number of young people had already experienced legal highs and mephedrone.

Substance Misuse - Met Needs

- The service is accessible and responsive to young people's needs.
- Young people are positive about the services received.

- All planned releases (100%) received information prior to release, had a pre-discharge risk assessment completed and had necessary information supplied to the Youth Offending Service.

Substance Misuse – Unmet Needs

- With the closure of juvenile places at HMYOI Hindley, need should be closely monitored and evaluated, as depending upon emerging needs, it may be necessary to review and reflect on resource, skill mix and facilities available. Additional funding or resource may be required to adapt premises, raise staff awareness, and provide additional training for staff groups who may not have experienced looking after young people undergoing clinical detoxification before.
- YPDASS and Primary Care providers will need to liaise with prison partners to identify appropriate locations where young people can be safely monitored and supported whilst receiving clinical interventions for stabilisation or detoxification.
- Monitoring of young peoples' experience and exposure to New Psychoactive Substances is essential to gauge emerging use and provide intelligence upon which to base information and advice.

A full list of local recommendations made can be found in section 17 of the HNA report.

2 Introduction

2.1 The purpose of a Health and Well-Being Needs Assessment (HWBNA)

Health and Well-Being Needs Assessments are conducted so that commissioners can make plans for healthcare and other services, based on a sound understanding of current service provision and young people's needs.

2.2 Why this Health and Well-Being Needs Assessment is needed

This Health and Well-Being Needs Assessment is being undertaken as part of the regional series of Health and Well-Being Needs Assessments described in the foreword of this report.

In accordance with Public Health England good practice guidelines, a multi-agency working group was established to oversee the Health and Well-Being Needs Assessment process with representation from all relevant stakeholders.

This Health and Well-Being Needs Assessment refreshes the Health Needs Assessment (HNA) conducted for HMYOI Werrington in 2013.

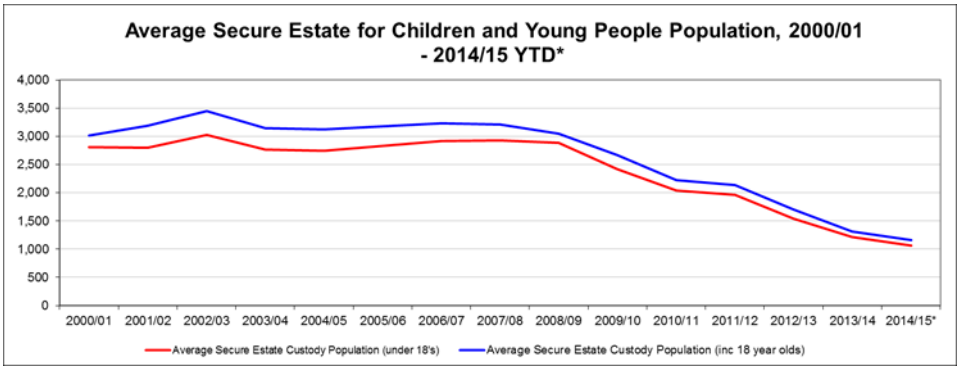
2.3 Young Offender Institutions (YOIs)

Responsibility for commissioning health services in Young Offender Institutions was transferred to the NHS between 2003 and 2006.

The overwhelming majority of children and young people in contact with the Youth Justice System remain in the community throughout contact, but a small number are remanded or sentenced to custody. The health and well-being needs of children and young people in custody tend to be particularly severe.

The last decade has seen a significant reduction in the number of young people held within the secure estate in England and Wales as illustrated below.

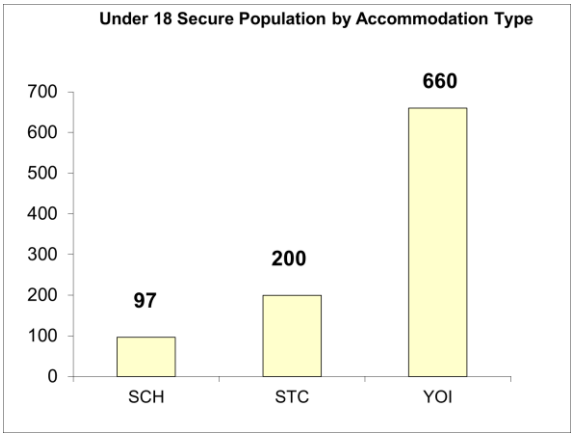
Figure 2 Average Population (Secure Estate for Children and Young People) 2000-2014[7]



[7] https://www.gov.uk/government/statistics/youth-custody-data

Of the 957 children aged under 18 years old held within the secure estate on 31st December 2014, 68.9% (n=660) were held in Young Offender Institutions, 20.9% (n=200) in Secure Training Centres and 10.1% (n=97) in Secure Childrens Homes.

Figure 3 Under 18 Secure Population by Accommodation Type



This reduction in the number of children and young people in custody has led to a review of the estate, and on 23rd October 2014 the Youth Justice Board announced:-

`Due to the welcome and continued reduction in the number of young people in custody, the Youth Justice Board will be reducing the number of commissioned places'

Since 2009, significant decommissioning has taken place but vacancies still exist across the youth secure estate. This is not an effective use of public funds and the YJB has therefore decided to withdraw from all 58 places at Hassockfield Secure Training Centre (STC), County Durham, and all of its 248 places at Hindley Under-18 Young Offender Institution (YOI), Wigan[8].

This decision has a direct impact upon HMYOI Werrington and is discussed at intervals throughout this report. There are now four Young Offender Institutions in England & Wales that hold young people aged between 15 and 18 years. These are HMYOIs Werrington, Cookham Wood, Feltham and Wetherby.

2.4 Children and Young People in the Youth Justice System

Children and young people in contact with the Youth Justice System have more – and more severe – unmet health and well-being needs than other children of their age. They have often missed out on early attention to health needs. They frequently face a range of other, often entrenched, difficulties, including school exclusion, fragmented family relationships, bereavement, unstable living conditions, and poor or harmful parenting that might be linked to parental poverty, substance misuse and mental health problems[9].

[8] Statement of Youth Justice Board 24th October 2014 at https://www.gov.uk/government/news/yjb-to-withdraw-from-hassockfield-stc-and-hindley-yoi

[9] Ryan, Tunnard.J, Evidence of needs paper 2011

In the January 2014 Impact Assessment for the government initiative ` Transforming Youth Custody- Putting education at the heart of detention' it states that "estimates, from the National Audit Office, suggest that just 5% of young offenders are responsible for nearly a third of all proven offences committed by under-18s. Yet when these offences result in a custodial sentence, 71% of young people released from detention go on to break the law again within 12 months" [10]. It continues, citing that "86% of young men in Young Offender Institutions have been excluded from school at some point, and over half of 15-17 year olds in YOIs have the literacy or numeracy level expected of a 7-11 year old".

2.5 The Young People's Secure Estate

Although this HWBNA relates mainly to HMYOI Werrington, it looks beyond the care provided by the unit alone. This is because commissioning health and well-being services in secure settings needs to take account of the importance of providing continuity of care for a child or young person at any point in the Youth Justice System: before, during and after their time in custody.

2.6 Defining Health & Well-Being

In this document, **health** refers to both physical and mental health, and to the impact of substance misuse, although on occasions each aspects of health is considered separately.

There is a strong focus on **well-being**. For vulnerable children and young people, including those in contact with the Youth Justice System, well-being is about strengthening the protective factors in their life. Well-being encompasses improving their resilience to the risk factors and setbacks that feature so largely for them and are likely to have a continuing adverse impact on their long-term development. Well-being is also about children feeling secure about their personal identity and culture.

This use of the term 'health and well-being' is consistent with the World Health Organisation definition of health – a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. It is consistent with the thinking underpinning Healthy Children, Safer Communities and with emerging developments around Health and Well-being Boards and joint health and well-being strategies. It takes account, too, of the duty of agencies to co-operate to improve children's well-being: section 10 of the Children Act 2004[11] places a duty to co-operate on the local authority, the police, the Probation Service, Youth Offending Services, the Strategic Health Authority and Primary Care Trusts, and Connexions partnerships.

2.7 Methodology & Data Sources

This HWBNA is based on information from a number of sources:

- Desk research into national and local policy and context
- Analysis of screening and assessment tools, SystmOne records, data from Public Health England observatories and the Ministry of Justice Analysis and Planning Department,

[10] http://www.parliament.uk/documents/impact-assessments/IA14-03K.pdf
[11] Children Act 2004

Healthcare monitoring files (performance dashboards) and quarterly substance misuse data sets
- Stakeholder views, elicited through questionnaires and focus groups
- Service mapping

2.8 The Main Policy Drivers

This is a time of considerable change in the organisational structures relevant to responding to the health and well-being needs of children and young people in contact with the Youth Justice System. Despite these changes, some messages from central government remain the same, and some earlier initiatives continue to be in-line with current priorities. These are about the importance of:

- Working to address health inequalities
- Targeted early intervention, at whatever age problems begin to arise for children and young people
- Intensive support and intervention for children living in families who are experiencing more complex and long-standing problems, and
- Making every opportunity to address children's health needs as important in Youth Justice Settings as in other settings

There is also recognition that, in times of budgetary restraint, it is more important than ever to ensure that services are effective and are achieving their intended outcomes for children and their families. This cannot be done in isolation or by healthcare and health services alone. The work will need to be underpinned by robust joint planning, commissioning and cross-agency approaches.

Below are the main policy drivers for responding to the health and well-being needs of children and young people in contact with the Youth Justice System.

- Children Act 2004 (the section 10 and 11 duties to co-operate to improve well-being and to safeguard and promote the welfare of children)
- Healthy Children, Safer Communities (2009)
- Healthy Child Programme 0-19 (2009)
- Working Together to Safeguard Children (2010)
- Public Health and NHS Outcomes Frameworks (2012)
- National Service Framework for Children, Young People and Maternity Services (2004)
- NHS England Health & Justice Indicators of Performance

2.9 Contents of the HWBNA

The HWBNA follows the Public Health England Child & Maternal Health Intelligence Network (ChiMat) template provided within the Youth Justice Health and Well-Being Needs Assessment

Toolkit[12], developed by the Department of Health as part of the Healthy Children, Safer Communities cross government strategy.

The report begins with a description of HMYOI Werrington and of its current and recent population profile. The report then considers in turn the physical, emotional, mental health, substance use and social vulnerability needs of the population. Following this, an account of the services delivered to meet need is provided. Gaps in meeting need are identified and recommendations are put forward. All recommendations are collated in the final section of the report.

3 Description of the Unit

HMYOI Werrington is a Young Offender Institution located in Stoke-on-Trent.

The institution opened in 1895 as an Industrial School and was purchased by Prison Commissioners in 1955. It became to a Youth Custody Centre in 1985 and in 1988 it became a Juvenile Centre. The unit therefore has significant history and experience of caring for detained young people.

The population consists of male young people aged 15 to 18 who have been sentenced or are on remand. The establishment has an operational capacity of 160.

There are two accommodation blocks, Denby and Doulton. Denby/C Wing houses the Rehabilitation and Support Unit with 6 single beds and two 'safer' rooms. Doulton is split into two wings - A (38 single and 14 double cells) and B (26 single and 18 double cells).

Within HMYOI Werrington, there is a purpose built gymnasium and Healthcare Unit. In recent years, a new reception has been built. There is also an exterior football pitch.

HMYOI Werrington was subject to an unannounced inspection by HMIP in September 2013. HMIP reported that 'health services remained good, with further progress since our last inspection. Young people were treated courteously, with timely access to Primary Care Services. Care planning was commendable. Wider access to speech and language therapy was needed. Young people had prompt access to dental checks. The pharmacy service was satisfactory. Mental health services were very good'[13].

In a survey conducted by HMIP during this inspection, 65% of young people who had accessed Healthcare were positive about the quality of services against the comparator of 54%[14].

In conjunction with HMIP, HMYOI Werrington was inspected against the following CQC standards

Outcome 2	Before people are given any examination, care, treatment or support, they should be asked if they agree to it
Outcome 4	People should get safe and appropriate care that meets their needs and supports their rights

[12] http://www.chimat.org.uk/yj/na/template
[13] HMYOI Werrington Unannounced Inspection by HMIP 23rd September-4th October 2014, p40
[14] HMYOI Werrington Unannounced Inspection by HMIP 23rd September-4th October 2014, p40

Outcome 6	People should get safe and coordinated care when they move between different services
Outcome 4	Staff should be properly trained and supervised, and have the chance to develop and improve their skills
Outcome 13	There should be enough members of staff to keep people safe and meet their health and welfare needs
Outcome 16	The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The service was assessed as meeting all standards. The CQC report states 'the young people we spoke with told us they were satisfied with the range of services available. We were told by one young person, "The nurses always take time to explain what's happening. They use the right words so I can understand." Another person said, "Usually I can see a nurse or doctor the next day. If they need to they'll come over to my wing and see me the same day."'[15]

The Annual IMB report for HMP Werrington reads 'observations of healthcare provision at Werrington for young people is that they are well supported and cared for by the Healthcare Team and backed up with established mature links with other departments including safeguarding, social workers and external providers'[16]. The report details that 'on speaking to young people at Werrington who had contact with Healthcare they were positive about the quality of service received, and felt comfortable in talking to Healthcare staff about their problems'[17].

Concerns were expressed regarding the time it takes to fill vacancies in the Healthcare Team when they arise[18] .

The narrative below is based upon statistics provided by the Analytical Services Directorate, Ministry of Justice.

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

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

At the time of undertaking this Health and Well-Being Needs Assessment there were 113 young people in the establishment.

[15] HMYOI Werrington Care Quality Commission Report September 2013, http://www.cqc.org.uk/location/R1EY1/inspection-report/INS1-973426885#report-top
[16] HMYOI Werrington Independent Monitoring Board Annual Report 1st June 2013-31st May 2014, p11
[17] HMYOI Werrington Independent Monitoring Board Annual Report 1st June 2013-31st May 2014, p11
[18] HMYOI Werrington Independent Monitoring Board Annual Report 1st June 2013-31st May 2014, p9

3.1 Population by Age

Figure 4 Population by Age

Population by Age Group	30 Jun 2013	30 Jun 2014	31 Dec 2014
15-17	97	94	96
18-20	20	11	17

In December 2014, Ministry of Justice data indicates 85% of young people at HMYOI Werrington were between the ages of 15-17. The remaining 15% were between the ages of 18-20 years old. On 12th March 2014, local data indicates:-

- 1.6% are aged 15 years old
- 21.6% are aged 16 years old
- 70.8% are aged 17 years old
- 5.8 % are aged 18 years old

3.2 Population by Nationality

Figure 5 Population by Nationality

Population by Nationality	30 Jun 2013	30 Jun 2014	31 Dec 2014
Not Recorded	21	*	0
Foreign National	6	*	12
UK National	90	95	101
All	117	105	113

The percentage of Foreign National young people fell from 23.1% in June 2013 to 11% in December 2014. Figures for December 2014 show the percentage of Foreign Nationals at HMYOI Werrington to be lower than the current national prison average of 13%.

3.2 Population by Ethnicity

Figure 6 Population by Ethnicity

Population by Ethnicity	30 Jun 2013	30 Jun 2014	31 Dec 2014
Asian or Asian British	*	*	15
Chinese or Other	*	*	*
Black or Black British	16	19	19
Mixed	21	13	*
White	64	61	66
All	117	105	113

Across the period, the majority of young people were white (54.7% June 2013, n=64 and 58% December 2014, n=58%).

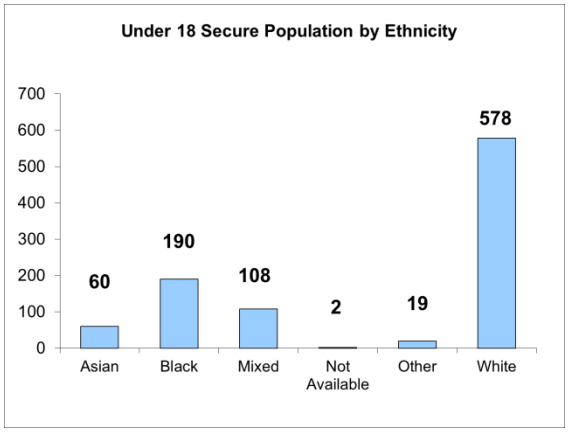
The percentage of young people of Black or Black British ethnicity had risen from 13.7% (n=16) in June 2013 to 17% (n=19) in December 2014.

The percentage of prisoners who were of Asian or Asian British ethnicities had also risen, accounting for 13.3% of the population in December 2014.

The number of mixed ethnicity young people had fallen by 17.9% from June 2013-December 2014.

Nationally, there is an over-representation of Black children and Black young people in custody. These ethnic groups comprise 17% of those in custody compared with 3% of the general 10-17 population.

Figure 7 Under 18 Secure Population by Ethnicity December 2014



This over-representation relates to children and young people coming within the census definition of 'Black', not to all children and young people from an ethnic minority group. So, for example, children and young people from an Asian background are under-represented in the Youth Justice System, both overall and in custody.

As can be deduced from the above summary, the national over-representation of young people from Black Minority Ethnic groups in the secure estate is reflected at HMYOI Werrington.

3.3 Length & Type of Sentence

Figure 8 Sentence Type

Population by Sentence Type	30 Jun 2013	30 Jun 2014	31 Dec 2014
Remand	20	18	27
Sentenced	97	87	86
Non-criminal	0	0	0
All	117	105	113

On 31st December 2014, there were no young people serving non-criminal sentences at HMYOI Werrington. 76% of young people were sentenced and the remaining 24% were remanded in custody. In June 2013 approximately 17% (n=20) of the population were remanded. In June 2014 the percentage of remands was also 17%. On 31st December 2014 23.89% (n=27) were remanded. These figures illustrate a 6.89% increase in the remand population. Although small, this requires monitoring as there is a significant workload attached to the screening and assessment of remand patients and addressing their immediate healthcare needs.

Figure 9 Sentence Length

Population by Sentence Length	30 Jun 2013	30 Jun 2014	31 Dec 2014
Less than or equal to 6 months	*	8	13
More than 6 months to 12 Months	15	9	8
More than 12 months to 4 years	58	45	50
More than 4 years to less than life	14	18	11
Indeterminate	0	0	*
Recalls	*	7	*
All	97	87	86

Of the 86 sentenced young people, 58% (n=50) were serving sentences of more than 12months to four years and 13% (n=11) were serving more than four years to life. These figures are similar to those published for June 2013, when 59.8% (n=58) of young people were serving more than 12 months to four years and 14.4% (n=14) were serving more than four years to life. However, the percentage of young people serving 12months or less has risen from 15.5% in June 2013 (n=15) to 24% in December 2014 (n=21).

3.4 Movements In & Out of the Unit

Between October 1st 2013 and September 30th 2014 there were a total of 294 receptions into the unit of whom 82 were new receptions, 162 were sentenced receptions and 50 were transfers from other establishments.

Between October 1st 2013 and September 30th 2014 there were a total of 136 young people released from HMYOI Werrington, giving a mean average of 11.3 releases per month.

This is a churn of approximately 2.6: the population replaces itself 2.6 times in a year.

Figure 10 Releases September 2013 to September 2014

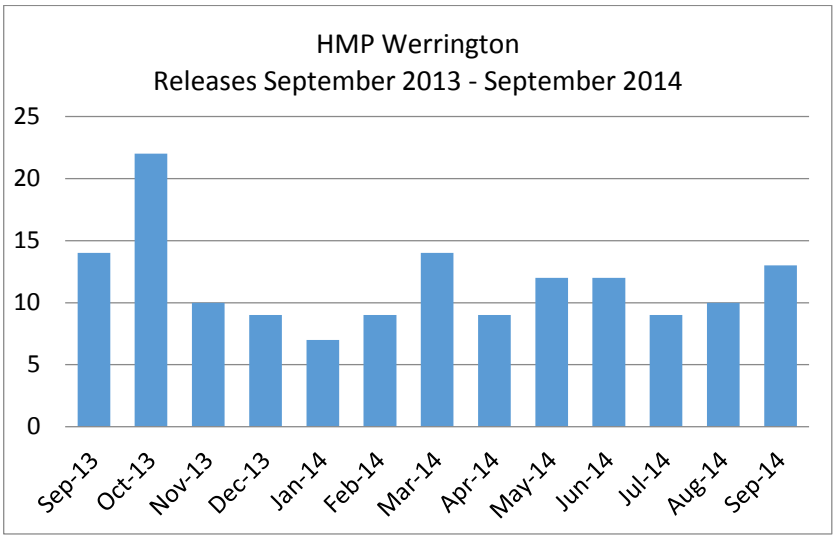
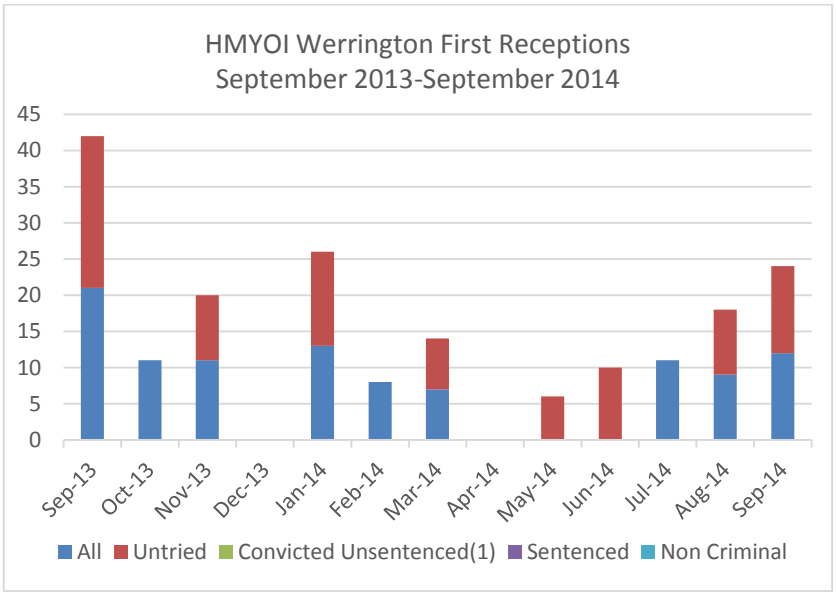


Figure 11 First Receptions September 2013 to September 2014



3.5 Population by Home Area

Local prison records indicate that 43.36% (n=49) of the current population come from Birmingham, Coventry or Wolverhampton. This generates an opportunity for close liaison with local Community Healthcare Services when planning for release and resettlement. However, there are small numbers of young people within HMYOI Werrington who are located long distances from home (for example from Leeds and London) and this may impact on the ability of family and friends to visit the establishment. This in turn may impact on the well-being of these young people, as well as on plans for discharge and continuity of care upon release.

Figure 12 Population by Home Area

HMYOI Werrington Population by Home Area

Area	No. of young people
Birmingham	28
Coventry	11
Wolverhampton	10
Derby	8
West Midlands	7
Leicester	6
Liverpool	6
Wrexham	4
Luton	4
All other areas (<4 young people per area)	29
Total number of young people	113

3.6 Key Findings – Population & Demographics

The population at HMYOI Werrington remains one of young males aged between 15 and 18 years of age.

The population recorded in December 2014 (113) is similar to that recorded on June 30th 2013.

With the reroll of HMYOI Hindley, it is expected that the population may increase slightly over the next year and that there may be some changes in presenting healthcare needs. These are discussed in relevant sections of this report.

In addition, the governments `Transforming Youth Custody' agenda will mean that healthcare departments will need to maximise the efficiency of the available time in which to access young people and find innovative ways of joint working with other colleagues and providers to deliver key health messages.

The majority of young people held at HMYOI Werrington are serving detention and training order sentences of at least 12 months. Young people on detention orders may serve approximately half of their sentence at HMYOI Werrington and the remainder released on licence, but will be recalled to custody if they breach the conditions of their licence. Less than a quarter (24%) are serving short sentences of less than 12 months. This gives healthcare services an opportunity for engagement, intervention and promotion of good health choices.

However, it is also noted that although constituting less than a quarter of the total population, the actual percentage of young people serving shorter sentences has increased. This emphasises a greater need to identify healthcare needs upon reception into the establishment and to have in place prompt referrals and interventions to address these needs within the timescales available.

Currently, due to the closure of juvenile places at HMYOI Hindley, a slight increase (estimated to be between 10 -15%) is expected, but this is speculation and may not be an accurate projection.

3.7 Recommendations – Population & Demography

- There is a need to monitor the population closely to assess the impact of the re-roll of HMYOI Hindley on the presenting health needs of the population at HMYOI Werrington. It is recommended that the next HNA refresh gives particular consideration to this.

- As the governments `Transforming Youth Custody' agenda is embedded, young people will spend significantly more time in education and training. Innovative ways in which healthcare engage with young people and maximise available face to face contact time will be required.

- The percentage of young people on short term sentences has increased, which has narrowed the window of opportunity in which healthcare teams must address the immediate needs of some of the young people in their care. Prompt responses to needs identified at reception screening need to continue, and from a public health perspective, opportunities must be maximised for bringing young people up to date with national screening and vaccination programmes.

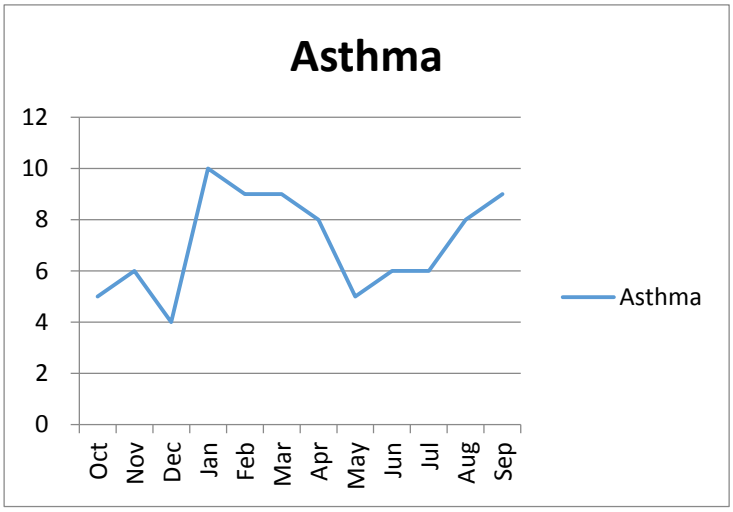
4 Physical Health and Well-Being Needs

4.1 Levels of Need

Whilst there is limited evidence about the specific health problems of children and young people in contact with the Youth Justice System, literature presents a clear message that young people in custody have significantly more severe physical health problems than the general population of young people. This is not surprising, given the prevalence of smoking, drinking, use of illegal drugs and mental health problems among children and young people in custody, and evidence disclosing their histories of neglect, social exclusion and difficult family circumstances. The continuing lack of data about the range and extent of physical health problems makes it all the more important for Units to build up their own knowledge about the young people in their care.

4.2 Asthma

Figure 13 Asthma: October 2013-September 2014



In September 2014, 9 patients were on the asthma register at HMYOI Werrington. In the period October 2013-September 2014, the number of young people on the asthma register for this establishment ranged from 4 to 10.

The actual prevalence of asthma (8% from SystmOne data) is higher than the national prevalence rate of 5.9% and also higher than prevalence estimates in the Birmingham toolkit (7%).

Asthma reviews are undertaken by a Registered General Nurse within the healthcare team and who has a diploma in Asthma. At the time of the Health and Well-Being Needs Assessment asthma reviews were up to date.

The QOF asthma register excludes patients who have not been prescribed asthma-related drugs in the previous 12 months and therefore the reported prevalence is of treated asthma.

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

Factors such as under diagnosis and reporting diligence are not taken into consideration. In addition, it has been suggested that registers should be treated with caution in the first few years of reporting as they are still being established and validated, and that apparent increases in prevalence may be due to improvement in recording and case finding, rather than a true increase in the prevalence of the population'[19].

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

4.3 Diabetes

At the time of undertaking the Health and Well-Being Needs Assessment; there were no patients with diabetes (QOF DM017). Previous Health Needs Assessments indicate no diabetic young people held at the establishment over the last three years.

It is estimated that 35,000 young people under the age of 19 have diabetes in the UK, of which approximately 96% have type 1 (insulin dependent) diabetes. More boys (52%) than girls (48%) have diabetes. The current estimate of the prevalence of Type 1 diabetes in children in the UK under the age of 19 is one per 430-530.[20]

These figures suggest that the number of young people entering HMYOI Werrington with diabetes will be very low and that there may be long periods when there are no young people with diabetes in the establishment. However, it remains essential that if a young person with diabetes is brought into custody, staff are able to facilitate essential continuity of care, including the continuance of prescribed insulin. In this circumstance, staff should access appropriate refresher training to enable up to date and informed clinical practice.

It was reported that nursing staff receive refresher training from the community paediatric diabetes nurse specialist periodically, which is commendable good practice. This existing arrangement should be drawn upon to provide refresher training at the earliest opportunity should a young person with diabetes be brought into custody at the establishment.

4.4 Epilepsy

At the time of undertaking the Health and Well-Being Needs Assessment; there were no patients on the epilepsy register (QOF EP001). The previous Health Needs Assessment reports no young people with epilepsy in 2008 and 2009, but no data is reported for 2010-2013.
A recent study by Meeraus et al [21] suggests a significant decrease over the last two decades in diagnosed epilepsy in children and found incidence was 33% lower among children born in 2003–2005 than in children born in 1994–1996. Annual incidence declined by 4% per annum between

[19] http://www.dhsspsni.gov.uk/index/stats_research/stats-resource/stats-gp-allocation/gp_contract_qof/statistics_and_research-qof-prevalence.htm
[20] https://www.diabetes.org.uk/Documents/About%20Us/Statistics/Diabetes-key-stats-guidelines-April2014.pdf

[21] Meeraus W.H, Peterson,I. Chin. R.F, Knott.F, Gilbert.R **: Childhood epilepsy recorded in primary care in the UK (2013) at** http://adc.bmj.com/content/early/2013/01/22/archdischild-2012-302237

2001 and 2008, after adjusting for age, gender and deprivation. The study concludes that the decline since the mid-1990s in epilepsy recorded in primary care may be due to more specific diagnosis, cessation of treatment for some forms of epilepsy, reduced exposure to risk factors or all of these factors.

Again, this data suggests that the number of young people entering HMYOI Werrington with epilepsy will be very low and that there may be long periods when there are no young people with epilepsy in the establishment.

As with diabetes, it is essential that if a young person with epilepsy is brought into custody, staff are able to arrange for continuance of prescribed medication and are able to access appropriate refresher training to enable up to date and informed clinical practice.

4.5 Obesity

In their overview of childhood obesity[22] Public Health England state that `the World Health Organisation regards childhood obesity as one of the most serious global public health challenges for the 21st century'.

Obese children and adolescents are at an increased risk of developing various health problems, and are also more likely to become obese adults.

Prevalence data relating to the age group of young people at HMYOI Werrington spans both childrens and adult data sets.

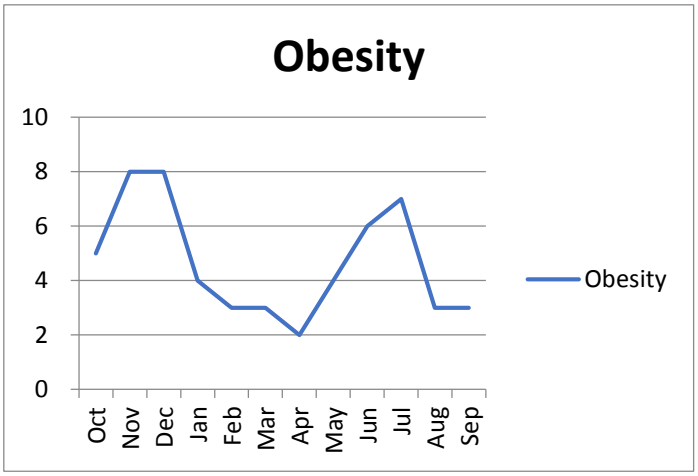
The most recent data from Public Health England suggests that the prevalence of obesity and being overweight changes with age[23].

Nationally, prevalence of overweight individuals and obesity is lowest in the 16-24 age group where only 24.3% males are overweight and 12.1% obese.

All young people are weighed and have their height and body mass index recorded as part of the physical screening process. SystmOne READ codes use this data to inform the local QOF obesity register.

[22] PHE Overview childhood obesity at http://www.noo.org.uk/NOO_about_obesity/child_obesity
[23] PHE Adult weight data factsheet
http://www.noo.org.uk/securefiles/150312_0549//AdultWeight_Aug2014_v2.pdf

Figure 14 Obesity: October 2013 -September 2014



Levels of obesity amongst the current population at HMYOI Werrington are below the national average.

There were 3 patients on the obesity register at HMYOI Werrington in September 2014. Numbers on the obesity register between October 2013 and September 2014 ranged from 2 to 8.

4.6 Recommendations – Physical Health and Well-Being Needs

- It is recommended that an audit is undertaken of physical health screening records to ensure that height, weight, and BMI are being routinely captured to ensure reporting is being captured accurately.

4.7 Infectious and Communicable Diseases

Tuberculosis

- All young people are screened for Tuberculosis and asked questions about symptomology and contact during healthcare reception screening.
- There has been one case of TB at HMYOI Werrington. This was reported in August 2014.

Measles Mumps and Rubella

The vaccination status of all young people is checked at reception screening.

In 2013 there was an outbreak of measles in Wales and the prisons were contacted regarding the need to implement an MMR catch up campaign.

Between October 1st 2013 and September 30th 2014, the vaccination status of all young people entering the establishment was checked and those eligible were offed vaccination. 63.75% of eligible young people declined vaccination.

All young people who accepted the offer of vaccination were vaccinated within 31 days of reception (n=52).

Figure 15 MMR Vaccination Uptake

HMYOI Werrington MMR Vaccination Uptake	
Total receptions	291
No. already vaccinated	142
No. eligible for vaccination	149
No. declining vaccination	95
No. vaccinated within one month	52

It is suggested that the healthcare team develop innovative and appealing materials to encourage vaccination uptake and also link with the education department to reinforce key messages about the benefits of vaccination to the population group.

Other Infectious/acquired infections

There is a Communicable Disease Policy developed in liaison with Public Health England and an Infection Control Policy and plan.

There is an up to date and completed Outbreak Plan.

There have been no infectious/acquired infections (MRSA, Clostridium Difficile, E Coli, Norovirus) within HMYOI Werrington.

The West Midlands Prisons Health Protection Report 2014 identifies that as HMYOI Werrington is part of the SSOTP cluster, regular infection control audits are carried out by SSOTP community Infection Prevention & Control (IPC) nurses.

The current Health and Well-being Centre was refurbished in 2010 and there are no identified infection control issues.

4.8 Blood Borne Viruses

The most recent data from Public Health England is shown in the table below and refers to the last quarter of 2013-2014.

Figure 16 Hepatitis Screening Data January-March 2014

HMYOI Werrington Hepatitis Screening Data January-March 2014		
Total receptions	79	
No. declining vaccination	28	0.47%
No. already vaccinated	19	0.24%
No. vaccinated within one month	31	0.97%
Total doses given	60	
% vaccination coverage	0.63%	
Hep C tests	0	
Hep C tests performed	0	

Of the 79 young people received into HMYOI Werrington during the period April 2013-March 2014, 24% (n-19) were already vaccinated against Hepatitis B. A further 35.4% (n=28) declined vaccination.

Of the remaining 32 young men, 31 received the Hepatitis B vaccination within a month of coming into the establishment.

Although the Healthcare Departments process for identifying need and initiating vaccination promptly is good, overall vaccination coverage of 63% falls below the Public Health England target (80%). The most likely reason for this is the number of young people declining vaccination. It is suggested that the Healthcare Team develop innovative and appealing materials to encourage vaccination uptake and also link with the education department to reinforce key messages about the benefits of vaccination to the population group.

Healthcare staff at HMYOI Werrington noted that the fast track Hepatitis B vaccination scheme is not used at the establishment as it would constitute off label use of the vaccine. Patient Group Direction can be developed for off label use, and NICE Medicines Practice Guidance on Patient Group Directions gives specific guidance on this.[24] Given the high rate of declines and the importance of Hepatitis B vaccination in protecting this potentially vulnerable group, it is recommended that this is reconsidered by the SSOTP medicines forum responsible for the development of Patient Group Directions. To employ the fast track system would be highly advantageous in this population group.

[24] [24] NICE Medicines Practice Guidance – Patient Group Directions
http://www.nice.org.uk/mpc/medicinespracticeguidelines/mpg2.jsp

There were no Hepatitis C tests performed at HMYOI Werrington during the reporting period and no young people were identified as being Hepatitis C positive.

No young people were identified as being HIV positive.

4.9 Disability

There is a lack of data on the prevalence of physical disability among children and young people in contact with the Youth Justice System or in custody. There is agreement that Learning Disability affects a number of children and young people in the Youth Justice System, but the lack of precise and reliable screening tools for identifying Learning Disability means that precise figures are not available.

In a patient survey undertaken at HMYOI Werrington as part of the September 2013 HMIP Inspection, approximately 16% of respondents regarded themselves as having some sort of disability, although type of disability is again not specified.

Although questions are asked during the screening reception regarding physical disabilities, accurate SystmOne reports on type of disability could not be generated. However, at the time of the Health and Well-Being Needs Assessment, it was reported that there were no young people with severe visual impairment, one young person with a hearing deficit in one ear, and no young people with mobility problems or other notable physical disability within the establishment.

A recommendation is made regarding READ coding and maintenance of a physical disability register.

Learning Disabilities and Autistic Spectrum Disorders are discussed separately in section 10 of this report.

4.10 Recommendations – Physical Healthcare

- The numbers of young people declining vaccinations is high. It is suggested that the Healthcare Team source or develop age appropriate, innovative and appealing materials to encourage vaccination uptake and also link with the education department to reinforce key messages about the benefits of vaccination to the population group.
- Given the high rate of declines and the importance of Hepatitis B vaccination in protecting this potentially vulnerable group, it is recommended that implementation of the fast track vaccination schedule is reconsidered by the SSOTP medicines forum responsible for the development of Patient Group Directions. To employ this would be highly advantageous in this population group. NICE guidance is available on developing Patient Group Directions Vaccinations for off label use in children and this vaccination scheme is used in other establishments[25].
- The prevalence of type I diabetes and epilepsy is very low and there have been no young people presenting with these conditions in recent years. Should a young person be received into the establishment who has epilepsy or diabetes, staff will require refresher training. This will ensure up to date evidence based practice and care is employed, and promote a secure knowledge and understanding of current medication regimes and approaches.

[25] NICE Medicines Practice Guidance – Patient Group Directions
http://www.nice.org.uk/mpc/medicinespracticeguidelines/mpg2.jsp

- Competency based and accredited training opportunities that enable Healthcare Assistants to expand their current role should be identified and accessed, with a view to remodelling the current service delivery model to maximise the use of Healthcare Assistants.
- A READ code formulary should be developed and all healthcare professionals (G.Ps, nurses, optician, dental personnel and physiotherapist) should be cognisant with the formulary and able to consistently READ code disabilities so that a comprehensive disability register can be maintained.

5 Emotional and Mental Health Needs

There is a growing body of evidence regarding the significant rates of emotional and mental health problems in young people in custodial settings in comparison to the general population.

Sadly the outcomes for such young people are disturbingly poor.

Young males in custodial settings are 18 times more likely than those in the general population to take their own lives [26] and tragically there have been 16 deaths of young people in secure care since 2000[27].

The death rate for this group is higher than in equivalent age groups who have a diagnosis of schizophrenia or eating disorder[28]. Drug use, suicide, and non-intentional injury are the leading causes of death among young offenders.

Mental health needs are three times more common among young people in the Youth Justice System than among their peers who do not offend[29].

Studies of young people in custody indicate higher than average levels of depression (18%), anxiety disorders (10%) and psychotic-like symptoms (5%)[30]. In 2008, Fazell reported that half of the sample of young people in custody met the criteria for a diagnosis of conduct disorder. In another study, almost 9 out of 10 young people aged 16-20 years in custody met the criteria for personality disorder diagnosis[31].

Prevalence rates of Attention Deficit Hyperactivity Disorder (ADHD) diagnosis in young offenders have varied across studies, dependent on the methodology of the study. However, rates of ADHD

[26] Fazell, D. (2008) 'Mental disorders among adolescents in juvenile detention and correction facilities: a systematic review and metaregression analysis of 25 surveys', *Journal of the American Academy of Child and Adolescent Psychiatry*, 47(9): 1010-19.
[27] Youth Justice Board (2014) *Youth Justice Statistics 2012/2013 England and Wales*. London: Youth Justice Board.
[28] Coffey, C.F. Veit, F. Wolfe, R. Cini, E. and Patton, G.C. (2003) 'Mortality in young offenders: retrospective cohort study', *British Medical Journal*, 326: 1064-7.
[29] Hagell, A. (2002) *The Mental Health of Young Offenders. Bright Futures: Working with Vulnerable Young People*. London: Mental Health Foundation.
[30] Chitsabesan, P., Kroll, L., Bailey, S., Kenning, C., Macdonald, W. and Theodosiou, L. (2006) 'Mental health needs of offenders in custody and in the community', *The British Journal of Psychiatry*, 188: 534-40.
[31] Lader, D., Singleton, N. and Meltzer, H. (2000) *Psychiatric morbidity among young offenders in England and Wales*. London: Office for National Statistics.

diagnoses are significantly greater in both male and female young offenders in comparison with the general population, with rates between 11-16%[32].

Learning difficulties and communication problems are also significantly more common in young people in secure settings[33],[34]. The majority of young people with an identified intellectual disability have impairment in the mild range, which may be overshadowed by their challenging behavior.

Nearly three quarters of young people in custody have been assessed as having some form of speech, language or communication need[35].

Initial studies looking at rates of traumatic brain injury in young offenders also suggest higher incidence in this population[36].

In addition, significant co-morbidity has been highlighted in a number of studies. For example, Lader and colleagues found that 8 out of 10 of young people had more than one mental health problem that met the criteria for a formal diagnosis[37]. Similarly, Ulzen and Hamilton[38] used the Diagnostic Interview for Children and Adolescents-Revised (DICA-R) to show that over 85% of young people in custody reached diagnostic criteria for at least one diagnosis.

6 Substance Misuse Needs

There are high levels of smoking, drinking and illegal drug misuse among young people in contact with the Youth Justice System.

Substance misuse in young people should be viewed in the context of 'normal' risk taking and adolescent behaviour. 65% of adolescents experiment with illegal drugs - mostly cannabis - with only 4% continuing to regular misuse and long-term problems.

Risk factors for regular misuse include living in an area where substance misuse is prevalent; experiencing exclusion factors such as truancy, offending behaviour and unemployment; experiencing social vulnerability factors including neglect, abuse or domestic conflict; and

[32] Teplin, L.A., Abram, K.M., McClelland, G.M., Dulcan, M.K., and Mericle, A.A. (2002) 'Psychiatric disorders in youth in juvenile detention', *Archives of general psychiatry*, 59(12): 1133-43.
[33] Kroll, L., Rothwell, J., Bradley, D., Shah, P., Bailey, S. and Harrington, R.C. (2002) 'Mental health needs of boys in secure care for serious or persistent offending: a prospective, longitudinal study', *Lancet*, 359: 1975-9.
[34] Ståhlberg, O., Anckarster, H. and Nilsson, T. (2010) 'Mental health problems in youths committed to juvenile institutions: prevalence and treatment needs', *European Journal of Child and Adolescent Psychiatry*, 19, 893-903.
[35] Bryan, K., Freer, J. and Furlong, C. (2007) 'Language and communication difficulties in juvenile offenders', *International Journal of Language and Communication Disorders*, 42: 505-20.
[36] Williams, W.H., Cordan, G., Mewse, A., Tonks, J. and Burgess, C.N. (2010) 'Self-reported traumatic brain injury in male young offenders: A risk factor for re-offending, poor mental health and violence?', *Neuropsychological Rehabilitation*, 20(6): 801-12.
[37] Lader, D., Singleton, N. and Meltzer, H. (2000) *Psychiatric morbidity among young offenders in England and Wales*. London: Office for National Statistics.
[38] Ulzen, T.P.M. and Hamilton, H. (1998) 'The nature and characteristics of psychiatric comorbidity in incarcerated adolescents', *Canadian Journal of Psychiatry*, 43: 57-63.

psychiatric, conduct or emotional disorder. There is also often an overlap between substance misuse and mental health problems[39].

Consumption of alcohol and drugs are key risk factors associated with offending for 10 to 15-year-olds. Research carried out for the Youth Justice Board into alcohol and drug misuse among children and young people (aged 12-18) in the secure estate found that their rates of smoking, drinking and illegal drug use prior to entering custody were substantially higher than among young people who do not offend[40]. Over 83% were regular smokers and over 80% had used an illegal drug once a month. With regards to alcohol misuse, over 60% drank alcohol daily or weekly, with 66% reporting binge drinking once a week and over 25% considered their drinking to have been out of control before entering custody.

Studies into the health needs of children and young people in the secure estate have found that staff consider alcohol to be one of the biggest problems, often more so than the misuse of illegal drugs.

Furthermore, young people who binge drink in adolescence are more likely to be binge drinkers as adults. Frequent drinking and binge drinking have been shown to increase the risk of developing alcohol dependence in young adulthood.

Alcohol use among young people is growing faster than the use of any other drug in the UK, and it causes the most widespread problems for them. It is also the least regulated and most heavily marketed drug available.

Regular alcohol consumption and binge drinking are associated with physical problems, anti-social behaviour, violence, and injuries and road traffic accidents, with school performance and offending behaviour also implicated.

7. Needs Related to Social Vulnerability Factors

Over the last 20 years there has been a growing understanding of the complex needs and vulnerabilities of young people in secure settings.

Children and young people in secure settings have experienced high rates of exposure to violence, abuse, neglect, loss and separation.

The below table, compares some of the needs of young people related to social vulnerability factors in the general population, such as absconscion and being separated from family, with those for the population of HMYOI Werrington.

Figure 17 Table: Predictors of Health (taken from Social Exclusion Unit[41])

[39] Mapping mental health interventions in the juvenile secure estate: report for the Department of Health, Tunnard J, Ryan M, Kurtz Z, 2005).
[40] Substance misuse in the secure estate, YJB, 2009
[41] Social Exclusion Unit (July 2002), Reducing re-offending by ex-prisoners, HMG Cabinet Office. http://www.thelearningjourney.co.uk/file.2007-10-01.1714894439/file_view

Predictors of Health

Characteristic	General Population	Prisoners	No. young people*
Ran away from home as a child	11%[42]	47% of male sentenced young people** [43]	40
Taken into care as a child	2%[44]	27%[45]	31
Long-standing illness or disability	29% men aged 18-49[46]	46% of sentenced male young people aged 18–49[47]	40

**Estimated prevalence no. of young people HMYOI Werrington

** Higher for remanded young people and much higher for those with mental health, drug and alcohol problems

1 in 20 boys in custody have disclosed sexual abuse (Social Exclusion Unit 2002) and 90% of young offenders have experienced at least one traumatic event, with over half being exposed 6 times or more [48].

Three quarters of children and young people in custody have lived with someone other than a parent[49].

84% of 12-18 year olds in custody have problematic drug use [50]and 86% of young people/79% of young women aged 15-18 in the Youth Justice System have been excluded from school[51].

Such high levels of adverse experiences also reflect a significant unmet need, with reports of over two thirds of those having suffered abuse of a violent, sexual or emotional nature claiming not to have received any help[52].

The percentage of Looked After Children coming in to contact with the Youth Justice System (7.3%) is more than twice that of all children and young people (3%)[53].

[42] The Children's Society, (1999) Still Running: Children on the Streets in the UK,

[43] N Singleton, H Meltzer, R Gatward, J Coid D Deasy, (1998) Psychiatric Morbidity among Prisoners: Summary Report, ONS,

[44] T Dodd and P Hunter, (1992) The National Prison Survey 1991, HMSO,

[45] BMRB, (2001) Estimating Criminality, (unpublished).

[46] Bridgwood, A., Malbon G, (1995) Survey of the physical health of prisoners 1994, HMSO.

[47] Bridgwood A, Malbon G (1995), Survey of the physical health of prisoners 1994, HMSO

[48] Abram, K.M., Teplin, L.A., Charles, D.R. , Longworth, S.L., McClelland, G.M. and Duncan, M.K. (2004) 'Post traumatic stress disorder and trauma in youth in juvenile detention', *Archives of General Psychiatry*, 61: 403-10.

[49] Youth Justice Board (2007). *Accommodation Needs and Experiences of Young People who Offend*. *Summary (B328)*. London: Youth Justice Board.

[50] Galahad SMS Ltd. (2009) *Evaluation of the Substance Misuse Project in the Young Person's Secure Estate*

[51] Parke, S (2009) *Children and young people in custody 2006-2008: an analysis of the experiences of 15-18 year olds in prison*. London: HM Inspector of Prisons/Youth Justice Board.

[52] HM Inspectorate of Prisons (1997) *Young Prisoners: A Thematic Review*. H M Chief Inspector of Prisons for England and Wales. London: Home Office.

[53] Department for Education (2011) Outcomes for Looked After Children as at March 2011 London: Department for Education

Over a quarter of men in Young Offender Institutions have spent time in Local Authority Care[54]. Local authorities have particular responsibilities towards Looked After Children in custody, however the legislation regarding Looked After Status is complicated and changed in 2012.

All children and young people remanded to custody are now regarded as Looked After, whether or not they were of `Looked After' status prior to remand.

Each Looked After Child requires an initial Health Needs Assessment and annual assessments thereafter whilst ever they remain of Looked After Status. On 31st December 2014, almost a quarter (23.89%) of young men at HMYOI Werrington were remanded. Combined with the annual population churn of HMYOI Werrington, a significant amount of Looked After Childrens Health Needs Assessments are generated each year.

Looked after Children's Health Needs Assessments are currently undertaken by the Community Looked After Children Nurse Specialist. However, commissioners and providers may wish to consider whether training one of the nurses at HMYOI Werrington to undertake assessments – and either re-allocating funding or cross charging for this - would be beneficial.

Children and young people lose their Looked After Status when they are sentenced to custody, as they are the regarded as accommodated by the secure estate rather than by the local authority.

However, when a child or young person is sentenced to custody, the local authority formerly responsible for the child's care must appoint a representative to visit the child to carry out an assessment of needs both whilst in custody and upon release. On leaving custody, the young person may be entitled to Leaving Care Support, therefore it is important that if a young person is transferred from the juvenile estate to the young adult estate, the receiving Healthcare Department are aware of their previous Looked After Status.

A flow chart illustrating the Looked After Pathway, taken from Prison Service Instruction (PSI) 08.2012 ` Care and Management of Young People' is provided in Appendix 2.

7.1 Recommendations

- Commissioners and providers may wish to consider training one of the nurses at HMYOI Werrington to undertake assessments and either re-allocate funding or cross charge for this service.
- SystmOne should be utilised to clearly flag to receiving establishments that a young person has previously been of Looked After Status to enable healthcare involvement in Leaving Care Support plans where required.

[54] Amy Summerfield (2011) Children and Young People in Custody 2010-2011: An analysis of the experiences of 15-18 year olds in prison London: HM Inspectorate of Prisons

8 Current Service Provision

8.1 The Staff

The table below shows staff resources.

Figure 18 Staff Resources

Staff Resources - Primary Care Services

Job Title	WTE currently in post	Vacancies	Comments
Team Leader RGN	1	0	
Senior Staff Nurse RGN	1	0	
Staff Nurse RGN	1	0	
Staff Nurse RMN	5	0	All have generic role within the team
Healthcare Assistant	3	0	
		CAMHS	
CAMHS	1.2 WTE	1 part of team of 3	See detail in section 10 of HNA report
		Drug & Alcohol (Psychosocial) Services	
Team Leader	1	0	
YP Drug and Alcohol Coordinator	3	1	New starter due in post on 15/12/14
Service Support Practitioner	1	1	Recruited – awaiting clearance for start date
Administrator	1	0	
		Drug & Alcohol (Clinical) Services	
Clinical Manager	0.3WTE		Band 7,Non-Medical Prescriber
Lead Recovery Nurse	Non-Medical Prescriber, RGN		
Recovery Nurse	RMN		
GP	Delphi Doctor		
		Other Services	
Pharmacy Services provided by Lloyds			
GP clinics – local GP practice – clinics Monday to Friday			
Out of Hours GP cover – Badger + OOH service provided by DARS clinical team			
Dentist and dental nurse – one session per fortnight			
Optician – one session per month			
Physiotherapy and podiatry – refer to outside services if required.			

There are qualified nursing staff on duty twenty four hours a day, including at weekends.

Primary care cover is as follows:

Weekday morning duty - two qualified nursing staff and a healthcare assistant.

Weekday evening duty - one qualified nurse and a healthcare assistant.

Weekend morning duty - one qualified nurse and a healthcare assistant.

Weekend evening duty - one qualified nurse

Night duty – one qualified nurse (usually based on first night centre but will move to wherever required within the establishment)

In addition to this, the Young Persons Drug and Alcohol Support Service provides a clinical and psychosocial on site presence. The CAMHS team provide onsite services from Monday to Thursday, but will also attend on Fridays if needs dictate.

8.2 The Facilities

There is a dedicated Healthcare Centre with a small patient waiting room, nurse and GP consultation rooms, dental suite and additional nursing offices. There are two wing treatment rooms and a reception room in the new reception block.

The healthcare rooms on the wings are opposite the server. Young people can attend for medicines and also have the opportunity to access `on the spot' advice or talk to the nursing staff and self-refer to clinics.

Nursing staff attend the wings in the morning to administer medicines, at lunchtime and in the evening. In between these times, if a young person needs to see a member of the Healthcare Team, officers will either ask nursing staff to attend a location or will bring the young person to the Healthcare Centre as required.

Access to nursing staff is excellent and this is confirmed through feedback from questionnaires (see section 12.2) in addition to service user feedback from the last HMIP inspection.

It is noted that `Transforming Youth Custody' will inevitably impact on the access healthcare staff have to young people and there may be competing pressures with others involved in the care of the young people at HMYOI Werrington (chaplaincy, voluntary groups, advocates etc.). Healthcare commissioners and providers will need to liaise closely with prison colleagues to assess the impact of Transforming Youth Custody. They will also need to consider ways in which to maximise the access time available and alternative ways to delivering healthcare within the setting.

8.3 The Processes for Promoting Health and Well-Being

8.3.1 Screening and Assessment

Detailed screening and assessment of the health and well-being needs of children and young people as they enter custody is essential. It provides an important opportunity to identify and address any needs that have previously remained unidentified or have been left unattended.

At HMYOI Werrington, the Department of Health Comprehensive Health Assessment Tool (CHAT) has been adopted.

The screening tool is in 5 parts:
Part 1 Initial reception health screen
Part 2 Physical health and social circumstances assessment
Part 3 Substance misuse assessment
Part 4 Mental health assessment

Part 5 Neurodevelopment and traumatic injury screen

A summary of the questions asked in each part of CHAT is provided in Appendix 1.

Part 1 of the screening tool is completed on the evening of reception and comprises a set of questions to collect baseline data for patient records and to identify any urgent needs requiring immediate attention for inclusion in the Immediate Management Plan.

Providing that answers to the questions in Part 1 do not trigger the need for an immediate and more comprehensive assessment, Parts 2, 3 & 4 of the assessment aim to be completed within the next 48 hours and Part 5 within 10 days of being in custody.

Referrals to the optician, dentist, Sexual Health Clinic etc. can be facilitated via the CHAT screening assessment.

8.3.2 Continuity of Care

The reception screening tool prompts questions to ascertain if the young person is on any current medication or has any outstanding healthcare appointments/ongoing treatment programmes.

The Healthcare Team seek confirmation of the young person's medical history with their General Practitioner or any other individuals involved in their care as appropriate.

The assessment tool also prompts the healthcare professional completing the assessment to obtain details and information regarding any other agencies involved in the young person's care so that information sharing and joint care planning can be considered where appropriate.

8.3.3 Sentence, Discharge and Transfer Planning

All young people are seen prior to discharge to ensure they are fit and well enough to leave the establishment.

If a young person is to be transferred, SystmOne patient records are transferred electronically to the receiving establishment, and if necessary a courtesy telephone call is made to the receiving Healthcare Team.

There is no formal preparation for the transfer to Young Offender Institutions for 18 year olds.

The HMYOI Brinsford Health Needs Assessment identified that 19 out of 22 juveniles transferring to the establishment in 2014 were from HMYOI Werrington. Therefore healthcare teams at HMYOI Brinsford & HMYOI Werrington have an opportunity to develop a transition pathway for young adults transferring between the two establishments.

It is suggested that the transition pathway recommended above is piloted and refined between HMYOI's Werrington and Brinsford and then extended to support young persons transferring in from other `out of area' juvenile establishments.

It is also recommended that the CAMHS Team liaise with In Reach Team colleagues to develop a transition pathway for young people transferring from CAMHs to Young Adult Mental Health Services.

8.3.4 Medicines and Pharmacy

Pharmacy services are provided by Lloyds Pharmacy.

Medicines are prescribed using HMPS Prescription Record Sheets.

Medicines are administered daily from the treatment rooms on the wings. All controlled medicines are administered from the Healthcare Department, and the young people must physically attend the department to receive these medications.

SystmOne prescribing functionality is not used to provide a central prescribing database. Co-prescribers (e.g. psychiatrist) need to scroll through textual consultations or refer to care plans for information on existing prescribed medications. Although poly-pharmacology will not present the same problems as it would in the adult estate where patients can be prescribed multiple medicines, it is nevertheless a clinical risk and a move to using SystmOne to prescribe medicines as soon as possible is recommended.

Very few in-possession medicines are authorised within HMYOI Werrington. These include inhalers, topical creams and antibiotics.

A small number of Patient Group Directions have been developed, however, it is recommended that these are reviewed and expanded to enable a more nurse led service.

8.3.5 Responding to Emergencies

There is 24 hour qualified nursing presence and an Emergency Response Service for any incidents which occur within the establishment and require healthcare presence.

The unit has automated defibrillators and all healthcare staff undergo mandatory life support skills training.

Nurses are trained in wound closure and suturing.

Three of the Registered Mental Health Nurses have had minor injuries training.

A condensed minor illness course is also being considered.

Prison staff in the Care and Separation Unit have undergone additional training to enable them to support young people with more challenging behaviours.

Healthcare staff work in close partnership with prison colleagues and attend incidents to complete F213 & F213SH forms (prison documentation relating to self-inflicted and other injuries). A member of the healthcare team will also attend any planned removals to monitor the physical well-being of the young person throughout the procedure.

8.3.6 Safeguarding

Safeguarding is particularly important in secure settings because the children and young people who are sentenced or remanded to custody are amongst the most vulnerable in society. Furthermore, they have been separated from their family, often for the first time, and they are living in an alienating environment. They need to be and to feel safe.

An important aspect of being able to safeguard young people is having appropriate information sharing and communication systems.

Consent to share information with others involved in their care is sought from each young person at reception screening and an information sharing agreement is in place within the establishment.

All healthcare staff attend mandatory safeguarding and information governance training.

There is close liaison between the establishments safeguarding team, social workers, Looked After Children's team, SSOTP Safeguarding Leads, healthcare providers, Youth Offending Services and the Local Authority Designated Officer.

A representative from the healthcare team attends the prison morning meeting which is held every morning at 9.15am so that the team is aware of what is going on in the prison on a day to day basis, and is aware of any concerns relating to specific young persons.

There is a weekly Multi Agency Safeguarding Hub meeting, endorsing the local multi-disciplinary approach to safeguarding and keeping young people safe. The meeting is used as a forum for appropriate information sharing and joint care and management planning for young people who are presenting as of concern or at risk.

The meeting is attended by representatives from healthcare, CAMHS, Young Persons Drug & Alcohol Recovery Service, wing officers, safeguarding, chaplaincy and security.

Healthcare also attend Resettlement, Security, and Safeguarding & Drug Strategy Meetings.

8.4 Recommendations – Current Service Provision

- Healthcare commissioners and providers will need to liaise closely with prison colleagues to assess the impact of Transforming Youth Custody and to consider ways in which to maximise access time available and consider alternative ways to delivering healthcare within the setting.

- Healthcare teams at HMYOI Brinsford & HMYOI Werrington have an opportunity to develop a transition pathway for young adults transferring between the two establishments.

- It is suggested that the transition pathway recommended above is piloted and refined between HMYOI's Werrington and Brinsford and then extended to support young persons transferring in from other `out of area' juvenile establishments.

- It is also recommended that the CAMHS team liaise with In Reach team colleagues to develop a transition pathway for young people transferring from CAMHs to Young Adult Mental Health Services.
- A review of the approach to in-possession medicines should be undertaken. The default status should be that young people should have medicines in possession unless there is reason not to do so. This will reduce the time taken to administer medicines which may be required when Transforming Youth Custody is embedded.

- A small number of Patient Group Directions have been developed, however, it is recommended that these are reviewed and expanded to enable a more nurse led service.
- It is strongly recommended that use of the SystmOne prescribing functionality is initiated as soon as possible. This will enable better audit of prescribing practice and trends, and will decrease the clinical (poly-pharmacology) risks inherent with when multi prescribers are involved in an individual's care.

9. The Services and Interventions Provided

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

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

The current primary healthcare provider is Staffordshire and Stoke on Trent Partnership NHS Trust.

The Young Persons Drug and Alcohol Support Services (YPDASS) is provided by Lifeline & Delphi Medical.

CAMHS are provided by ENGAGE (South Staffordshire and Shropshire NHS Foundation Trust).

A number of regular primary healthcare clinics are held.

Dental and physiotherapy services are provided by Staffordshire and Stoke on Trent Partnership NHS Trust.

Optician/ophthalmology services are contracted to a local ophthalmologist.

Monthly nurse led Sexual Health Clinics are held.

There are no regular physiotherapy or podiatry clinics as need for these services is very low and they are therefore accessed on an individual needs led basis.

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

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

It is not possible for healthcare and health services to meet all the needs identified through this Health and Well-Being Needs Assessment. Other services - including education, social care, care and discipline staff, and the third sector also have an important role to play.

10 Physical Health

10.1 GP Clinics

Daily GP Clinics are held from Monday to Friday.

Access to GP's is via submission of a health application form, which has been specifically designed to include pictures to aid understanding by young people with literacy or language problems.

There is no GP waiting list and emergency appointments can be seen immediately on the same or next available working day.

Figure 19 GP Clinics

GP Clinics	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	June 14	Jul 14	Aug 14	Sep 14
No. contracted sessions per month	24	20	20	22	20	21	22	20	24	26	24	22
No. sessions cancelled	0	0	0	0	0	0	0	0	0	0	0	0
Average time from application to first appointment (days) for new referrals	1	1	1	1	1	1	1	1	1	1	1	1
Total no. patients seen	120	123	124	133	161	126	125	126	211	195	146	160
Number of DNAs	4	1	2	7	3	5	4	2	5	3	4	4
% DNAs	3	1	2	5	2	4	3	2	2	2	3	2
No. of patients on waiting list at month end	0	0	0	0	0	0	0	0	0	0	0	0

From October 2013-September 2014, the GP saw 1,750 patients (an average of 145.8 patients per month). The average waiting time for GP Clinics was 1 day from application to appointment and DNA's raged from 1-5%, with a total number of 44 appointments unattended.

During conversations with healthcare staff at HMYOI Werrington, it was commented that many young people request to see the GP for skin problems. If one of the nursing team was able to attend an accredited Dermatology Course, this element of service could be predominantly nurse led.

The Out Of Hours service provision is through Badger. No data was obtained regarding use of Out Of Hours services, however staff reported that the Out of Hours service is only very occasionally contacted, but is responsive and helpful when required.

10.2 Nurse Clinics

Applications to see a nurse are made via the health application system.

Nursing Clinics include:

CHAT Screening Clinics (daily)

Primary Mental Health Assessments

Dressings (as required)

Venepuncture (as required)

Vaccinations Clinic (weekly-see section 4.6)

Asthma Reviews (as required-see section 4.2)

Sexual Health Clinic (see section 9.7)

General Clinics

Healthcare Assistants undertake some clinic tasks, however, there is the opportunity to further develop the Healthcare Assistant role to expand the range of competencies currently utilised.

10.3 Physiotherapy

Demand for physiotherapy at HMYOI Werrington is very low and there are no regular physiotherapy clinics. Young people are usually referred for physiotherapy via the fracture clinic following injury and this is arranged on individual patient need basis.

There is a prison sports injury officer and the healthcare department liaise with him where required.

10.4 Optician

Optician services are provided by a local contracted provider, who is a specialist optometrist and also provides services for HMPs Stafford, Featherstone & HMYOI Brinsford.

The optician is contracted to provide one session per month.

Service provision incorporates

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

From October 2013-September 2014, the optician saw 64 patients (an average of 5.3 patients per month). Waiting times ranged from 0-61 days.

73.4% of patients were seen within the target six week period.

DNA's ranged from 0-20%, although no data was available for the months of October 2013, February 2014 and April 2014. Data for March and September 2014 was unavailable, however, for the remaining months, a total of 4 appointments were unattended.

Clinic utilisation rates are not routinely reported - providers and commissioners may wish to consider routinely capturing the number of appointments per clinic session, number of young adults called up to appointments and actual attendance numbers in order to report against future HJIP indicators A13K10 – A13K12.

Figure 20 Optician Services

HMYOI Werrington Optician Services

Optician	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	June 14	Jul 14	Aug 14	Sep 14
No. contracted sessions per month	0	1	1	1	0	1	0	1	1	1	1	1
No. sessions cancelled	0	0	0	0	0	1	0	0	0	0	0	0
Average time from application to first appointment (days) for new referrals	0	29	41	10	0	33	0	49	61	46	37	22
No. of patients seen within 6 weeks of referral	0	6	3	6	0	8	0	3	2	5	6	8
% patients seen within 6 weeks of referral		75	60	100		100		43	29	63	86	100
Total no. patients seen	0	8	5	6	0	8	0	7	7	9	7	8
Number of DNAs	0	0	1	1	0		0	1	0	2	1	
% DNAs		0	17	14		0		13	0	20	13	0
No. of patients on waiting list at month end	11	4	2	5	12	12	16	12	13	0	1	4

The level of service offered is comprehensive and appears to meet current need.

10.5 Podiatry

The need for Podiatry services at HMYOI Werrington is very low and is arranged on an as needs basis.

10.6 Dentist

The dental health of those in custody is much poorer than that of the general population: there is more tooth decay and less attention to restoring teeth. The need for dentistry in the secure estate is estimated to be four times higher than in the general population of similar background. There is a poorer attitude to dental health, often reflecting less knowledge and awareness, and an increased likelihood of not having visited a dentist in the previous two years. The National Strategy and Good Practice Guidance for Dental Health Services in Prison both highlight the importance of hygienist provision and other preventive measures to ensure good oral health.

Custody Health and Well-Being Needs Assessments have identified dental health as one of the main physical health problems.

In `Strategy for Modernising Dental Services for Prisoners in England'[55], it is recommended a minimum of one 3 hour dental session per week should be provided for every 250 prisoners and that appointments for routine care should not normally exceed six weeks.

Figure 21 Dental Services

HMYOI Werrington Dental Services

Dentist	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	June 14	Jul 14	Aug 14	Sep 14
No. contracted sessions per month	2	2	3	2	2	3	2	1	3	2	2	2
No. sessions cancelled	0	0	1	0	0	0	1	0	0	0	0	0
Average time from application to first appointment (days) for new referrals	28	19	36	47	33	30	34	62	50	34	39	12
Total no. patients seen	14	13	14	14	14	15	8	6	17	12	13	14
Number of DNAs	0	2	1	0	2	0	3	0	5	1	0	0
% DNAs	0	13	7	0	13	0	27	0	23	8	0	0
No. of patients on waiting list at month end	17	13	11	14	17	12	13	18	23	20	3	15

From October 2013-September 2014, the dentist saw 168 patients (an average of 14 patients per month). Waiting times ranged from 12-62 days, with an average waiting time was 35.3 days.

75% of patients were seen within the target 6 week period.

DNA's ranged from 0-27%, with a total number of 176 appointments unattended.

Dental hygiene sessions were trialled but have ceased as young people repeatedly failed to attend.

As dental clinics are fortnightly, dental emergencies occurring in between clinics need to be managed by the prison GP or the young person needs to attend the dental hospital.

Clinic utilisation rates are not routinely reported - providers and commissioners may wish to consider routinely capturing the number of appointments per clinic session, number of young adults called up to appointments and actual attendance numbers in order to report against future HJIP indicators A13K10-A13K12.

Access to routine dental care is good and provided equitably with access to NHS dental services in the wider community.

A review of urgent care pathways may identify alternative options (e.g. nurse triage protocols for management of dental pain and abscesses).

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

10.7 Sexual Health

Transmission of Sexually-Transmitted Infections and teenage pregnancy are important issues related to sexual health in adolescents. Young people (aged 16-24) are those most at risk of being diagnosed with a Sexually-Transmitted Infection, accounting for 65% of Chlamydia, 50% of genital warts and 50% of gonorrhoea infections diagnosed in genitourinary medicine clinics in the UK in 2007.

Custody Health and Well-Being Needs Assessments have identified Sexually-Transmitted Infections as one of the main physical health problems of young people.

Figure 22 Sexual Health Clinics

HMYOI Werrington Sexual Health Clinics

Sexual Health Clinics	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	June 14	Jul 14	Aug 14	Sep 14
No. contracted sessions per month	1	1	1	1	1	1	2	1	1	1	2	1
No. sessions cancelled	0	0	0	0	0	0	0	0	0	0	0	0
Average time from application to first appointment (days) for new referrals	35	21	46	35	26	49	33	55	65	36	52	60
No. of patients starting consultant led treatment within 18 weeks	0	0	0	0	0	0	0	0	0	0	0	0
Total no. patients seen	7	7	6	4	5	4	12	6	6	6	11	5
Number of DNAs	3	0	0	0	0	0	1	1	0	0	1	0
% DNAs	0	0	0	0	0	0	8	14	0	0	8	0
No. of patients on waiting list at month end	10	9	6	15	13	17	9	13	16	9	1	7

73 patients were seen by Sexual Health Services in the period October 2013-september 2014, an average of 6.1 patients per month.

Waiting times ranged from 21-65 days with an average wait of 42.8 days.

DNA's ranged from 0-14%.

There were 6 unattended appointments in this period.

All young men are signposted to the Sexual Health Service at reception and are routinely offered Chlamydia screening.

Young people can be referred to the Sexual Health Clinic by members of the healthcare team or can self-refer through the health application process.

The Sexual Health Nurse will undertake screening and assessment including obtaining any swabs, blood samples or other biological samples required.

Confidential advice and education is provided.

There appears to be a community Patient Group Directions for Doxycycline for the treatment of Chlamydia, but not for Azithromycin.

Public Health England report that of the 446,253 new Sexually-Transmitted Infection diagnoses made in 2013, the most commonly diagnosed Sexually-Transmitted Infections were chlamydia (47%), genital warts (17%), genital herpes (7%), and gonorrhoea (7%)[56].

10.8 Health Promotion & Well-Being

10.8.1 Smoking

Smoking is the greatest cause of preventable illness and premature death in the UK. Smoking by young people is rapidly increasing, with 450 starting every day. An estimated 200,000 young people in England aged 9 to 15 are smokers. By age 15, 26% of girls and 21% of boys are smokers, and they are highly likely to continue smoking in adulthood. The effectives of smoking are harsher for the economically deprived, widening inequalities in health among social groups.

HMYOI Werrington is a non -smoking environment. Support with smoking cessation is offered and two healthcare staff are trained in smoking cessation. Young people can be prescribed nicotine replacement patches to help with smoking cessation. There were no young people on the programme at the time of the Health and Well-Being Needs Assessment.

10.8.2 Healthy Eating & Weight Management

As reported in section 6 of this report 2.6 % (N=3) of the current population are obese according to reception screening Body Mass Index.

If required, weekly weight checks and weight management support are offered via nurse clinics.

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

The 2013 HMIP Inspection found 'portion sizes reasonable and food quality good'. The report documents 'the budget for meals was £2.40 per young person per day. The four-week menu cycle included a nutritionally balanced range of options, including vegetarian, vegan, religious and medical diets. Breakfast provided the option of cereal or porridge and toast and was adequate. Fresh fruit and vegetables were available each day. The menu was regularly checked by a nutritionist'.

Advice regarding healthy eating is incorporated into health promotion campaigns.

10.8.3 Physical Exercise

There are small outside areas for physical exercise and young people have access to the gymnasium.

During the 2013 HMIP Inspection it was reported that 5% of young people stated they didn't want to go to the gym. However 32% of young people stated they went to the gym one or two times a week

[56] Public Health England: Health Protection Report: Weekly Infection report Volume 8 Number 24 published 17 June 2014 at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/345181/Volume_8_number_24_hpr2414_AA_stis.pdf

and a further 51% stated they visited the gym between three and five times a week. This suggests good access to opportunities for physical exercise.

Where required, the physiotherapist also liaises with the prison physical education department on behalf of individual young people and prescription exercise can be requested where appropriate.

10.9 Secondary Care

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

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

Due to the age and relative fitness of young people at HMYOI Werrington, hospital appointments are not as problematic as they can be in very busy, big prisons.

Analysis of prison escort and bedwatch spreadsheets indicate that in the eleven months from April 2014 to February 2015 there was a total of 165 hospital escorts and 6 bedwatches (where a young person stayed in hospital over a night or number of nights requiring officers to stay with him).

Of the 165 escorts to appointments, 123 were to University Hospital North Stafford. All six bedwatches also took place at this hospital.

Escorts peaked in November 2014, but this was due to one young person who attended hospital 36 times in the period studied, and also accounted for two of the bedwatches.

Figure 23 Escorts and Bedwatches April 2014-February 2015

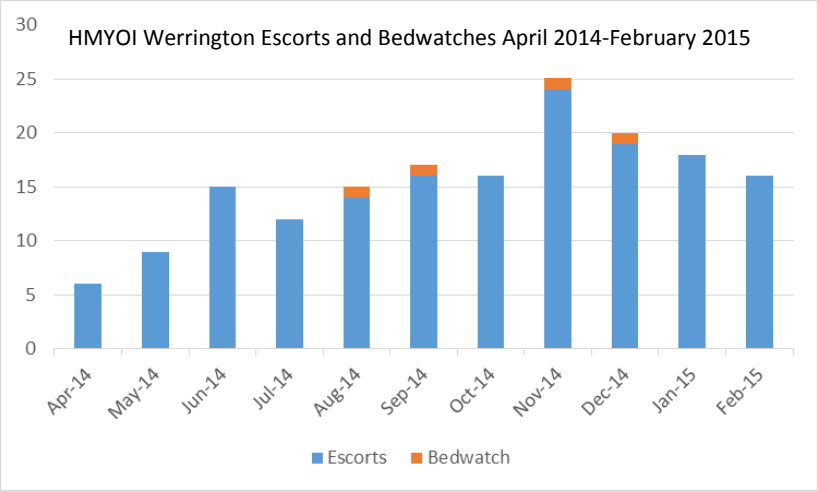
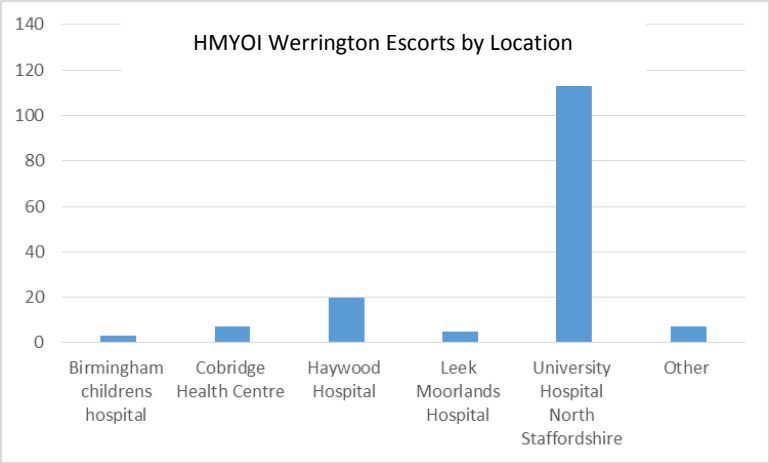


Figure 24 Escorts by Location



The data required to undertake a detailed analysis of hospital appointments was not available without accessing individual records. Therefore although some recommendations have been made, it is suggested that a further piece of work is undertaken in order to be able to make more specific recommendations.

10.10 Recommendations: Physical Health

- It was commented that many young people request to see the GP for skin problems. If one of the nursing team was able to attend an accredited Dermatology Course, this element of the service could be predominantly nurse led.

- From October 2013-September 2014, the GP saw 1,750 patients (an average of 146 patients per month / approximately 6 young men per day). The GP resource could be reviewed as a session every weekday appears to be in excess of requirements. Any changes made need to be mapped to Youth Justice Board requirements and Prison Audit Standards to ensure that the cover offered complies with prison requirements.

- A review of urgent care pathways for dental pain may identify options other than referring young people to GP or out to dental hospital (e.g. nurse triage protocols for management of dental pain and abscesses).

- Mobile nurse triage and vaccination clinics may be required to maximise time available once Transforming Youth Custody is embedded. In addition and in liaison with prison colleagues, it may be necessary for commissioners and providers to undertake a review of current clinic times. They may consider holding nurse clinics at weekends and evenings, however, the workforce and cost implications associated with the reallocation of clinic activity will also require consideration.

- The Head of Healthcare should forge strong links with senior managers in the Accident & Emergency Department and Outpatients Departments at University Hospital North Staffordshire and at Haywood Hospital to jointly explore ways in which hospital escorts can be planned to maximum efficiency.

- A further detailed Escort and Bedwatch Analysis should be undertaken to identify additional actions and opportunities for reducing escorts.

11 Emotional and Mental Health

11.1 Primary Mental Health Service

Primary mental health services are provided by Staffordshire and Stoke on Trent Partnership Trust. There are 5 fulltime Registered Mental Health Nurses who work as part of the generic nursing team, working shift patterns including night shifts.

Primary mental health nurses complete Part 4 (Mental Health) and Part 5 (Neurodevelopmental Disabilities) of the Comprehensive Health Assessment Tool. These are completed as per standard timeframes for the measure, within 72 hours (Part 4) and 10 days (Part 5) of the young person entering custody.

Between April and September 2014, 134 Primary Mental health assessments were completed (an average of 24 per month).

Referrals to the CAMHS service are made for any identified mental health need (see appended referral pathway) and are via the TAG paper based referral system which can be scored according to priority.

Referrals can also be made via a paperless system following CHAT using SystmOne, although this is not referred to in the CAMHS referral pathway.

There is a once weekly Multi Agency Safety Hub meeting, attended by healthcare, CAMHS, safeguarding and discipline staff to discuss all referrals between services for young people considered vulnerable or at risk or where there are specific mental health concerns.

Primary mental health nurses also can provide input to the Care and Separation Unit, attending Good Order and Discipline Reviews and completing SCU algorithms which assess young peoples suitability for the unit in terms of physical and mental health needs.

Primary mental health staff also offer general support but do not offer any specific short term interventions.

Primary mental health staff provide input into ACCT reviews which can also be attended by health care assistants (ACCT – Assessment, Care, and Custody Teamwork - is a prison led multi-disciplinary process for providing ongoing monitoring and support for vulnerable prisoners).

Between April 2013 and March 2014 there were 144 ACCTS opened (mean average of 12 per month). A total of 521 ACCT reviews were undertaken. The performance dashboard indicates that healthcare attended 12.7% of reviews. However, it is suspected that this is under-reported as feedback from prison colleagues indicates good attendance from healthcare at ACCT reviews and input from the team into ACCT caremaps.

Levels of superficial self-harm are high amongst young people and it can be difficult and sometimes distressing to look after and support young people who are prolific and severe self-harmers.
As there is no Inpatient Unit, young people who are particularly challenging to look after and at high risk of harming themselves or others are often located in the Care and Separation Unit. Although this is clearly not ideal, it was explained that if located in the Care and Separation Unit there was more opportunity for one to one out of cell engagement with the young person. Recent cases within the establishment have highlighted the need for an agreed constant watch protocol that clearly identifies whether the constant watch required is clinical or non-clinical.

The HMIP report recommended that 'specific child focussed skills and knowledge training, including mental health, be available to nursing staff'. This recommendation has not been completed to date as all primary care nursing staff are yet to access training from CAMHS.

Registered mental health nurses get quarterly supervision from an external registered mental health nurse supervisor, but staffing levels have sometimes prevented attendance.

11.2 CAMHS

CAMHS provision is by ENGAGE (South Staffordshire and Shropshire NHS Foundation Trust).

Provision consists of 0.5WTE consultant clinical psychologist and service lead; 0.8WTE psychological therapists; 2 sessions per month consultant psychiatrist; 0.5WTE admin support.

Current vacancies are 0.4WTE psychological therapist and 0.5WTE admin support

A CAMHS service is offered in HMYOI Werrington 9am-5pm Monday-Thursday, however cover can be provided Monday-Friday if needed. Out Of Hours mental health service is not commissioned at present.

11.2.1 Referral Pathway

CAMHS accepts referrals from all departments and self-referrals can also be generated using a Referral form that has been circulated and is on SystmOne.
Referrals are accepted from anyone in the prison - i.e. discipline staff, social work, substance misuse, education staff and are prioritised according to need with urgent referrals (acute psychosis/high risk suicide/self-harm) seen same day/next working day and priority 1 one referrals seen within a week. Referral thresholds are low and referrals are accepted for anyone with an

emotional health need. The service generally operates without a waiting list and young people are generally seen within 2 to 3 weeks of the referral being accepted.

11.2.2 CAMHS Assessments and Interventions

The CAMHS caseload average is 20-25 young people.

CAMHS staff work to an assessment plus 6 session and review model so that work and progress can be regularly reviewed.

CAMHS offer pharmacological treatment and individual psychotherapy.

There is a medication management protocol in place for management of psychotropic medications. There has been an increase in the percentage of CAMHS caseload prescribed medicated in the last 6-12months from 20% to 40%. This increase may be related to the increases in the remand population, the closures in the wider youth secure estate concentrating young people into one place, and the types of referrals received. The most common medications prescribed are for ADHD, followed by medication psychosis and emotional disorders.

Psychotherapy is usually integrative depending on the young person's specific needs and readiness for change, and therapists work from a wide range of psychological models including attachment, systemic, narrative, cognitive behavioural, EMDR, and play-based therapies. Interventions are currently offered on an individual basis as there is insufficient resource to offer group based interventions, although these would be seen as a valuable addition to what is currently provided. Possible future focusses for group work would include CBT/DBT groups for managing emotions, psychoeducational groups about specific conditions (ADHD; Depression; hearing voices; impact of trauma; bereavement), groups relating to identity development – for example themed around manhood; fatherhood; violence or skills development focused interventions such as problem solving or assertiveness development.

CAMHS are not currently commissioned for specific offence focussed work, however they will work around harmful sexual behaviour if it presents in the context of an emotional problem.

11.2.3 Clinical Outcomes

Length of treatment is currently determined by clinical need/length of stay at HMYOI Werrington, and is not predetermined.

As outcome measures the CAMHS team use the HONOSCA (Health of a Nation Outcome

Scales) and a screening tool called the MAYSI-2 (Massachusetts Youth Screening Instrument – Second Version).

The MAYSI-2 is a standardized, reliable, 52-item, true-false method for screening every youth of ages 12-17 entering the Youth Justice System, in order to identify potential mental health

problems in need of immediate attention.

The MAYSI-2 provides information that alerts staff to the potential for the following mental health and behavioural problems:

Alcohol/Drug Use
Angry-Irritable
Depressed-Anxious
Somatic Complaints
Suicide Ideation
Thought Disturbance
Traumatic Experiences

The MAYSI-2 is not a diagnostic instrument. It serves as a "triage" tool for decisions about the possible need for immediate intervention. It does not take the place of more comprehensive assessments that are needed for decisions about long-range placement or treatment planning. Requiring less than 10 minutes to administer and using the young person's self-report, the MAYSI-2 is appropriate for use at initial assessment and discharge.

The CAMHS team are currently in the process of reviewing initial outcome data from use of the above two outcome measures, in addition to patient satisfaction data.

11.2.4 Transitions

HMYOI Werrington CAMHS workers have in the past had split posts with community CAMHS and strong links exists to community teams. In terms of transitions to the community for young people in custody with mental health needs, the main point of contact is Community Youth Offending Teams health or CAMHS workers, although specific arrangements to transition care to community child or adult mental health services will be made on a case by case basis. Although there are clear referral routes to the medium secure adolescent inpatient network, inpatient beds have been difficult to access - only 1 referred young person has been accepted in 4 years, with an average of 1 or 2 per year referred and declined.

11.3 Mental Health Training and Consultation

CAMHS offer consultation to all staff working in the prison environment about young people where there are mental health concerns including education, safeguarding/social work/voluntary sector workers/chaplaincy and prison officers. These are organised on a needs led basis. CAMHS staff also attend the weekly MDT MASH meeting and try to support staff via that route and by issuing email advice about challenging and worrying young people.

The most recent HMIP report recommended mental health awareness training (including on learning disabilities) for prison staff should be prioritised. CAMHS staff have previously offered training on

mental health to prison staff, however this has not yet been taken up due to the prison prioritising other training needs. Previous training delivered includes:

General mental health awareness/introduction to mental health in children
Managing challenging behaviour
Understanding ADHD
Bereavement & grief

11.2.6 Neurodevelopment Disabilities

Assessment and intervention for young people with neurodevelopmental disabilities is provided by the clinical psychologists in the service who have core training in learning disability, ADHD and Autistic Spectrum Conditions. In addition there is liaison and consultation with community CAMHS specialist learning disabilities service where required.

There is not any Speech and Language Therapy input commissioned as part of CAMHS at present.

11.4 CAMHS Staff Training & Development

Clinical supervision for CAMHS staff is provided within their trust monthly or 3 monthly for the Consultant Clinical Psychologist. The CAMHS team have received additional training in:

DDP
EMDR
Systemic Therapy
Theraplay
Play Therapy
Hypnotherapy
DBT
Risk Assessment (generic and relating to sexual offending)

11.5 Recommendations

- Healthcare commissioners, providers and prison colleagues should develop a jointly agreed Constant Watch protocol that clearly defines criteria for clinical and non-clinical constant watches and supports associated decision making processes.

- A READ code should be assigned for attendance at ACCT reviews and used by all staff so that the healthcare team can clearly evidence the proportion of their workload associated with this, as this currently appears to be under-reported on monitoring spreadsheets.

- There is no clear evidence base for the use of TAG as a referral form and prioritisation system in young people and this system is not developmentally appropriate for use with this population.

The Healthcare Standards recommend use of a CHAT comprehensive care plan derived from the integrated information from each of the screenings, and this would form a more appropriate basis for assessing urgency and making a clinical judgement as to priority in order to make onward referral to secondary care.

- Although a small multi-disciplinary team, CAMHS provide a broad range of evidence based interventions, although these do not include Speech and Language Therapy or Occupational Therapy as recommended in the Healthcare Standards. There is no capacity to provide group work approaches and this is an area for development.

- The most recent HMIP inspection recommends 'specific child focussed skills and knowledge training, including in mental health, be available to nursing staff'. It is recommended that a programme of child focussed skills and knowledge training is developed to include a wide range of physical and mental & emotional health training from CAMHS, Looked After Children's Team, Paediatric Nurse Specialists and Specialist Children's Charities.

12 Substance Misuse

12.1 Service Provision

The substance misuse service at HMYOI Werrington is called the Young Persons Drug & Alcohol Support Service or `YPDASS' and has been in place since October 2013.

Lifeline are the service contract managers and provide the psychosocial element of service.

Delphi is subcontracted by Lifeline to provide clinical services.

YPDASS is commissioned by the local authority and is separate to Primary Care Services although the two work closely together.

Young people come in to reception and then go onto C wing for induction which lasts between 5-7 days.

YPDASS see all young people the day after reception to complete CHAT Part 3 screening assessment.

The team have access to ASSET and also contact the young person's Youth Offending Service or Community Drugs Team workers where required.

If the young person comes into the service they are allocated a worker and a care plan is developed in accordance with YDASS care pathways.

Work is undertaken predominantly on 1:1 basis.

The YDASS Worker attends the young person's initial review. The team are in the process of remodelling group work. The induction group has been maintained and is co-delivered with Delphi.

Cannabis and Alcohol groups are ready to pilot.

New Psychoactive Substances are beginning to emerge as a problem in young people but not to the extent seen in adult prisons.

A Notice to Staff and Notice to Young People has been drafted to provide information about New Psychoactive Substances.

Manchester College provide education – induction training includes substance use information.

There is a clear definition between education and psychosocial intervention.

1:1 interventions work well with the population age group, providing positive engagement and quality.

YDASS engage with approximately 80-90% of prison population.

Data in the tables below has been extrapolated from data provided by the service and is for the period November 2013 to March 2014.

12.2 YPDASS Clients

For the period studied, over 84% of young people (n=115) accessing the service were 16-17 years old. Approximately 4% were aged 15 and 12% were aged 18 or over.

Approximately 55% of the client group were of White ethnicity, 18% Black/Black British, 8% Asian/Asian British and approximately 18% of mixed ethnicity.

Figure 25 YPDASS Client Group

HMYOI Werrington YPDASS Client Group

	Oct-Dec 2013	Jan-March 2014	Total no.	%
		Age		
15	2	3	5	3.68
16-17	45	70	115	84.56
18+	7		16	11.76
Total	54		136	100
		Ethnicity		
White	28	47	75	55.15
Black/black British	10	15	25	18.38
Asian/Asian British	4	7	11	8.09
Mixed	12	12	24	17.65
Other	0	1	1	0.74
Not stated	0	0	0	0
Total	54	82	136	100

12.3 YPDASS Referrals

Over the 5 months for which figures are recorded there were 95 new referrals, of which 9 were transfers in to the establishment and 2 were re-referrals/relapses. This provides a mean average of 19 new referrals per month - an estimate of approximately 228 new referrals per annum.

Figure 26 YPDASS New Referrals

YYDASS New Referrals

	Nov 13	Dec 13	Jan 14	Feb 14	March 14	Total
New referrals	9	10	19	28	29	95
Continuity of care(transfers in)	3	3	3	0	0	9
Re-referral/relapse	0	0	0	2	0	2
Pre-release	0	0	0	0	0	0
Total	12	13	22	30	29	108

One of the referrals to the service required clinical/pharmacological interventions. 97 received psychosocial interventions.

To date, any young people requiring clinical interventions have been diverted to juvenile establishments with Inpatient Units (e.g. HMYOI Wetherby or HMYOI Hindley). However, with the closure of juvenile places at HMYOI Hindley, it is possible that young people requiring clinical interventions may be received into HMYOI Werrington. YPDASS and Primary Care providers will need to liaise with prison partners to identify appropriate locations where these young people can be safely monitored and supported whilst receiving clinical interventions for stabilisation or detoxification.

The YPDASS Team Lead has visited HMYOI Hindley to ascertain the number of young people received requiring clinical interventions.

Information suggests that at HMYOI Hindley approximately 12 young people underwent pharmacologically supported alcohol detoxification in 2013, but this reduced to 3 in 2014. Although exact numbers were not provided, very few, if any young people received opiate or benzodiazepine detoxification.

Delphi, who are an experienced provider of clinical substance misuse services in secure environments, have clinical protocols, nationally approved evidence based clinical assessment tools, and staff resources available to meet this need. However, this will need to be closely monitored and evaluated, as dependent upon emerging needs, it may be necessary to review and reflect on resource, skill mix and facilities available. Additional funding or resources may be required to adapt premises, raise staff awareness, and provide additional training for staff groups who may not have experienced looking after young people undergoing clinical detoxification before.

Figure 27 YPDASS Referral Breakdown

YDASS Referral breakdown	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Total
Psychological interventions	12	12	20	24	29	97
Opiate substitution programme	0	0	0	0	0	0
Opiate stabilisation programme	0	0	0	0	0	0
Alcohol detoxification	0	0	0	0	0	0

Referred but not entered to treatment	2	2	2	6	11	22

12.4 Preferred Substance Use

The table below demonstrates that Cannabis was the most popular primary substance of choice, with alcohol being second.

No young people cited heroin or benzodiazepines as primary substances

A small number of young people had already experienced legal highs and mephedrone.

Figure 28 Primary substance of choice

Primary substance of choice	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Total	%
Cocaine	2	3	2	1	1	9	2.73
Cannabis	49	46	56	68	70	0	87.58
Alcohol	3	5	6	6	8	0	8.48
Legal highs	0	0	0	1	2	0	0.91
Mephedrone	0	0	0	0	1	22	0.31
Totals	54	54	64	76	82	330	100

12.5 Group Work

The table illustrates the range of group sessions provided and the number of young people who attended. The team are currently in the process of revising group work with the aim of re-launching groups and targeting more young people through this mode of delivery.
The impact of the Transforming Youth Custody agenda will mean that there is less time for agencies (including YPDASS, CAMHS, Primary healthcare, chaplaincy, advocate groups etc.) to see young people and therefore the time that is available will need to be used efficiently and innovatively.

Figure 29 Group Sessions Delivered

Group work sessions delivered						
Introduction week 1: Intro to YPDASS and overdose	4	5	4	3	4	20
Introduction week 2: BBV and sexual health	4	5	5	4	3	20
Alcohol and violence	1	1	1	0	1	5
Stimulants	2	1	0	1	1	4
Cannabis awareness	0	1	1	2	1	6
Dealing forum	1	0	0	0	2	1
Total	12	13	10	10	0	56
Group work no. of individuals attending						
Introduction week 1: Intro to YPDASS and overdose	24	18	20	14	18	94
Introduction week 2: BBV and sexual health	25	20	19	18	11	93
Alcohol and violence	3	2	1	0	3	10

Stimulants	0	3	0	3	3	8
Cannabis awareness	7	3	1	4	5	20
Dealing forum	2	0	0	0	0	2
Total	61	0	41	39	40	181

12.6 Release Planning

All planned releases (100%) received information prior to release, had a pre-discharge risk assessment completed and had necessary information supplied to the Youth Offending Service.

12.7 Recommendations

- With the closure of juvenile places at HMYOI Hindley, need should be closely monitored and evaluated, as dependent upon emerging needs, it may be necessary to review and reflect on resource, skill mix and facilities available. Additional funding or resources may be required to adapt premises, raise staff awareness, and provide additional training for staff groups who may not have experienced looking after young people undergoing clinical detoxification before
- YPDASS and Primary Care providers will need to liaise with prison partners to identify appropriate locations where young people can be safely monitored and supported whilst receiving clinical interventions for stabilisation or detoxification.
- The team should continue to develop group work and also to consider innovative alternatives to 1:1 face to face consultations - for example:-
    - sharing of key messages through information technology and computer based programmes that may be accessed through joint working initiatives with education
    - use of prison media channels
    - participation in peer mentorship programmes and family initiatives to promote awareness and personal responsibility
    - self-help age appropriate work books and health `passport' initiatives to increase engagement and motivation
- The new programme of group work should be formally evaluated
- Should the number of young people requiring pharmacological support increase, the team should liaise with the primary care team to agree the most efficient way of administering medicines - with the small numbers involved it would make sense for all medicines to be administered at one time point, rather than young people attending separately for YPDASS medicines.
- The emergence of New Psychoactive Substances and their use in younger populations requires close monitoring and the team should continue to raise awareness of the risks of use.

13 Feedback from Consultation

13.1 Methodology

The Health and Well-Being Needs Assessment comprised both qualitative and quantitative approaches and combined interviews, focus groups, and service user questionnaires.

Semi-structured face to face interviews were conducted with the Acting Head of Healthcare, CAMHS Lead, and YPDASS team leads. In addition, discussions were held with nursing staff and the healthcare assistant on duty and a small number of visitors visiting the unit. A telephone interview

was conducted with the physiotherapist, ophthalmologist and the governor with responsibility for healthcare.

28 Service user questionnaires were distributed. The questionnaires had been reviewed by a reader group of young people in custody and incorporated some pictorial symbols to increase understanding for those with lower literacy levels.

A small focus group was also held and themes from these incorporated into the Health and Well-Being Needs Assessment, along with themes and comments from general field notes made during on-site activities.

13.2 Questionnaires

28 General questionnaires were distributed and 28 returned, giving an excellent response rate of 100%.

General Questionnaire results are illustrated in figure 17 below.

Not all young people answered all questions so responses do not always total 28 in number.

Figure 30 Age of Respondents

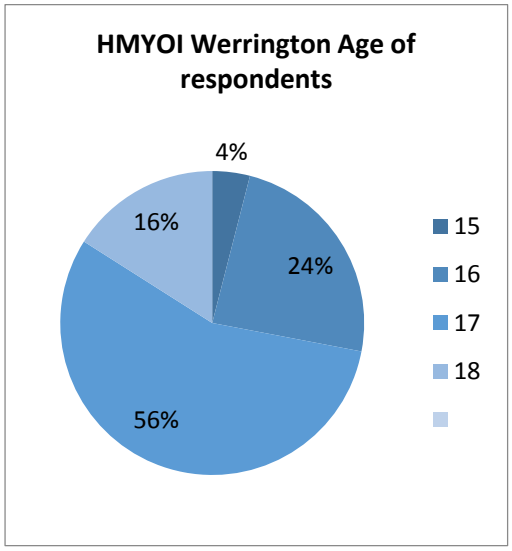
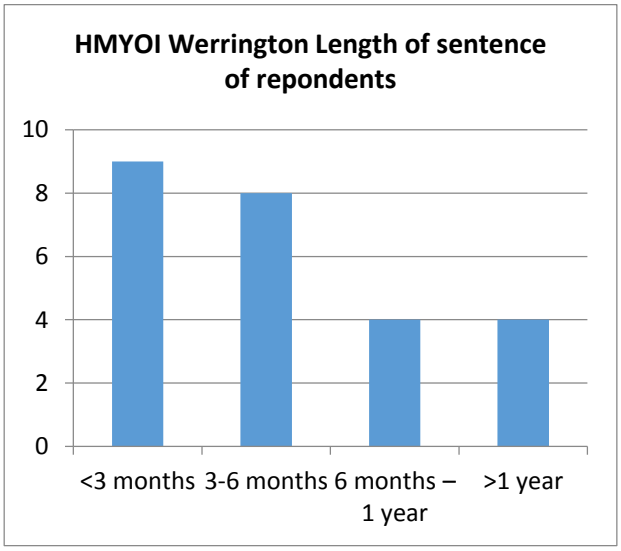


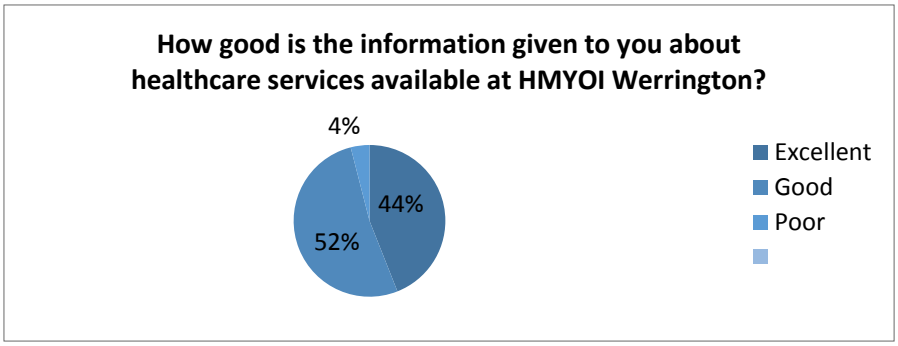
Figure 31 Length of Sentence of Respondents



The majority (56%, n=14) of respondents were aged 17. 24% (n=6) were aged 16 years, 16% (n=18) were aged 18 years and 4% (n=1) were 15 years old.

36% (n=9) were serving sentences of less than 3 months, 32% (n=8) were serving sentences of 3-6 months, 16% (n=4) were serving sentences of 6months-1 year and 16% (n=4) were serving sentences of more than 1 year.

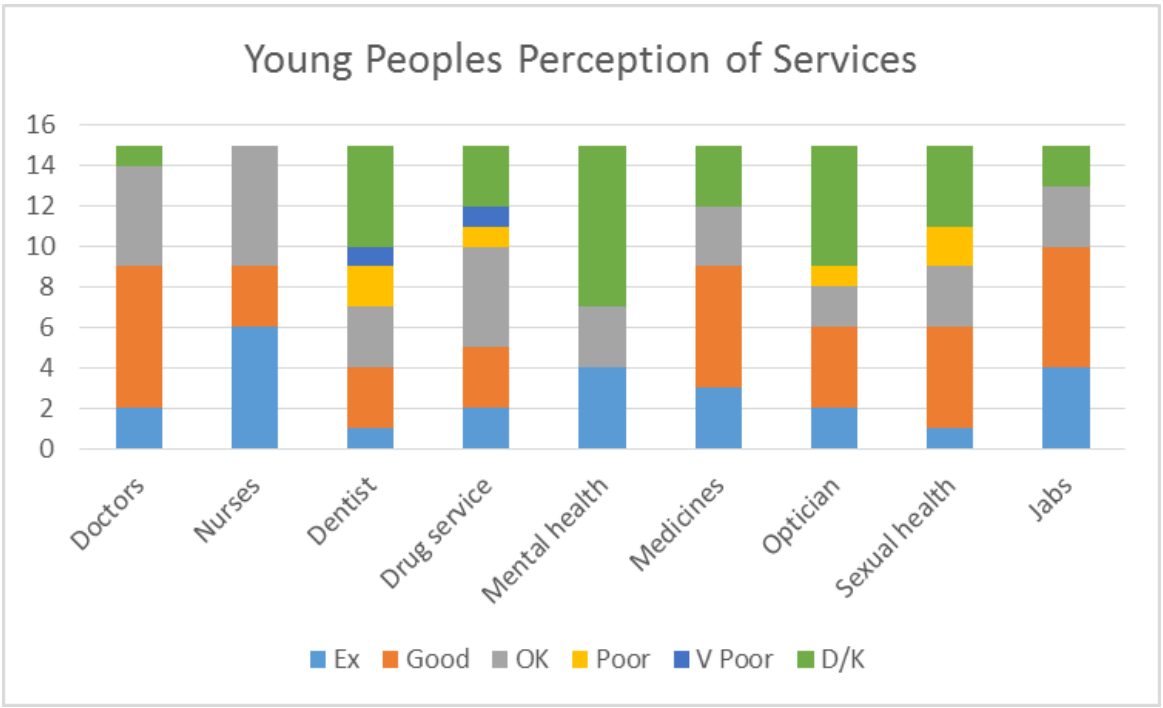
Figure 32 Perception of information provided about healthcare services



52% (n=13) of respondents perceived the information given to them about the healthcare services available at HMYOI Werrington to be 'good'. A further 44% (n=11) rated the information 'excellent'. 4% (n=1) deemed it to be 'poor'.

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

Figure 33 Young Peoples Perception of Services at HMYOI Werrington



Nurses, Doctors (GP Clinics), medicines (pharmacy) and jabs (immunisations and vaccinations) were highly rated. Dentist and Sexual Health Services appear to be viewed less positively.

Figure 34 Comments from Questionnaire

HMYOI Werrington Comments from Questionnaire

What are the best things about healthcare services in this prison?	Are there any things about healthcare services that you think could be improved?
They are polite	They should do a healthcare course to tell you more about what they do
They do their best	They take a long time with jabs
Look after you	They should do a healthcare course
When you ask to see them they come as quickly as possible	More healthcare available
Look after me	Get things done a little quicker
When I ask to see them they come	I put my name on dentist two months ago and still haven't got to see him at night I ask for paracetamol but don't get it
Always reliable	Have better understanding
Always there when you need them	The dentist coming in more
They're always jokeful and friendly	The optician coming in more
They are always there when you need them	Regular check ups
They are polite and respectful	More details
They are there when you need them	Length of waiting time for an appointment
You can talk to them at lunch if you're unsure about something	More nurses and doctors so we can have an appointment quicker
You get better healthcare than outside of prison	They could be quicker when requested and some staff are rude
You get seen my doctors quick	Nothing x3
They get your meds for you on time	Quicker appointments
Easy to access	Urgency
Helps you whenever you need it	Take you seriously
Nurses are always around for help if needed	Appointments
Free	Medication
Helpful	They could be quicker to deal with issues
They are polite and give help when needed	
They help you and look after you	
They're always about	
Respect	
Always polite	
Always down to help	
They know what to do and what to give you	
It gives you options to get jabs	
They help you with problems	
Free glasses	
Free jabs	
They listen well and act appropriately	
Help you with what you need	
They're very nice	
They will always get you an appointment	
Give you what you need	

13.3 Qualitative Feedback

Comments from service user questionnaires are summarised above. In addition, 5 young people were invited to a service user focus group. 2 young people attended, 2 were engaged in other on site activities at the time the focus group took place and 1 young man declined to take part.

Of 2 young people who attended, 1 was serving a sentence of 2 months, the other a sentence of 3 months. Both young people confirmed they had accessed healthcare services within the prison but commented that they didn't like interrupting other activities (both attended education and had a job within the YOI) to visit healthcare.

The young people were asked what healthcare was like at HMYOI Werrington and responded positively. They described healthcare staff as friendly, approachable and 'never too busy'. One service user commented 'at the other YOI I was in I didn't go see healthcare because you had to queue-here you get seen quickly unless they are dealing with someone else'. The young people explained that wing officers support them if they want to see a member of the healthcare team by requesting they are visited on the wing or by taking them across to the healthcare department.

When asked what was good about healthcare services at this prison, the young people talked about reception screening. One man commented that while it was beneficial to be seen straight away, that some screening checks were left until later was 'good because it's a bit of a shock on the first night'. That vaccinations were offered on screening was also appreciated by the young men, as 'outside you wouldn't go for it'. However, vaccinations were also identified as an area of healthcare services which could be improved as due to waiting times, some young people leave the establishment before they have had the chance to be vaccinated.

The young people who attended the focus group could not identify any services they did not have access to that they thought they should have, commenting there was 'nothing that you can't get'. When asked to list the services available to them, nurses, dentist, optician and sexual health services were identified. Neither young man could identify any opportunities they had to be involved in their own healthcare whilst serving at HMYOI Werrington.

Both young people perceived the healthcare services they received at HMYOI Werrington to be better than those they would receive in the community. However, one commented that he did not access healthcare service outside of prison. When questioned about healthcare services they might access in the community, the young men said they were unsure about walk in centres and wouldn't think to access services/advise provided by their local pharmacist. Both acknowledged the recent A&E crisis (having watched it on the television) and one said he would use the NHS non-emergency number if he was ill (although failed to recall the number itself). 999 would be dialled in an emergency situation.

Three parents and one sibling visiting the establishment were asked about their perceptions of healthcare and their awareness of services provided. All were unanimous is stating that they do not know very much about the healthcare services offered and could not recall receiving information about the healthcare services available to the young people serving at HMYOI Werrington.

13.4 Recommendations - Stakeholder Feedback

- In preparation for release, it may be beneficial for the healthcare department to liaise with education and caseworkers to develop awareness sessions and information resources to inform young people about accessing healthcare services in the community, and particularly about the role of community pharmacists and walk in centres.
- A Young Persons Healthcare Peer Mentoring Scheme should be developed. Again, with a view to maximising time available, this could be a joint primary care and YPDASS initiative.
- Posters and information leaflets should be developed for the visitors' centre and visits hall to inform families and friends of the health care services available for young people.
- Innovative use of funding opportunities could be made to purchase fun activities and resources that can be used for health promotion and education campaigns but also used to encourage young people who are parents to share messages with their families (for example, the author has used a `sneezing pig' resource with young parents to show their children how `germs' spread as part of the `Catch it, Bin it, Kill it, campaign)

14 Compliments and Complaints

There were two formal complaints received by prison healthcare for the twelve month period October 2013-September 2014. These complaints were in regard to access and waiting times for healthcare services.

In addition, there were 3 PALS contacts during this time.

15 Incidents & Serious Untoward Incidents

1 serious untoward incident was reported between October 2013-September 2014. This was in March 2014 and was the result of violence and aggression.

There were 5 incidents reported in the 12 month period: 1 in October 2013 (an incident related to medication), 1 in November 2013 (security incident) and 3 in January (incidents related to violence and aggression).

The number of incidents are too low identify themes and trends.

16 Deaths In Custody

There have been no deaths in custody at HMYOI Werrington.

17. Local recommendations

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

No.	Area	Recommendation
1	Population	There is a need to monitor the population closely to assess the impact of the re-roll of HMYOI Hindley on the presenting health needs of the population at HMYOI Werrington. It is recommended that the next Health and Well-Being Needs Assessment refresh gives particular consideration to this.
2	Population	As the governments `Transforming Youth Custody' agenda is embedded, young people will spend significantly more time in education and training. Innovative ways in which healthcare engage with young people and maximise available face to face contact time will be required. Healthcare commissioners and providers will need to liaise closely with prison colleagues to assess the impact of Transforming Youth Custody and to consider ways in which to maximise access time available and consider alternative ways to delivering healthcare within the setting.
3	Population	The percentage of young people on short term sentences has increased, which has shortened the time in which the healthcare team have to address the immediate needs of some of the young people in their care. Prompt responses to needs identified at reception screening need to continue, and from a public health perspective, this is especially important when maximising opportunities for young people to be brought up to date with national screening and vaccination programmes.
4	Public Health	The numbers of young people declining vaccinations is high. It is suggested that the healthcare team source or develop age appropriate, innovative and appealing materials to encourage vaccination uptake and also link with the education department to reinforce key messages about the benefits of vaccination to the population group.
5	Public Health	Given the high rate of declines and the importance of Hepatitis B vaccination in protecting this potentially vulnerable group, it is recommended that implementation of the fast track vaccination schedule is reconsidered by the SSOTP medicines forum responsible for the development of Patient Group Directions. To employ the fast track schedule would be highly advantageous in

		this population group. NICE guidance is available on developing Patient Group Directions Vaccinations for off label use in children and the fast track vaccination scheme is used in other establishments .[57]
6	Primary Care	The prevalence of type I diabetes and epilepsy is very low and there have been no young people presenting with these conditions in recent years. Should a young person be received into the establishment who has epilepsy or diabetes, staff will require refresher training to ensure up to date evidence based practice and care is employed, and there is secure knowledge and understanding of current medication regimes and approaches.
7	Primary Care	Competency based and accredited training opportunities that enable Healthcare Assistants to expand their current role should be identified and accessed, with a view to remodelling the current service delivery model to maximise the use of health care assistants.
8	Primary Care	A READ code formulary should be developed and all healthcare professionals (G.Ps, nurses, optician, dental personnel and physiotherapist) should be cognisant with the formulary and able to consistently READ code disabilities so that a comprehensive disability register can be maintained.
9	Primary Care	Healthcare teams at HMYOI Brinsford & HMYOI Werrington have an opportunity to develop a transition pathway for young adults transferring between the two establishments. It is suggested that the transition pathway recommended above is piloted and refined between HMYOI's Werrington and Brinsford and then extended to support young people transferring in from other `out of area' juvenile establishments.
10	Primary care	It was commented that many young people request to see the GP for skin problems. If one of the nursing team was able to attend an accredited Dermatology Course, this element of service could be predominantly nurse led.
11	Primary care	From October 2013-September 2014, the GP saw 1,750 patients (an average of 146 patients per month/approximately 6 young men per day). The GP resource could be reviewed as a session every weekday appears to be in excess of requirements. Any changes made need to be mapped to Youth Justice Board requirements and Prison Audit Standards to ensure that the cover offered complies with prison requirements.
12	Primary care	A review of urgent care pathways for dental pain may identify options other than referring young people to GP or out to dental hospital (e.g. nurse triage protocols for management of dental pain and abscesses)
13	Primary care	Mobile nurse triage and vaccination clinics may be required to maximise time available once TYC is embedded. In addition and in liaison with prison colleagues it may be necessary for commissioners and providers to undertake a review of current clinic times

[57] NICE Medicines Practice Guidance – Patient Group Directions http://www.nice.org.uk/mpc/medicinespracticeguidelines/mpg2.jsp

		and consider holding nurse clinics at weekends and evenings. The workforce and cost implications of reallocation of clinic activity will require consideration.
14	Primary care	The Head of Healthcare should forge strong links with senior managers in the Accident & Emergency Department and outpatients departments at University Hospital of North Staffordshire and Hayward Hospital.
15	Medicines	It is strongly recommended that use of the SystmOne prescribing functionality is initiated as soon as possible. This will enable better audit of prescribing practice and trends, and will decrease the clinical (poly-pharmacology) risks inherent with when multi prescribers are involved in an individuals care.
16	Medicines	A review of the approach to in-possession medicines should be undertaken. The default status should be that young people should have medicines in possession unless there is reason not to do so. This will reduce the time taken to administer medicines which may be required when TYC is embedded.
17	Medicines	A small number of Patient Group Directions have been developed, however, it is recommended that these are reviewed and expanded to enable a more nurse led service.
18	Mental Health	Healthcare commissioners, providers and prison colleagues should develop a jointly agreed Constant Watch Protocol that clearly defines criteria for clinical and non-clinical constant watches and supports associated decision making processes.
19	Mental Health	A READ code should be assigned for attendance at ACCT reviews and used by all staff so that the healthcare team can clearly evidence the proportion of their workload associated with this, as this currently appears to be under-reported on monitoring spreadsheets.
20	Mental Health	There is no clear evidence base for the use of TAG as a referral form and prioritisation system in young people and this system is not developmentally appropriate for use with this population. The Healthcare Standards recommend use of a CHAT comprehensive care plan derived from the integrated information from each of the screenings, and this would form a more appropriate basis for assessing urgency and making a clinical judgement as to priority in order to make onward referral to secondary care.
21	Mental Health - CAMHS	It is recommended that the CAMHS team liaise with In Reach team colleagues to develop a transition pathway for young people transferring from CAMHs to young adult mental health services.
22	Mental Health- CAMHS	CAMHS provide a broad range of evidence based interventions, although these do not include Speech and Language Therapy or Occupational Therapy as recommended in the Healthcare Standards. It is recommended that the need for these services is accurately scoped to inform future commissioning decisions.
23	Mental Health – CAMHS	There is no capacity for CAMHS to provide group work approaches. It is recommended that group work is included in the service offering as this will be essential to accommodate TYC changes.

24	YPDASS	YPDASS and Primary Care providers will need to liaise with prison partners to identify appropriate locations where these young people can be safely monitored and supported whilst receiving clinical interventions for stabilisation or detoxification.
25	YPDASS	Dependent upon emerging needs, it may be necessary to review and reflect on YPDASS resource, skill mix and facilities available. Additional funding or resource may be required to adapt premises, raise staff awareness, and provide additional training for staff groups who may not have experienced looking after young people undergoing clinical detoxification before
26	YPDASS	The team should continue to develop group work and also to consider innovative alternatives to 1:1 face to face consultations. For example:- - sharing of key messages through information technology and computer based programmes that may be accessed through joint working initiatives with education - use of prison media channels - participation in peer mentorship programmes and family initiatives to promote awareness and personal responsibility - self-help age appropriate work books, health `passport' initiatives to increase engagement and motivation.
27	YPDASS	The new programme of group work should be formally evaluated.
28	YPDASS	Should the number of young people requiring pharmacological support increase, the team should liaise with the primary care team to agree the most efficient way of administering medicines - with the small numbers involved it would make sense for all medicines to be administered at one time point, rather than young people attends separately for YPDASS medicines.
29	YPDASS	The emergence of New Psychoactive Substances and their use in younger populations requires close monitoring and the team should continue to raise awareness of the risks of use.
30	Social Vulnerability / Looked After Status	Looked After Children's Health Needs Assessments are currently undertaken by the Community Looked After Children Nurse Specialist, however commissioners and providers may wish to consider whether training one of the nurses at HMYOI Werrington to undertake assessments (and either re-allocating funding or cross charging for this) would be beneficial.
30	Social Vulnerability / Looked After Status	SystmOne should be utilised to clearly flag to receiving establishments that a young person has previously been of Looked After Status to enable healthcare involvement in leaving care support plans where required.
31	Staff Development	The most recent HMIP inspection recommends 'specific child focussed skills and knowledge training, including in mental health, be available to nursing staff'. It is recommended that a programme of child focussed skills and knowledge training is developed to

	include a wide range of physical and mental & emotional health training from CAMHS, Looked After Childrens Team, Paediatric Nurse Specialists and Specialist Children's Charities.

APPENDIX 1 Screening Questions – CHAT

COMPREHENSIVE HEALTH ASSESSEMENT TOOL (CHAT)

CHAT Part 1 – INIITIAL SCREEN

- Personal details – name, prisoner number, date of screening
- Immediate management plans
- Further details – address, ethnicity, gp, next of kin, dependants
- Confidentiality consent and information sharing
- Physical health needs - dietary requirements, allergies, HIV or Hep B, respiratory, heart, skin, pain, shock, recent trauma, diabetes, epilepsy/blackouts, physical disability, pregnancy, medication and vital signs
- Substance misuse – has young person taken substances recently? Are they currently intoxicated, are the withdrawing from alcohol/benzodiazipines/opiates/cannabis/ stimulants? Are they currently taking medication for substance misuse management?
- Mental health – persistent low mood, unusual speech, delusions, hallucinations. Medication
- Immediate safety risks and concerns – actual self-harm, desire to self-harm now, previously attempted suicide, suicidal feelings now, depressed, general risks/concerns

CHAT Part 2 – PHYSICAL HEALTH

- Personal details
- Confidentiality consent and information sharing
- Assessment of capacity, consent for assessment, consent for information sharing, consent for parent/guardian involvement.
- Other agencies involved now (Is the young person currently receiving support from any other agencies?)
- Social circumstances – living arrangements, parent/guardian details, siblings, children, illnesses in family members, substance misuse
- Subject to child protection order? Looked after child? Been in care?
- Education, training and employment – school/college/university, type of job, previous jobs, religious affirmation, sexual orientation, current legal situation
- Physical health assessment – height, weight, respiration, pulse, blood pressure, temperature, BMI, Immunisations, general appearance
- General physical health – appetite, weight, fatigue, fever, sweats, pain, major illnesses, hospital visits, operations, reaction to medication, current medication
- Cardio vascular system + vital signs
- Respiratory system + vital signs. Coughs, asthma, hay fever
- Gastro intestinal system – feelings of sickness, actual sickness, discomfort eating or drinking, pain in tummy after eating, diarrhoea or constipation

- Eyes, hearing and oral health – eye problems, need for glasses, hearing problems, sense of smell, oral health problems, and last visit to dentist
- Genito urinary system and maturation – any problems passing urine
- Males - expected stage of maturation, any problems, sexually active, any sores/discharge
- Females – expected stage of maturation, periods, problems, bleeding between periods, sexually active, sores/discharge, pregnancies – past/present/possibility pregnant but unaware now
- Endocrine system – developing as expected, thyroid disfunction, diabetes
- Muscoskeletal – exercise, pain, stiffness, frame, posture, gait, trauma, previous broken/fractured bones
- Nervous system – orientation problems, memory, headaches, unsteady gait, fits faints or seizures
- Disability and impairment – invitation to declare,
- Care plan: physical health and social circumstances
- Comprehensive care plan following completion of parts 1-5 pf CHCA

CHAT Part 3 – SUBSTANCE USE

- Personal details
- Confidentially consent and information sharing
- Consent for assessment, consent for information sharing, consent for parent guardian involvement
- Substance misuse assessment – issues arising from other info, substance misuse issues (self-report) + documents to confirm? Do friends/family/housemates use?
- Drug/alcohol history and misuse
- Withdrawal – alcohol, benzodiazipines, opiates, cannabis, stimulants, nicotine, drug test when charged?
- Substance misuse practices – needles/syringes, shared equipment, vein problems, infection/abscesses from injecting?
- Where to they use, how much do they spend on it, how they fund it
- Familial risk and protective factors, youth culture risk and protective factors, educational risk and protective factors, employment risk and protective factors, impact of substance misuse
- Communicable diseases – hep b – ever tested ever vaccinated, invitation for both. Same for hep c. HIV. Sexual activity – sex in exchange for drugs/alcohol, unprotected sex, STI's
- Substance misuse education – any?
- Previous treatment experience
- Care plan: substance misuse and assessment

CHAT Part 4 – MENTAL HEALTH & WELLBEING

- Personal details
- Confidentiality consent and information sharing

- Consent for assessment, consent for information sharing, consent for parent guardian involvement
- Issues arising from other info + Mental health services contacts
- Depression, deliberate self-harm, suicide risk factors, anxiety, post-traumatic stress, psychoses, hyperactivity disorder, eating disorders,
- Care plan: mental health assessment

CHAT Part 5 – ACQUIRED BRAIN INJURY, LEARNING DISABILITY & AUTISITIC SPECTRUM DISORDER

- Personal details
- Confidentiality consent and information sharing
- Consent for assessment, consent for information sharing, consent for parent guardian involvement
- Traumatic brain injury – head injuries, knocked out, medical attention, symptoms such as headaches/dizziness
- Learning disability – struggled with schoolwork? Can attend to personal hygiene? Tell time? Easily led? Difficulty expressing themselves?
- Speech and language – plan pool or make a cup of tea, deduction task
- Autism spectrum disorder – ever diagnosed? Notes anything about family concerns?
- Conversational observations and social interaction observations
- Care plan: neurodevelopment and traumatic brain injury

APPENDIX 2 – Looked After Children – Flowchart

Source : PSI 08/2012 Care and Management of Young People