

West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 5 of 11
HMP & YOI Drake Hall : Final Version April 2015

HMP & YOI Drake Hall

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Acknowledgements

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

Thanks are extended to Staffordshire & Shropshire Local Area Team, the HNA Steering group, to all at HMP & YOI Drake Hall (Healthcare, DARS, In Reach, Primary Mental Health, contracted service providers, HMPS and NOMS colleagues) and to the ladies 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 Needs Assessment has been commissioned by NHS England Health & Justice Staffordshire & Shropshire Local Area Team.

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

The Health Needs Assessments have been undertaken utilising the Public Health England Health and Justice Health Needs Assessment Template: Adult Prisons.¹

The initial report in the series provides an introduction and context to the HNAs, including a review of the burden of disease and the met and unmet needs of the prison population. It is therefore recommended that this local report is read in conjunction with Report Number 1 for a wider overview of the health needs of the prison population.

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

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

1

www.gov.uk/government/uploads/system/uploads/attachment_data/file/331628/Health_Needs_Assessment_Toolkit_for_Prescribed_Places_of_Detention_Part_2.pdf - Accessed 07.02.15

Executive Summary

Drake Hall is a closed prison for women and a nominated Foreign National Centre with a certified normal holding capacity of 315.

The prison is situated in rural Staffordshire, 10 miles from Stafford. The women are accommodated in 15 houses, each with approximately 20 rooms; most being single rooms, with a small number of doubles. The Adult Learning Centre is managed by Milton Keynes College, healthcare is provided by South Staffordshire Primary Care Trust and the library is run by Staffordshire County Council. There is a prison shop contracted to DHL Booker who also run a warehouse in Drake Hall from which 10 other prison shops are supplied. This provides work for 41 prisoners at Drake Hall. Work is also provided through the kitchen, gardens, the laundry, the CFM workshop, the Recycling Unit and hair & beauty salons².

This Health Needs Assessment has been commissioned by NHS England Health & Justice Staffordshire & Shropshire Local Area Team and was carried out between December 2014 and February 2015. At the time of undertaking the Health Needs Assessment, there were 314 prisoners in the establishment.

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

Population & Demography

- There has been a slight shift in the age of the population since the last Health Needs Assessment, with a higher percentage of women over the age of 50 than before.
- Following the Womens Custodial Estate Review (2013)³, the creation of a strategic hub between HMPs Styal, Foston Hall and Drake Hall provides an opportunity for enhanced liaison between healthcare providers to develop shared care pathways, streamline sharing of healthcare information and promote efficiencies in the transfer process to support continuity of care.
- As only approximately 5% of the population are serving sentences of less than 12 months, there is an excellent opportunity to foster engagement with healthcare services, promote personal responsibility for health and develop a culture that seeks to consistently support and prepare women for discharge and resettlement throughout their term of imprisonment.
- As HMP & YOI Drake Hall is a designated resettlement prison, healthcare providers will need to build links with community providers and with Community Rehabilitation Companies to support 'through the gate initiatives' and continuity of care on resettlement.

² <http://www.justice.gov.uk/downloads/publications/corporate-reports/imb/annual-reports-2012/drake-hall-2011-2012.pdf>

³ Robinson.C , Womens Custodial Estate Review: National offender Management Service 2013

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Facilities & Resources

- Facilities are good but additional space for clinic delivery would be beneficial.
- There have been recent staffing issues in primary care resulting in a necessary reliance on agency staff.
- A review of primary care staffing levels and skill mix may be beneficial, with consideration of how health care assistants and associate practitioners could compliment qualified nursing staff to provide the optimal staffing structure.

Screening

- From October 2013 to September 2014 there were 377 women received in to the prison.
- Reception screening is very thorough.
- Reception screening templates have been developed that have background READ codes and include prompts for referrals to review clinics and other primary care services.
- Uptake of some national screening programmes could be improved.
- Cervical screening (93.8%) uptake is good.
- Breast screening uptake data was not available for this HNA.
- The NHS Bowel Cancer Screening Programme has not yet been introduced. At the time of the HNA, there were 11 women eligible. Across 2014, there had been 25 women who would have been eligible.
- Recommendations have been made regarding the implementation of national screening programmes.

Primary Care

- Service user perception of services is positive.
- Access to GPs and nurses is good and compares favourably with the wider community.
- GP, nurse and physiotherapy clinic waiting times are good.
- An additional female GP session per month would be advantageous.
- Health application forms have pictures and tick boxes to improve accessibility for those for whom English is not their first language or who have lower literacy levels.
- The target for waiting times to see the optician was only met for 24% of appointments throughout the 12 months reviewed and requires monitoring. A recommendation has been made regarding ocular triage to support a reduction in waiting times.
- The prison and healthcare providers have a joint approach to non-attendance and DNA levels are good across all clinics.

Management of Physical Disease and Long Term Conditions

- Management of Long Term Conditions is good.
- The actual prevalence of treated asthma (16.24% from SystemOne data) is much higher than national prevalence of 5.9%⁴ and also higher than prevalence estimates for treated asthma in the Birmingham toolkit (7%).
- Of the 32 patients on the asthma register, 29 (91%) have had an asthma review within the last 12 months.

⁴ Asthma prevalence by CCG area at <http://fingertips.phe.org.uk/search/ASTHMA#gid//pat/44/ati/19/page/0/par/E40000002/area>

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- Of the 11 patients with diabetes, 9 had recent blood pressure recordings, 7 had Cholesterol and HbA1c levels, 9 had received seasonal influenza vaccine and 6 had received a diabetic foot examination within the last 12 months.
- Prevalence of type I diabetes (0.63%) is lower than the 1.1% prevalence for type 1 diabetes in prison provided in the PHE toolkit for HNAs in prescribed places of detention.
- Prevalence of epilepsy (3.18%) is above national general population prevalence⁵. In comparison, prevalence in 2010 was similar (3.5%).

Communicable Disease

- Screening and vaccination programmes for Hepatitis B and screening and treatment programmes for Hepatitis C are good.
- Based on the most recent available information from PHE, of the 98 women received into HMP & YOI Drake Hall during the period January 2014-March 2014, 64% were already vaccinated against Hepatitis B.
- There is a high number of women who have already been vaccinated as HMP & YOI Drake Hall does not take remand prisoners, therefore all women are transferred from other prisons and will have been offered vaccination as part of their initial health reception screening.
- Of the 24 women requiring vaccination, all were vaccinated within 31 days of entering the establishment.
- Vaccination coverage was above target at 90%.
- There have been no cases of TB.
- The prison has an outbreak plan that has been shared with PHE.

Sexual Health

- Prevalence data was not available for the HNA due to the sexual health nurse leaving. It is therefore recommended that this is an area of focus when the next HNA/ HNA refresh is undertaken.
- Arrangements should be made for the continuance of sexual health services at the prison as soon as possible.

Physical Disability

- Data capture regarding physical disability is poor and it is suspected that physical disability is under-reported.
- A local SystemOne READ code formulary should be developed and screening templates background coded to ensure all data regarding disability is accurately recorded.

Lifestyle, Health Promotion and Well-being

- Health promotion is excellent
- An Annual Health Promotion Fair was in progress on the day of the HNS site visit.
- There is a Health Trainer Programme which is currently being relaunched.
- Women have access to smoking cessation support, dietary and weight management support and opportunities for both indoor and outdoor exercise.

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

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Social Care Needs

- Social care is not an NHS commissioning responsibility and is therefore outside of the remit of this NHS England commissioned HNA.
- The prison and local authority have entered into discussions regarding meeting the needs of prisoners under the Social Care Act from April 2015.
- There is a gap in the identification of those with previous Looked After Status who may be entitled to support leaving care. Recommendations have been made regarding this.

Mental Health

- Primary Mental Health Services are provided by Staffordshire and Stoke on Trent Partnership NHS Trust (SSOTP) and a prison In Reach service is provided by South Staffordshire & Shropshire Healthcare NHS Foundation Trust.
- A stepped care approach is employed, with primary mental health and In-Reach teams working in close liaison to provide support for those with mental health needs. It may be beneficial to monitor the significant resources required to meet the needs of patients with personality disorders in order that the personality disorder pathway can be effectively implemented and evaluated.
- The limited primary care mental health nurse capacity appears to be impacting upon the secondary care caseload. It is recommended that consideration of the advantages and disadvantages of a primary / secondary care model versus an integrated mental health model is undertaken to determine the best service delivery model for HMP & YOI Drake Hall.
- Service user and stakeholder feedback regarding In Reach services was very positive at this prison.

Learning Disability & Autistic Spectrum Disorders

- There are significant gaps in the identification, referral, assessment and support of prisoners with learning disabilities and Autistic Spectrum Disorders.
- This is evident from interviews with clinical leads, HMPS & NOMS colleagues, paucity of SystmOne data and through comparison of the existing services delivered with current clinical guidance and care pathways from the National Institute of Health & Care Excellence.
- A number of recommendations have been made regarding this, some of which will be carried forward to regional recommendations.

Substance Misuse

- Substance Misuse Services are provided through a partnership delivered by Lifeline and Delphi Medical.
- At the time of the Health Needs Assessment, there were 148 women accessing Lifeline psychosocial support and 55 on the Delphi clinical caseload.
- The service delivery model encompasses 1:1 support and group work, peer led recovery and support and family work and involvement. It is described as a recovery peer led holistic therapy programme and includes mental health and mindfulness, relaxation and acupuncture and has a focus on long-term recovery.
- From April 2013 to April 2014, there was a total of 414 new receptions of whom 214 (36.7%) began treatment episodes at HMP & YOI Drake Hall.

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- Of the total 228 new treatment entrants at the prison, 52.6% (n=120) were opiate users, 17.5% (n=40) were non-opiate new treatment entrants and 29.8% (n=68) were primary alcohol new treatment entrants.
- NDTMS data suggests a significant increase in women accessing the service between 2013 and 2014. Although the 2013 HNA suggests 2013 data may not be accurate, monitoring of this is required to ensure resources continue to meet need.
- The service will need to consider ways in which to resource support for the women who will reside in the open house and who may still require psychosocial support prior to resettlement back into the community.
- The service provider and recovery champions should explore innovative ways of developing and delivering a recovery drop in clinic, researching all available options for potential premises and locations.

Planned & Unplanned Secondary Care

- A number of recommendations have been made to potentially reduce escorts and bedwatches.
- It is recommended that Commissioners undertake a regional cost benefit analysis for the commissioning of a mobile diagnostic unit (x-ray and ultrasound) to regularly visit HMP & YOI Drake Hall. This has the potential to reduce escorts substantially and is further discussed in the regional analysis.
- A training needs analysis should be undertaken and training identified (minor injury, illness assessment and wound closure – suturing and gluing etc.) to support on site management and reduce avoidable escorts to Accident & Emergency.

A total of 36 recommendations have been made.

A full list of recommendations made can be found in section 22 of the HNA report.

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Table of Abbreviations

AAA	Abdominal Aortic Aneurysm
ACCT	Assessment, Care, and Custody Teamwork
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autistic Spectrum Disorder
BME	Black Minority Ethnic
BMI	Body Mass Index
CBT	Cognitive Behavioural Therapy
CHD	Chronic Heart Disease
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care
CQC	Care Quality Commission
CQUIN	Care Quality
CVD	Cardio Vascular Disease
DART	Drug and Alcohol Recovery
DIP	Drug Interventions Project
DNA	Did Not Attend
DRSS	Diabetic Retinopathy Screening Service
EBW	Escorts and Bedwatches
EDR	Expected Date of Release
ENT	Ears Nose and Throat
GP	General Practitioner
HMIP	Her Majesty's Inspectorate of Prisons
HMPS	Her Majesty's Prison Service
HNA	Health Needs Assessment
INR	International Normalised Ratio
IPC	Infection Prevention and Control
LTC	Long Term Conditions
MASH	Multi Agency Safeguarding Hub
MHA	Mental Health Act
MHFA	Mental Health First Aid
MOJ	Ministry of Justice
MSK	Musculo-Skeletal
NDTMS	
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
ROTL	Released On Temporary Licence
SCU	Separation and Care Unit
SSOPT	Staffordshire and Stoke-on-Trent Partnership NHS Trust

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STI	Sexually Transmitted Infection
TAG	Threshold Assessment Grid
UDA	Units of Dental Activity

1. HMP & YOI Drake Hall - Prison Population & Demographics

Drake Hall is a closed prison for women with a certified normal holding capacity of 315. The prison is situated in rural Staffordshire, 10 miles from Stafford. The women are accommodated in 15 houses, each with approximately 20 rooms; most being single rooms, with a small number of doubles. At the time of undertaking this Health Needs Assessment there were 314 women held in the establishment.

1.1 Women in Prison & the Womens Custodial Review (2013)

Report 1 of this series reviews the met and unmet health needs of prisoners, and outlines some of the specific gender issues to be considered for women prisoners.

However, when discussing population and demographics, it is essential to briefly comment on studies describing the social impact of womens imprisonment, and to describe the findings of the National Offender Management Service Womens Custodial Review (2013)⁶, in order to provide regional context within the national agenda.

Repeatedly, studies have found that there is an enormous social impact associated with imprisonment of women, who are often primary carers within their family unit.

The Oxford Health Study of Women in Prison in 2004⁷ suggested that

- 70% of women in prisons were mothers
- 55% were teenage mums
- 27% were single mums prior to prison, compared to 8% of the general population

A 1994 Home Office study⁸ of mothers held in prison indicated that

- 35% percent had been in care at some point
- 15% had been in a children's home
- 25% of those with a care history had at least one child in care at the time of their imprisonment (compared with 6% who had no care history)

33% of women surveyed in the Oxford study and 41% in the Home Office Study had children who were being looked after by other relatives (usually grandparents) and it was reported that 23% of children were separated from siblings following their mothers' imprisonment.

The recommendations from the Womens Custodial Review aim to

- Reconfigure the female custodial estate to facilitate closeness to home.
- Create a system for managing women offenders through the prison system without the need for open prisons.

⁶ Robinson.C, Women's Custodial Estate Review: National Offender Management Service 2013

⁷ Plugge, E. Douglas, N, & Fitzpatrick, R. The Health of Women in Prison: Study Findings, University of Oxford, 2006

⁸ Caddle and Crisp, Imprisoned Women and Mothers, Home Office Research Study 162, Home Office, 1997

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- Provide opportunities for women in custody to maintain better contact with their children and families, where appropriate.
- Increase opportunities for female offenders to work in custody and to gain employment through the gate and beyond; and ensure that education in prisons is more directly focussed on preparing women for employment.
- Improve support for female prisoners to maintain contact, where appropriate, with their children and families Improving support for female offenders to obtain appropriate housing on release from custody, which will allow them to be re-united with their children, where appropriate.

The review found that the womens estate of 2013 included a surplus of places in the east of the country but insufficient accommodation for women in the west, with particular shortfalls in the south west and the west midlands.

As a result of the review, a strategic hub has been created between HMPs Styal, Foston Hall and Drake Hall. The creation of the strategic hub provides

- Access to a wider range of regime opportunities for women while remaining in their home region
- A progression route to Drake Hall for women who are suitable for less secure conditions
- Opportunities to sequence the interventions within the three prisons by enabling women to move between them as required by their sentence plans
- Flexibility in the use of prison places to maximise effective use of the estate within the region

As a result of this an additional 25 places are being created in a unit placed immediately outside of the perimeter fence of Drake Hall to support resettlement of women to their home communities.

The population data below is based upon statistics provided by the Analytical Services Directorate, Ministry of Justice (MOJ).

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

In 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.

The data indicates a 10.95% increase in population from June 2013 to December 2014.

1.2 Age

Figure 1 Population by Age

Population by Age Group	30 Jun 2013	30 Jun 2014	31 Dec 2014
18-20	*	8	16
21-24	37	34	25
25-29	62	54	49

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30-39	92	107	118
40-49	58	70	68
50-59	21	33	27
60 +	*	7	11
All	283	313	314

On 31st December 2014 37.57% (n=118) of the population at HMP & YOI Drake Hall were between the ages of 30-39 years old. 13.05% (n=41) of women were less than 25 years old and 12.10% (n=38) were above the age of 50. 3.5% (n=11) of women were 60 years or older.

In June 2013, a similar proportion of the population (approximately 13.07 %) were under 25 years old, but there were fewer women aged over 50 years (approximately 7.42%). The actual number of women over 60 years old has been suppressed and must therefore be less than 1.76%. The figures below show the slight age shift of the population over this 18 month period.

Figure 2 Age Distribution June 2013

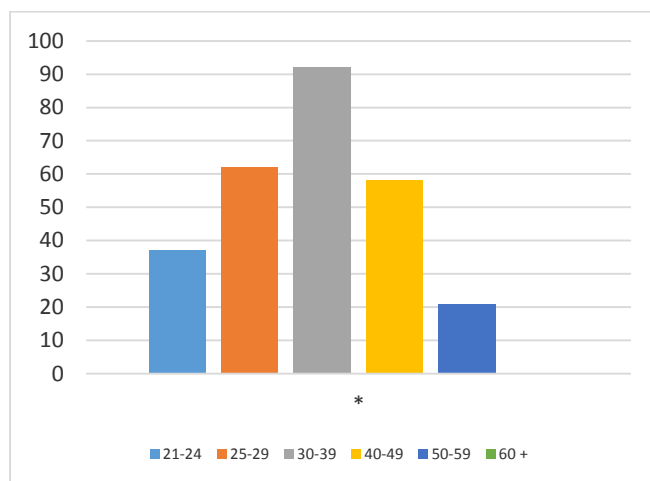
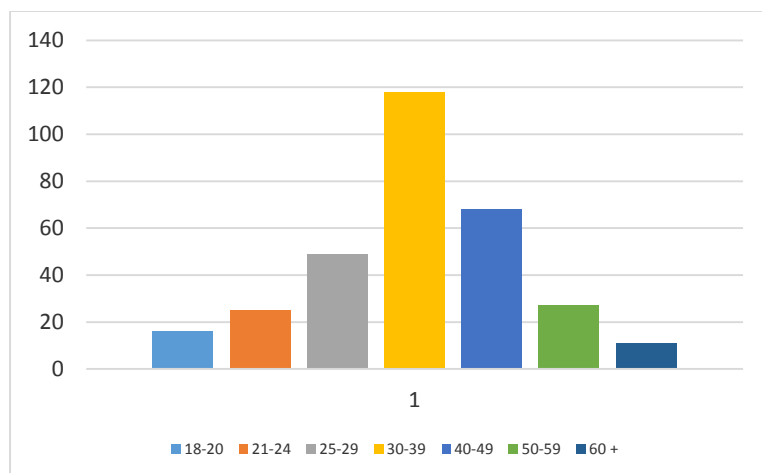


Figure 3 Age Distribution December 2014



1.3 Nationality

Figure 4 Population by Nationality

Population by Nationality	30 Jun 2013	30 Jun 2014	31 Dec 2014
Not Recorded	*	0	0
Foreign National	*	43	23
UK National	231	270	291
All	283	313	314

In December 2014, 93% (n=291) of prisoners were UK Nationals. The remaining 7% (n=23) were foreign nationals, which is a slight reduction from June 2014. This is lower than the current national prison average of 13%⁹.

1.4 Ethnicity

Figure 5 Population by Ethnicity

Population by Ethnicity	30 Jun 2013	30 Jun 2014	31 Dec 2014
Unrecorded	*	*	*
Asian or Asian British	15	16	18
Chinese or Other	*	8	*
Black or Black British	33	33	28
Mixed	18	18	17
Not Stated	0	*	*
White	207	232	244
All	283	313	314

On 31st December 2014, approximately 78% (n=244) of prisoners at HMP & YOI Drake Hall were white. 9% (n=28) were of black or black British ethnicity, 6% (n=18) were of Asian or Asian British ethnicity and 5% (n=17) of mixed ethnicity.

In June 2013, approximately 73% of the population were white, 11.66% black or black British, and 5.3% Asian or Asian British.

1.5 Length & Type of Sentence

Figure 6 Population by Sentence Length

Population by Sentence Length	30 Jun 2013	30 Jun 2014	31 Dec 2014
Less than or equal to 6 months	*	0	8
More than 6 months to 12 Months	*	7	8
More than 12 months to 4 years	79	84	94

⁹ Ministry of Justice Statistics at <https://www.gov.uk/government/publications/offender-management-statistics-quarterly>
 Accessed 03.01.15

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More than 4 years to less than life	158	187	169
Indeterminate	19	21	21
Recalls	13	14	13
All	278	313	313

In December 2014, the majority (54%) of prisoners at HMP & YOI Drake Hall were serving sentences of more than four years to less than life. 30% were serving more than 12 months to four years, 7% were serving indeterminate sentences, 4% were license recalls and 5% were serving sentences of 12 months or less. This is similar in profile to June 2013.

Figure 7 Population by Sentence Type

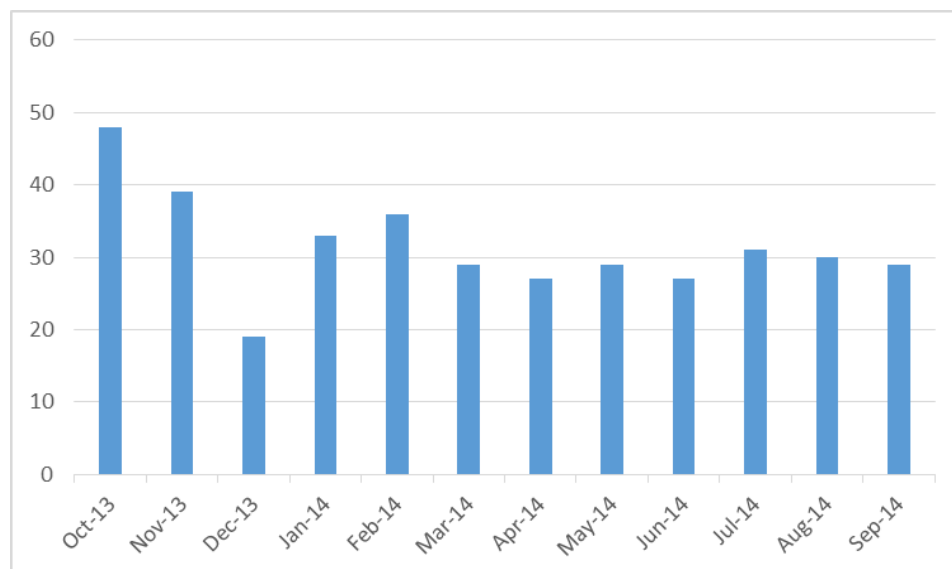
Population by Sentence Type	30 Jun 2013	30 Jun 2014	31 Dec 2014
Remand	*	0	0
Sentenced	280	313	314
Non-criminal	*	0	0
All	283	313	314

HMP & YOI Drake Hall is a training prison and therefore all prisoners are sentenced.

1.6 Movements In & Out of Prison

In the 12 months from October 2013 to September 2014, there was a total of 377 receptions to HMP & YOI Drake Hall. The number of receptions per month ranged from 19 in December 2013 to 48 in October 2013, with a mean average of 31.41 receptions per month.

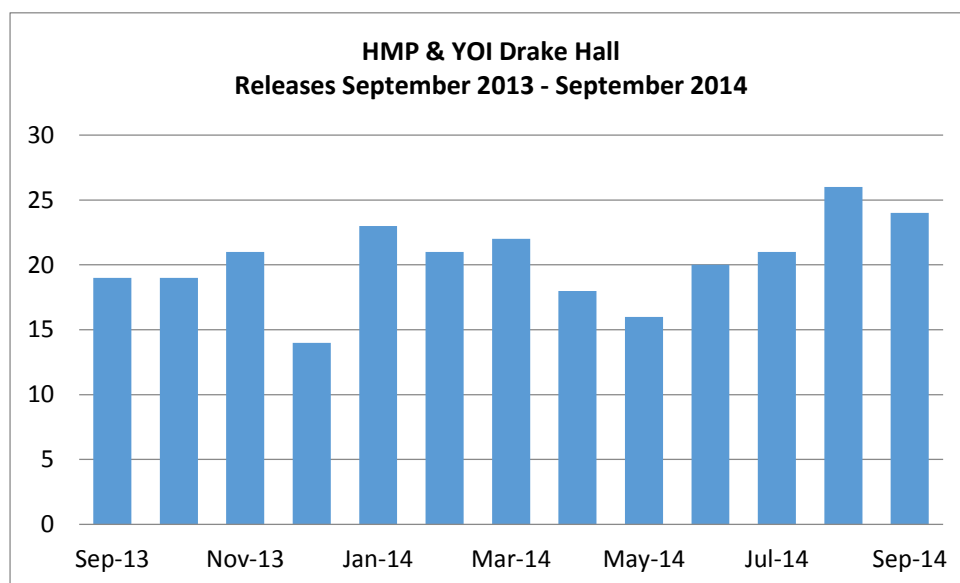
Figure 8 Receptions October 1st 2013 - September 30th 2014



There were a total of 264 releases in the year, an average of 22 per month, and approximately 8 women per month transferred to other establishments.

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Figure 9 Releases October 1st 2013 to September 30th 2014



Within the Ministry of Justice/National Offender Management Services ‘Transforming Rehabilitation’ programme, all womens prisons, including HMP & YOI Drake Hall have been designated a resettlement prison. Resettlement prisons will hold a population where a maximum 40% of prisoners will be within 3 months of release and 80% of prisoners will be released back into a designated resettlement area.

This has implications on screening and assessment of prisoners, and for discharge planning and preparation for release, including liaison with through the gate providers and Community Rehabilitation Companies.

From a public health perspective, resettlement establishments must ensure opportunities are taken to maximise uptake in vaccination and national screening programmes, to foster engagement in monitoring and review of long term conditions, and to increase opportunities to encourage healthy lifestyle choices through health education and promotion and promotion of engagement with community services upon release.

2014 Public Health Profiles¹⁰ suggest:-

The health of people in Stafford is varied compared with the England average. Deprivation is lower than average and life expectancy for both men and women is higher than the England average (7.7 years lower for men in the most deprived areas of Stafford than in the least deprived areas). The rate of alcohol related harm hospital stays is worse than the average for England (956 stays per year), as is the rate of self-harm hospital stays (278 per year). The rate of smoking related deaths is better than the average for England. Estimated levels of adult excess weight are worse than the England average and in 2012, 21.4% of the adult population were classified as obese. Rates of sexually transmitted infections and TB are better than average. The rate of new cases of malignant melanoma is worse than average. Rates of statutory homelessness, violent crime, long term

¹⁰ Public health profiles at <http://www.apho.org.uk/resource> Accessed 14.01.15

unemployment, drug misuse, early deaths from cardiovascular diseases and early deaths from cancer are better than average.

1.7 Recommendations - Population & Demographics

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

- The creation of a strategic hub between HMPs Styal, Foston Hall and Drake Hall provides an opportunity for enhanced liaison between healthcare providers to develop shared care pathways, streamline sharing of healthcare information, and promote efficiencies in the transfer process to support continuity of care.
- As only approximately 5% of the population are serving sentences of less than 12 months, there is an excellent opportunity to foster engagement with healthcare services, promote personal responsibility for health, and develop a culture that seeks to consistently support and prepare women for discharge and resettlement throughout their term of imprisonment.
- As HMP & YOI Drake Hall is a designated resettlement prison, healthcare providers will need to build links with community providers and with Community Rehabilitation Companies to support 'through the gate initiatives' and continuity of care on resettlement.

1. Overview of Health Services Provided

At HMP & YOI Drake Hall 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 on site nursing presence:-

From 07.45hrs to 19:00hrs Monday to Thursday

From 07.45hrs to 17.30hrs on Friday

From 08.30hrs to 17.30hrs on Saturdays, Sundays and Bank Holidays

The nursing team provide an immediate emergency response for incidents occurring within the prison that require attendance from a healthcare professional.

GP services are provided by Crown Surgery, Eccleshall and clinics are held each weekday morning.

Out of Hours GP services are provided by Badger, a local social enterprise Out of Hours provider.

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

The Drug and Alcohol services (DARS) is provided by Lifeline & Delphi Medical.

Mental Health In-Reach services are delivered by South Staffordshire & Shropshire Healthcare NHS Foundation Trust.

A number of regular primary healthcare clinics are held. Physiotherapy and dental services are provided by SSOTP, and optician/ophthalmology services are contracted to a local provider.

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

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.

3. Facilities & Resources

3.1 Staff Resources

- GP services are provided by Crown Surgery, Eccleshall
- Out of Hours GP services are provided by Badger, a local GP Out of Hours service
- Primary Care Nursing services are provided by Staffordshire and Stoke on Trent Partnership NHS Trust
- Secondary Mental Health Services are provided by South Staffordshire & Shropshire NHS Trust
- Dental provision is provided by Staffordshire and Stoke on Trent Partnership NHS Trust
- Optician services are provided by a local Optometrist, Eccleshall
- Physiotherapy is provided by South Staffordshire & Shropshire NHS Trust
- Podiatry services are provided by a contracted independent provider

Primary Care Staff resources are outlined in the table below.

Figure 10 Primary Care Staff Resources

Primary (Physical Health Care) Staff Resources			
Job Title	WTE currently in post	Vacancies	Comments
Head of Healthcare	0.5	0	
Staff Nurse	3.08	1.00	Vacancy recruited, awaiting clearance
Senior Staff Nurse	1.00	0	Dual qualified RGN /RMN
HCA	0.9	0.7	Vacancy to be re-advertised
Primary Mental Health Services Staff Resources			
Team Leader	1.00		
Staff Nurse	1.00		
Administration Staff Resources			
Clinic Co-ordinator (Band 4)	1.00		
Administrator (Band 2)	0.5		

Healthcare staff, patients and prison colleagues commented upon recent problems with staffing levels and the use of agency staff who are not as familiar with the prison and delivering healthcare within a secure establishment. This is further discussed in the stakeholder feedback section (Section 16 of this report).

Although services are very efficiently managed and co-ordinated, the current staffing levels are not able to facilitate required attendance at prison and MDT meetings, and concerns were expressed that it could be difficult responding to incidents in the prison on occasions when there are few staff on duty. In addition it has been suggested that the In Reach threshold is perhaps lower than it could be if there was additional primary mental health resource.

A review of primary care staffing levels and skill mix may be beneficial, with consideration of how health care assistants and associate practitioners could compliment qualified nursing staff to provide the optimal staffing structure.

3.2 Facilities

In comparison to many other prisons, HMP/YOI Drake Hall has improved Healthcare facilities. Asset Investment Project Funding Bids have been submitted for Healthcare refurbishments/improvements in November 2014 for financial year 2015-16. Women queuing outside for medicines administration is unacceptable, particularly in inclement weather conditions and a solution to this should be sought.

The table below details the healthcare facilities.

Figure 11 Healthcare Centre Facilities

Healthcare Centre Facilities		
	No. of rooms	Comments
Reception area/reception office	1	Small but comfortable and safe, offering privacy (located in main reception area)
Staff offices/work areas	4	Manager's office (located in healthcare porta cabin) - comfortable size with access to SystmOne and HMP computer and printer. Nurses office - large with access to two SystmOne computers and printer Administration office - small in size with access to SystmOne and HMP computer Team Leaders office - comfortable size with access to SystmOne and HMP computer
Consulting rooms	3	All rooms are large in size with access to SystmOne computer and have an examination couch
Patient waiting rooms/areas	1	Medium sized waiting area with health promotion material displayed
Patient toilet facilities	0	No patient toilet facilities - asset Investment bid submitted for financial year 2015-16 for building of patient toilet facilities and sluice room
Dental Suite	1	Medium sized dental suite with access to System 1 computer and decontamination room No extractor fan is fitted - Asset Investment bid submitted for financial year 2015-16 for fitting of air extractor fan
Pharmacy	0	No Pharmacy on site
Medicine administration areas	1	Large medicine administration room with two dispensing hatches Access to two SystmOne computers and printer
Other	1	Large conservatory used for group work

3.3 Recommendations: Facilities & Resources

- A review of primary care staffing levels and skill mix may be beneficial, with consideration of how health care assistants and associate practitioners could compliment qualified nursing staff to provide the optimal staffing structure.
- A solution should be sought as soon as possible to women waiting outside to queue for medicines.

4. Screening

4.1 Reception screening

All new receptions received into HMP & YOI Drake Hall have a comprehensive transfer health screen. The screening template is linked to QOF Read codes and prompts Long Term Conditions Reviews, referral to national screening programmes, and referrals to other healthcare professionals and clinics where appropriate.

The screening assessment comprises:

- Baseline observations (Height, Weight, BMI, Blood pressure, pulse, urinalysis)
- Identification of disability
- Opportunity for referral to optician for sight problems
- Opportunity for referral to dentist
- Full medical history, cardiac history, and family history. Prompt for referral to CVD clinic
- Long term conditions review and prompt for referral to appropriate LTC clinic for review
- Identification of any currently prescribed medications and plans for continuity
- Allergy status
- Vitamins herbal supplements and other medicines
- In possession risk assessment
- Prompt for Medicine Use Review
- Full vaccination history (Hepatitis B, MMR, Meningitis, Influenza, Pneumococcal, Tetanus, DIPHTHERIA, Hepatitis C)
- Sexual health Screening. Prompt for referral to GUM / Sexual Health Clinic if required
- Chlamydia screening offered (25years and under)
- Hepatitis C, HIV screening offered
- Womens health screen – menstrual history, gynaecology and pregnancy
- Prompts for breast screening for women aged over 50years
- Prompts HPV vaccination (women aged 18years)
- Mental health assessment
- Prompts to refer to PMH or In reach team and complete TAG assessment as appropriate
- Identification of any immediate physical, mental health or substance use health concerns (observed, assessed or self -reported) or injuries
- Self- harm history, exploration of any intent to self- harm, prompt for consideration of opening ACCT (Assessment Care Custody & Teamwork Document)
- Substance misuse assessment and referral to DARS as appropriate
- Identification of any outstanding doctors /hospital appointments, ongoing treatment and plans for continuity of care
- Identification of any currently prescribed medications and plans for continuity
- First Night risk assessments completed
- Any immediate actions or referrals required identified
- Consent for information sharing obtained
- Information leaflet regarding healthcare services provided
- TB screening questions and follow up /referral to GP if indicated

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- Vaccination history (childhood vaccinations, MMR, Meningitis C, Tetanus, Diphtheria, Hepatitis A, Hepatitis B, Influenza)
- Sexual health and Blood Borne Virus history and offer of screening /referral if required
- Lifestyle questions regarding smoking and exercise
- Information about health promotion and health champion initiative
- Offer of smoking cessation support
- A continuity of care check is prompted to ensure any pending operations or treatments are transferred and managed appropriately
- Carer responsibilities identified and prompt for any safeguarding considerations.
- Consent to share information
- Assessment for fitness to work and reside on normal location, cell sharing risk assessment.

4.2 National Screening Programmes

4.2.1 Cervical Screening

At the time of conducting the HNA, 93.8% of the eligible population had received cervical screening in the previous 5 years.

4.2.2 Breast Screening

The NHS Breast Screening Programme (NHSBSP) is a rolling national programme that provides free breast screening mammograms every three years for all women aged 50 and over up until the age of 70 years. The NHS Breast Screening Programme has lowered mortality rates from breast cancer in the 55-69 age group¹¹.

At HMP & YOI Drake Hall women attend the local hospital for breast screening appointments. During 2014 SystemOne reports indicate that 155 women would have been within the eligibility age range. However, without trawling individual patient records it has not been possible to identify what percentage of those eligible had attended for screening.

4.2.3 Bowel Cancer Screening

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

At the time of the HNA During 2014 there were 11 women eligible, and during the whole of 2014 there had been 25 women who would have been eligible. Bowel cancer screening is not currently routinely offered to those eligible at HMP & YOI Drake Hall and a recommendation has been made regarding this.

4.2.4 CVD Risk Screening

The NHS Health Check (CVD risk screening) is offered to adults aged between 40 – 74 years old without a pre-existing condition. Those eligible are invited by their GP surgery to undergo a health check or 'MOT' every five years. At HMP & YOI Drake Hall at the time of the HNA 106 women fell within the eligible age range, however it was not possible to determine how many of these had pre-

¹¹ Effect of NHS Breast Cancer Screening Programme on Mortality from Breast Cancer in England and Wales, 1990-8: Comparison of Observed with Predicted Mortality. BMJ 2000;665-669 as cited
<http://www.cancerscreening.nhs.uk/breastscreen/screening-programme.html>

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existing conditions. The screening template includes questions regarding cardiovascular history and a prompt to refer to the CVD clinic, however, it was unclear how many women were reviewed as a result of this.

4.3 Recommendations: Screening

Reception screening is very thorough and SystmOne screening templates have been well constructed to incorporate back ground READ codes and prompts for referral to review clinics. However, the opportunity for women to access some national screening programmes is not being maximised.

- A referral process review is required to ensure that all eligible women are afforded the opportunity to take part in national screening programmes.
- With reference to HJIP indicators A01K04 (NHS CVD Screening) and A02K03 (Bowel cancer screening) a SystmOne READ code formulary should be developed incorporating the suggested READ codes for national screening programmes. All offers of screening and screening uptake should be appropriately coded to enable accurate reports for screening against national targets to be generated.

5. Primary Care Clinics

Access to primary care clinics is via health application form or by dropping into the healthcare centre to book appointments directly.

The HMIP Inspection undertaken in March 2013 commented 'the appointment request form had no pictures, making it less accessible to prisoners with poor English or literacy'. This has been addressed and all health application forms now have tick boxes and pictures to facilitate understanding and access for those with lower literacy levels.

Upon receipt of applications, a reply slip is completed and returned so that women are aware their application has been received and processed.

As part of the Incentives and Enhanced Privileges Scheme (IEP) women are expected to attend **all** appointments or scheduled activities within the prison, and if they do not attend a warnings and sanctions system is endorsed (with the exception of appointments where a mental health issues or deterioration may have contributed towards non-attendance). It appears that this is highly effective as the DNA rates within this prison are much lower than those of all others within the cluster, and it is recommended that this approach is shared for consideration and discussion with other HMPS and healthcare providers across the cluster.

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5.1 GP Clinics

Figure 12 GP Clinics October 2013 to September 2014

GP Clinics	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Number of contracted sessions per month	25	22	21	23	20	23	19	21	21	24	22	24
Number of sessions cancelled/not delivered this month	0	0	0	0	0	0	0	0	0	0	0	0
Average time from application to first appointment (Number of days) NEW REFERRALS	<1	<1	<1	<1	<1	<1	<1	<1	<1	<1	<1	<1
Total number of patients seen	338	270	260	297	238	270	225	261	281	313	275	292
Number of DNA's	9	4	14	11	17	27	30	24	25	19	15	17
% of DNA's	3%	1%	5%	4%	7%	9%	12%	8%	8%	6%	5%	6%
Number of patients on the waiting list on the last day of the month	7	-	3	1	7	8	2	0	10	1	0	1

A total of 3,320 patients were seen during the year, an average of 277 appointments per month. Previous HMIP inspections had commented on women not having access to female GPs if required. Two female GPs provide regular surgeries and women are able to request to see a female GP should they wish to do so, although it was commented upon by both staff and patients that an additional female GP session would be beneficial.

Waiting times are reported on the performance dashboard (see above) as very low. Emergencies are seen on the same or next working day. At the time of the HNA visit there was a 5 day wait for the next available routine appointment. There is a waiting list for the female GP sessions and it was felt that an additional female session would be advantageous.

Information from the Performance dashboard for the same 12 months shows DNA rates of between 1% and 12%, with a total of 212 appointments being lost to non-attendance during the year. This compares favourably to DNA rates across most other prisons in the cluster, and to unpublished data regarding DNA rates in other female prisons.

The Out Of Hours service provision is through Badger.

5.2 Nurse Clinics

- Applications to see a nurse are made via the health application system.
- There are daily triage and discharge clinics and reviews of women reporting sick for work or education.
- There are weekly venepuncture and vaccination clinics.
- There is a named nurse for asthma, diabetes and over 50's clinics.
- In addition an emergency response service is provided for incidents within the prison.
- Nurses attend CSU to complete algorithms where required and contribute to ACCT and Good Order & Discipline Reviews.

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5.3 Physiotherapy

Figure 13 Physiotherapy clinics October 2013 to September 2014

Physiotherapy	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Number of contracted sessions per month	5	5	4	5	3	5	4	3	4	4	4	4
Number of sessions cancelled / not delivered this month	0	0	0	0	0	0	0	0	0	0	0	1
Average time from application to first appointment (Number of days) NEW REFERRALS	18	27	22	23	25	22	23	20	33	21	32	19
Number of new patients seen within 5 weeks of referral	10	14	9	11	20	22	4	9	5	4	40	43
% of patients seen within 5 weeks of referral	18%	47%	28%	26%	69%	61%	14%	32%	14%	10%	100%	100%
Total number of patients seen	56	30	32	43	29	36	28	28	36	41	40	43
Number of DNA's	0	2	2	1	2	1	0	1	3	0	1	2
% of DNA's	0%	6%	6%	2%	6%	3%	0%	3%	8%	0%	2%	4%
Number of patients on the waiting list on the last day of the month	10	13	7	17	20	12	13	14	12	12	10	8

The physiotherapist is contracted to provide one session per week.

442 patients were seen between October 2013 and September 2014 (new referrals and follow ups), giving a mean average of 36.8 patients per month.

DNA rates were again very low and ranged from 0 – 6%.

Waiting times ranged from 18 – 33 days, although according to the performance dashboard the percentage of patients seen within the 5 week referral target time varies greatly from 10 – 100%. However, it is noted that when reporting on small numbers this is not a reliable indicator, and the numbers of patients on the waiting list indicate that demand is met and appears to be managed well.

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 patients called up to appointments and actual attendance numbers in order to report against future HJIP indicators A09K05.

The physiotherapist employs a multi-disciplinary approach to care and liaises closely with GPs, pharmacist, nursing staff and prison Physical Education Officers (PEO's).

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

The physiotherapist links with the pharmacist and nursing staff to review and assess compliance with medications and links with MSK symptomology.

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Consultations and treatment plans are recorded on SystmOne and READ coded to enable clinical reporting and audit.

The service offered is comprehensive and in many ways exceeds community services with regard to access to care, multi-disciplinary working and care continuity.

5.4 Optician

Optician services are provided by a local contracted provider, who is contracted to provide one session per fortnight.

Figure 14 Optician Sessions October 2013 to September 2014

Optician	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Number of contracted sessions per month	2	2	2	2	3	2	2	2	2	3	1	2
Number of sessions cancelled / not delivered this month	0	0	0	0	0	1	0	0	0	0	0	0
Average time from application to first appointment (Number of days) NEW REFERRALS	77	66	69	69	69	38	22	56	49	64	51	27
Number of new patients seen within 6 weeks of referral	0	0	0	0	1	2	3	4	2	2	11	25
% of patients seen within 6 weeks of referral	0%	0%	0%	0%	8%	13%	23%	31%	20%	8%	85%	100%
Total number of patients seen	19	17	15	10	12	16	13	13	10	25	13	25
Number of DNA's	1	4	5	0	3	0	0	0	1	1	0	5
% of DNA's	5%	19%	25%	0%	20%	0%	0%	0%	9%	4%	0%	17%
Number of patients on the waiting list on the last day of the month	45	33	28	44	37	38	37	34	41	23	17	26

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

For the period reviewed (October 2013-September 2014), waiting time for routine care ranged from 22 - 77 days. There is no data for comparison in the previous HNA, however, waiting time to see the optician was raised as a concern in the March 2013 HMIP inspection.

Waiting times appear to have improved over the year but remain extremely variable.

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Over the 12 months reviewed, on average less than a quarter (24%) of women saw the optician within the 6 week target date.

In October 2013 women were waiting an average of 11 weeks to see the optician. In September 2014 this had reduced to approximately 4 weeks. At the time of the HNA site visit (21st January 2015) the waiting time was 45 days.

DNA rates ranged from 0-5%.

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 patients called up to appointments and actual attendance numbers in order to report against future HJIP indicators A13K10 – A13K12.

The optician service does not appear to meet current *demand*. Waiting times remain in excess of target and further data is required to separate demand from actual need. Recommendations have been made regarding this.

5.5 Podiatry

Podiatry services are provided by a local podiatrist.

Figure 15 Podiatry October 2013 to September 2014

Podiatrist	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Number of contracted sessions per month	1	1	1	0	1	1	0	1	1	1	2	1
Number of sessions cancelled / not delivered this month	0	0	0	0	0	0	0	0	0	0	0	0
Average time from application to first appointment (Number of days) NEW REFERRALS	41	37	19	50	67	67	99	81	90	95	57	62
Number of new patients seen within 5 weeks of referral	0	No data	No data	No data	6	7	0	0	0	0	0	0
% of patients seen within 5 weeks of referral	0%	0%	0%	No data	46%	70%	0%	0%	0%	0%	0%	0%
Total number of patients seen	13	12	10	0	13	10	0	10	10	10	30	10
Number of DNA's	0	1	2	0	0	1	0	2	2	0	3	0
% of DNA's	No data	8%	17%	No data	0%	9%	0%	17%	17%	0%	9%	0%
Number of patients on the waiting list on the last day of the month	13	20	30	30	39	37	44	46	50	32	32	8

The Podiatrist provides one session per month.

From October 2013 to September 2014, a total of 128 patients were seen.

Waiting time for routine care ranged from 19 -99 days.

DNA rates ranged from 0- 17% with 11 DNAs in the 12 month period.

5.6 Dentist

Figure 16 Dental Clinics October 2013 to September 2014

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Dentist	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Number of contracted sessions per month	9	6	8	7	7	9	7	5	9	8	5	9
Number of sessions cancelled / not delivered this month	0	0	0	1	0	0	0	0	0	0	0	0
Average time from application to first appointment (Number of days) NEW REFERRALS	22	32	43	50	51	49	46	48	39	41	58	71
Total number of patients seen	69	58	65	66	55	75	58	49	81	72	48	83
Number of DNA's	4	5	13	8	10	7	9	10	7	5	5	1
% of DNA's	5%	8%	17%	11%	15%	9%	13%	17%	8%	6%	9%	1%
Number of patients on the waiting list on the last day of the month	43	43	36	43	46	56	61	30	41	36	44	39

In 'Strategy for Modernising Dental Services for Prisoners in England'¹², 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.

For the period reviewed (October 2013-September 2014) the dentist delivered 779 appointments (mean average of 65 appointments per month) and waiting times for routine care ranged from 22 – 71 days, therefore during the 12 months analysed for eight months out of the twelve reported waiting times were above the target 6 weeks. However this has improved and waiting time at the time of the HNA was 39 days.

DNA rates ranged from 2-17% with 91 appointments not attended in the 12 month period analysed (Average monthly DNA rate 14.6%)

There is a separate health application form for the dentist which requests further details regarding the reason for the dental application and enables triaging of the dental waiting list.

5.7 Recommendations: Clinics

- The introduction of female GP sessions since the last HMIP inspection is very positive, however, requests to see a female GP are high and an additional female session per month would be advantageous.
- Providers and commissioners may wish to consider routinely capturing the number of appointments per opticians, physiotherapy clinic session, women called up to appointments and actual attendance numbers for future reporting against HJIP indicators A13K10 – A13K12 and A09K05.
- The highly effective joint prison and healthcare provider approach to management of DNA should be shared for consideration and discussion with other HMPS and healthcare providers across the cluster.

¹² Department of Health (2003), Strategy for Modernising Dental Services for Prisoners in England 2003, HMSO, London

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- Over the 12 months reviewed, on average less than a quarter (24%) of women saw the optician within the 6 week target date. A review of patients accessing the service should be undertaken to separate need from demand
- Training of nurses to undertake ocular triage (supported by ocular triage protocols) may assist in management of the optician waiting list.

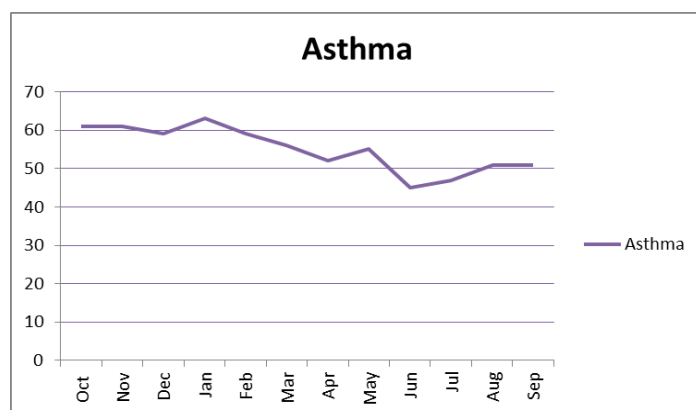
6. Prevalence of Physical Disease and Conditions

There is limited published UK data pertaining to the prevalence of non-communicable disease and physical illness amongst prisoner populations. This is summarised in Report 1 of this regional series.

A 2008 survey¹³ found that 25% of all newly sentenced prisoners had either a long-standing physical disorder or disability, however this is across all age groups and not specific to women. Accurate prevalence data pertaining to prison populations is still in the process of being developed, and it is anticipated that the newly introduced Health & Justice Indicators of Performance will help to support this aim and enable comparisons across segments of the prison population.

6.1 Asthma / COPD

Figure 17 Asthma: October 2013 – September 2014



Over the 12 month period October 2013-September 2014, the number of women on the asthma register ranged from 45 – 63.

The actual prevalence of treated asthma (16.24% from SystmOne data) is much higher than national prevalence of 5.9%¹⁴, and also higher than prevalence estimates for treated asthma in the Birmingham toolkit (7%). It is reported in the last HNA (2013) that in 2009 Asthma prevalence at HMPYOI Drake Hall was 17%, and rose to 26% in 2010. Although fluctuating, presentations are consistently higher than national averages.

The SystmOne QOF 'How Am I Driving' report indicates that at the time of undertaking this HNA there were 32 patients on the asthma register. Of these, it is evidenced that 29 (91%) have had an asthma review (including reversibility testing) within the last 12 months.

¹³ Stewart, D, The problems and needs of newly sentenced prisoners: results from a national survey, Ministry of Justice 2008

¹⁴ Asthma prevalence by CCG area
<http://fingertips.phe.org.uk/search/ASTHMA#gid//pat/44/ati/19/page/0/par/E4000002/area>

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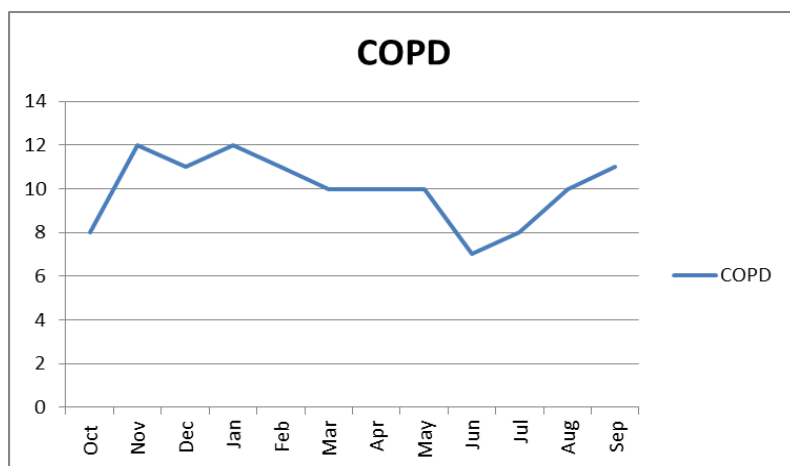
The QOF asthma register excludes patients who have not been prescribed asthma-related drugs in the previous twelve months, and therefore the reported prevalence is of treated asthma.

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

Factors such as under diagnosis and reporting diligence are not taken into consideration. In addition, it has been suggested that registers should be treated with caution in the first few years of reporting as they are still being established and validated, and that apparent increases in prevalence may be due to improvement in recording and case finding, rather than a true increase in the prevalence in the population¹⁵.

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.

Figure 18 COPD: October 2013 - September 2014



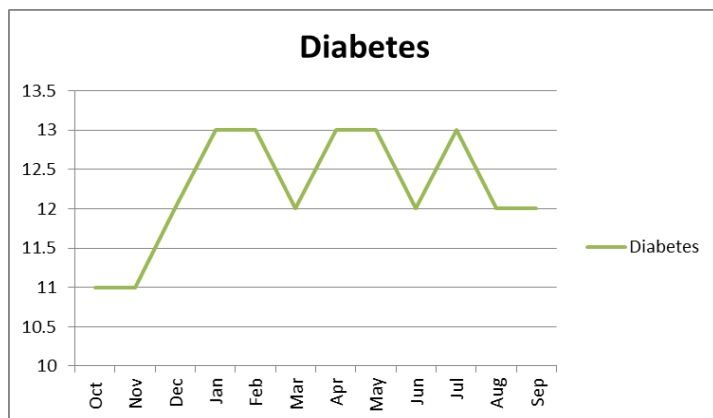
Over the 12 month period October 2013-September 2014, the number of women on the COPD register ranged from 7 – 12.

¹⁵ http://www.dhsspsni.gov.uk/index/stats_research/stats-resource/stats-gp-allocation/gp_contract_qof/statistics_and_research-qof-prevalence.htm

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6.2 Diabetes

Figure 19 Diabetes: October 2013 - September 2014



At the time of undertaking the health needs assessment; there were 2 women with type I diabetes and a further 9 women with type II diabetes.

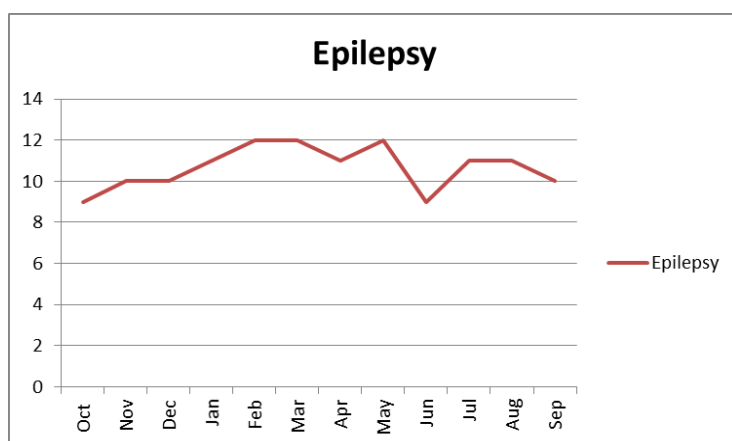
The 2013 HNA indicates that there were 13 women with diabetes in 2010, but does not provide any data for after this date and does not differentiate between type I and type II diabetes.

Of the current 11 patients with diabetes, 9 had recent blood pressure recordings, 7 had Cholesterol and HbA1c levels, 9 had received seasonal influenza vaccine and 6 had received a diabetic foot examination within the last 12 months.

Prevalence of type I diabetes (0.63%) is lower than the 1.1% prevalence for type 1 diabetes in prison provided in the PHE toolkit for HNAs in prescribed places of detention.

6.3 Epilepsy

Figure 20 Epilepsy: October 2013 - September 2014



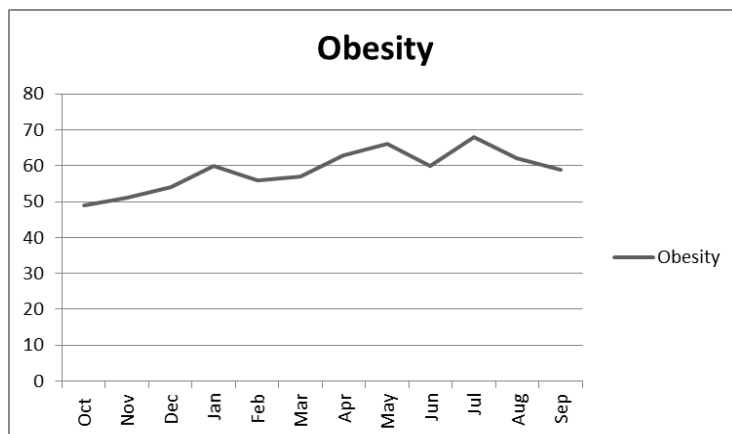
At the time of undertaking the health needs assessment; there were 10 women on the epilepsy register (QOF EP001). Epilepsy is currently reviewed by the GP as required.

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Prevalence of epilepsy (3.18%) is above national general population prevalence¹⁶. In comparison, prevalence in 2010 was similar (3.5%)

6.4 Obesity

Figure 21 Obesity: October 2013 - September 2014



The current prevalence of obesity (18%) is below national prevalence (23%)¹⁷.

In a study of risk factors of non-communicable disease in prisoners by Herbert, Plugge & Foster¹⁸ it was suggested that prisoners are less likely to be obese than the general population, as discussed in report number 1 of this regional series.¹⁹

Long term conditions appear to be well managed. Referral for required reviews is orchestrated from the reception screening assessment. Reflecting the national pattern, Asthma prevalence appears to have reduced over the last 12 months, but it is too early to suggest whether this is likely to be a continuing trend. Prevalence of diabetes and epilepsy remains above national and expected prevalence levels. Recording and management of physical health conditions appears to be evidence based and clearly linked to QOF indicators.

7. Communicable Diseases

7.1 Tuberculosis

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

There have been no cases of active TB at HMP & YOI Drake Hall.

¹⁶ Joint Epilepsy Council, 2005. Epilepsy prevalence, incidence and other statistics. <https://www.epilepsy.org.uk/> Accessed 23.01.15

¹⁷ www.yhpho.org.uk/

¹⁸ Herbert K, Plugge E, Foster C. (2012): Prevalence of risk factors for non-communicable diseases in prison populations worldwide: a systematic review, Lancet 379

¹⁹ Herbert K, Plugge E, Foster C. (2012): Prevalence of risk factors for non-communicable diseases in prison populations worldwide: a systematic review, Lancet 379

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A woman transferred from HMP Styal required follow up screening as part of a PHE/NHSE contact tracing exercise following diagnosis of a patient with TB at HMP Styal following identification. Screening was negative and no further follow up was required.

There have been no infectious / acquired infections.

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

7.2 Hepatitis

The reader is referred to report 1 of this series for review of the burden of disease in prisons.

The most recently published PHE Sentinel Report²⁰ provides the following statistics:-

Number of individuals tested for anti-HCV in UK prisons January to December 2013 N= 4,242

Number of individuals in prisons tested positive for anti HCV N= 400 (9.4%)

Number of individuals tested for HBsAg in prisons January to December 2013 N= 3,477

Number of individuals testing positive to HBsAg in prisons N= 51 (1.5%)

Figure 22 Hepatitis B & C Screening & Vaccination Coverage

	Total Receptions	No. of prisoners declining vaccination	No. Already Vaccinated	No. vaccinated within one month	Total Doses Given	% Vaccine Uptake*	% Declined	% Already Vaccinated	% Vaccine Coverage	Hep C Tests	% Hep C tests performed
HMP & YOI Drake Hall	98	10	64	24	44	100%	29%	65%	90%	10	10%

Based on the most recent available information from PHE, of the 98 women received into HMP & YOI Drake Hall during the period January 2014-March 2014, 64% were already vaccinated against Hepatitis B. There is a high number of women who have already been vaccinated as HMP & YOI Drake Hall does not take remand prisoners, therefore all women are transferred from other prisons and will have been offered vaccination as part of their initial health reception screening

Of the 24 women requiring vaccination, all were vaccinated within 31 days of entering the establishment.

Vaccination coverage was above target at 90%.

10 prisoners were screened for Hepatitis C within 31 days of reception within the quarter reported. Data was not available to indicate how many women tested positive to Hepatitis C.

The Staffordshire Prisons Hepatitis Care Pathway and prisons vaccination policy has been developed in liaison with PHE.

²⁰ PHE Annual report from the sentinel surveillance study of blood borne virus testing in England: data for January to December 2013 Infection reports Vol 8 (29) Published : 25 July 201

8. Sexual Health

A Nurse Led Sexual Health Clinic was held weekly up until the end of 2014, but has now ceased as the sexual health nurse has left.

At the time of writing this report, providers were awaiting a decision from commissioners regarding the commissioning of future service for the prison.

The Offender Management Unit (OMU) at HMP & YOI Drake Hall estimate that at any time, the percentage of women at the prison who are, or who have been sex workers is at least 20%, therefore need for the service is high.

Figure 23 Sexual Health Services October 13 - September 2014

Sexual Health Services	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Number of contracted sessions per month	4	3	1	4	2	-	0	2	1	4	1	3
Number of sessions cancelled / not delivered this month	0	0	0	0	3	-	0	0	0	0	0	0
Average time from application to first appointment (Number of days) NEW REFERRALS	see below		see below	18	9	26	36	38	52	4	6	11
Total number of patients seen	15	14	4	24	2	-	0	16	8	26	4	20
Number of DNA's	0	2	1	2	0	-	0	2	1	4	0	0
% of DNA's	0%	13%	20%	8%	0%	-	-	11%	11%	13%	0%	0%
Number of patients on the waiting list on the last day of the month	0	6	9	3	10	11	11	15	4	3	0	-

133 women were seen in the 12 months from October 2014 to September 2014. The time from first application to first appointment averaged 22.2 days.

Prevalence data was not available for the HNA as the nurse had left employment at the time of writing the report. No prevalence or activity data was reported in the 2013 HNA. A recommendation regarding collection and collation of future prevalence data has been made.

Public Health England report that of the 446,253 new STI diagnoses made in 2013, the most commonly diagnosed STIs (across all genders) were chlamydia (208,755; 47%), genital warts (73,418; 17%), genital herpes (32,279; 7%), and gonorrhoea (29,291; 7%).²¹

All women were signposted to the sexual health services from reception and offered comprehensive screening and support services.

Women could be referred to the specialist nurse by members of the healthcare team or can self-refer through the health application process.

The sexual health nurse undertook screening and assessment including obtaining any swabs, blood samples or other biological samples required.

²¹ Public Health England: Health Protection Report: Weekly Infection report Volume 8 Number 24 published 17 June 2014 at:
www.gov.uk/government/uploads/system/uploads/attachment_data/file/345181/Volume_8_number_24_hpr_2414_AA_stis.pdf

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All women aged 25 and under are offered chlamydia screening. All 18 year old women are offered HPV vaccination.

Pre-test counselling is offered for HIV and blood borne virus screening.

Confidential advice and education is provided and lubricants and dental dams available.

8.1 Recommendations: Sexual Health

- Prevalence data was not available for the HNA due to the sexual health nurse leaving, therefore it is recommended that this is an area of focus when the next HNA/ HNA refresh is undertaken.
- Arrangements should be made for continuance of sexual health services at the prison as soon as possible.

9. Physical Disability

In the last HMIP Inspection of March 2013, the inspectorate commented

‘The prison had identified 12% of the population as having a disability, similar to 15% in our survey’
‘The DLO saw all women who declared a disability and produced care plans, but these were not formally discussed or reviewed with prisoners or health care staff, and some women did not know that they had a plan. Prisoners spoke highly of the support they received from equalities staff ‘.

A question is asked during the screening reception regarding physical disabilities. Healthcare liaise with the Prison Disabilities Liaison Officer and where necessary Personal Emergency Evacuation Plans (PEEPS) are developed. The list of women with PEEPS is updated weekly.

At the time of writing this HNA report there were 14 women (4.45% of population) with PEEPS in place:-

- 3 women had severely impaired sight, with one being registered blind
- 6 had reduced mobility, of whom 5 used either walking sticks or crutches
- 3 had hearing impairment and wore hearing aids
- 2 others had PEEPS for reasons suppressed within the HNA report for confidentiality reasons

There are no fully adapted cells for women with disabilities, but individual adaptations are provided where required (e.g. grab rails, raised seats etc.)

10. Health Promotion and Wellbeing

There was excellent health information in the women’s waiting area in the healthcare centre, with a poster clearly outlining the contribution of healthcare to the establishments visioning for the 9 pathways to reduce re-offending, taken from Breaking The Cycle²² This followed the theme from the prison gate area where the reducing reoffending vision was clearly mapped out on large posters for all visitors to the prison to see. Posters outlined the prisons objectives in supporting women in:-

- Accommodation

²² Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders. Ministry of Justice London 2010

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- Education & Employment
- Mental & Physical Health
- Drugs & Alcohol
- Finance & Debt
- Children & Families
- Abuse & Violence
- Sex Industry Workers
- Attitudes, Thinking & Behaviours

10.1 Health promotion

On the day of the site visit for the HNA, the Annual Health Fair was taking place in the prison gymnasium. The day was well attended and there was a variety of information stalls and interactive activities, including information regarding infection control, sexual health, drug and alcohol services, smoking cessation, general health promotions, education and advice, and information regarding the re-launching of the health trainers scheme.

HMP & YOI Drake Hall have had an established Health Trainer Scheme, however this has recently lost momentum and the Health Trainers Scheme is in the process of being 're-launched' at the prison with women having the opportunity to gain qualifications (Level 2 Royal Society of Public Health & Food & Nutrition. Health Trainers Core Competencies, Birmingham College, City & Guilds Level 3 Certification) whilst providing a peer support and signposting service for health and wellbeing within the establishment.

10.2 Smoking

81% of the population are smokers, which is similar to the percentage of smokers reported in the 2013 HNA (83%).

The QOF 'How Am I Driving?' report indicates that 92.5% of women have been offered support.

10.3 Weight Management

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

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

Advice regarding healthy eating is incorporated in to health promotion campaigns.

The physiotherapist also liaises with the prison physical education department and prescription exercise can be requested where appropriate.

10.4 Exercise

The HMIP inspection report of March 2013 suggests that women prefer to go outside for exercise rather than go to the gym.

20% of women reported that they didn't want to go to the gym at all, whilst 26% visited the gym one or two times a week and 15% visited the gym more than 15 times a week.

In comparison, only 12% of women reported that they didn't want to go outside for exercise whilst 44% reported going outside for exercise more than 5 times each week.

Outdoor exercise clearly remains a topical issue as women in the focus group held during the HNA site visit volunteered (unprompted and in response to a general question) that they would like more outdoor activity. They reported that if they play rounders they are asked to stop and have nowhere to go jogging. Women said they would like more structured exercise areas with exercise stations and instructions.

11. Social Care Needs

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

There are a number of women at HMP & YOI Drake Hall who have social care needs and the prison have a number of trained wheelchair pushers.

Healthcare have been invited to local meetings between the local authority and the prison to discuss meeting the needs of women with social care needs and how this will be facilitated.

Referring back to section 1 of this report about 5% (n=16) of the population are aged between 18 and 20 years old. It is noted that under the Children's Act 1989 and Leaving Care Act 2000, those aged 18–21 years of age (or 24 if in full-time education and/or have a disability) who were previously Looked After will be entitled to 'leaving care services'.

Young people receiving leaving care services have a pathway plan outlining the level of continued engagement which the local authority will have with them and it is essential that these young people are identified so that Adult Services are aware and can cater for those with 'Former Relevant' status.

It is noted that the reception health screen does not ask questions regarding previous 'Looked After' status.

As HMP & YOI Drake Hall is one of the designated resettlement prisons within the region, a recommendation is put forward that healthcare identify those of 'former relevant status' at screening and liaise with colleagues to create a pathway in preparation for discharge and resettlement, ensuring contact is made with the prisoner's personal advisor where appropriate.

The Department of Health 'Children (Leaving Care) Act 2000 Regulations and Guidance'²³ states that 'A holistic health assessment and the maintenance of detailed health records will provide the platform for pathway plans to promote a healthy lifestyle, ensure appropriate use of primary health care services, plan access to specialist health and therapeutics services where necessary and promote leisure interests'.

The guidance emphasises the need to help young people to take responsibility for their own health care and states that 'pathway planning should also pay attention to the need for young people to

²³ Department of Health 'Children (Leaving Care) Act 2000 Regulations and Guidance' at <http://resources.leavingcare.org/uploads/b6c26382befe1023c5ecbf2880bca3c9.pdf> accessed 03.02.15

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have accessible information on healthy living, sexual health and sexuality, and mental health as well as the health, dietary and cultural needs of young people from minority ethnic communities’.

Recommendations are made below regarding discharge and pathway planning.

11.1 Recommendations – Social Care

- A question regarding previous ‘Looked After’ status should be added to the reception screening template to ensure appropriate healthcare contribution to leaving care pathways on release from prison.

12. Mental Health

Research repeatedly shows that there are significant gender differences in the mental health needs of male and female prisoners. Both the Bradley report²⁴ and The Corston Report²⁵ suggest that prisons hold some of the most mentally vulnerable women in society. The box below summarises statistics regarding women and health from the prison reform trust

Figure 24 Prison Reform Trust Statistics - Mental Health of Women Prisoners²⁶

30% of women have had a previous psychiatric admission before they entered prison.

25% of women in prison reported symptoms indicative of psychosis. The rate among the general public is about 4%.

26% of women said they had received treatment for a mental health problem in the year before custody.

57% of female sentenced prisoners have a personality disorder.

49% of women in a Ministry of Justice study were assessed as suffering from anxiety and depression. In the general UK population 19% of women are estimated to be suffering from different types of anxiety and depression.

46% of women prisoners reported having attempted suicide at some point in their lives. This is more than twice the rate of male prisoners (21%) and higher than in the general UK population amongst whom around 6% report having ever attempted suicide.

²⁴ The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system; London, Department of Health April 2009

²⁵ Corston, J, The Corston Report: A review of women with particular vulnerabilities in the Criminal Justice system Home Office London 2007

²⁶ <http://www.prisonreformtrust.org.uk/projectsresearch/mentalhealth> Accessed 07.03.15

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Figure 25 Prevalence of Mental Health Problems in Women Prisoners

	Prevalence Statistics	
	National (England)	Sentenced female Prisoners
Mental health Disorder		
Generalised Anxiety Disorder	3.4%	8%
Depression	1.9%	8%
Functional Psychoses/ psychotic disorders	0.3%	7%
Obsessive compulsive disorder	0.9%	7%
Personality Disorder	Data not recorded	64%

Source: PHE Health Needs Assessment Toolkit for Places of Prescribed Detention 2014 (Part 2)

12.1 Primary Mental Health

Primary Mental Health services are delivered by Staffordshire & Stoke on Trent Partnership Trust, with the staffing compliment as detailed in section 3 of the report (two whole time equivalent nurses).

All women are screened for mental health concerns during the reception screen.

Referrals to the Primary Mental Health Team are made using the TAG (Threshold Assessment Grid) referral form. Referrals are then assessed and prioritised by Primary and Secondary Mental Health teams during weekly meetings and designated a priority rating of urgent (seen within 72hours) , moderate (14 days) or standard (28 days).

The stepped care model is utilised and care plans are flexible and patient led.

Between October 2013 and September 2014, the team assessed 133 new referrals with an average of 11 new referrals seen per month over the year.

The Primary Mental Health caseload averaged 20 women per month.

It is noted that the primary mental health caseload is smaller than the In reach mental health case load.

The team attend ACCT reviews and contribute to ACCT caremaps. Between October 2013 and September 2014 there was a total of 89 ACCT documents opened and Primary Mental Health attended 115 ACCT reviews.

12.2 Prison In Reach Services

Prison In Reach Services are provided by South Staffordshire & Shropshire NHS Foundation Trust who also provide services into HMPs Drake Hall, Dovegate, Featherstone, Stafford, and Stoke Heath & Swinfen Hall.

Provision is provided on a needs led, centrally based 'In-Reach' basis.

The prisons are covered by two sub teams. Team 1 covers Featherstone, Brinsford & Drake Hall. Team 2 covers Stoke Heath, Stafford & Swinfen Hall.

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The table below details the human resources within the team to deliver services into the above prisons (with the exception of HMP Dovegate, which has a separate delivery model in partnership with the incumbent healthcare providers).

Figure 26 Prison In Reach Team Staff Resources

Prison In Reach Team Staff Resources			
Job Title /Grade	WTE currently in post	Vacancies	Comments
Service Manager 8b	1WTE	0	Covers whole service for 7 prisons
Clinical Lead 8a	1WTE	0	Covers 6 prisons above
Team Leader 7	2WTE	0	1 post is a senior S/W and 1 is RMN
OT Band 6	2WTE	0	1 in each team
Social Worker 6	1.8WTE	0	Awaiting start date - 1 for each team
Team secretary 3	0.67WTE	0	Centrally based in Stafford
Medical Secretary 4	1WTE	0	Centrally based in Stafford Recently recruited - commences in post 16 th Feb 2015
RMN Band 5	2WTE	0	
RMN Band 6	5.49WTE	0	
Consultant Psychiatrist sessions	0.79WTE	0	
Speciality Doctor	0.2 WTE	0.2	

Client records are held on the RiO electronic patient record system and also on SystemOne.

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

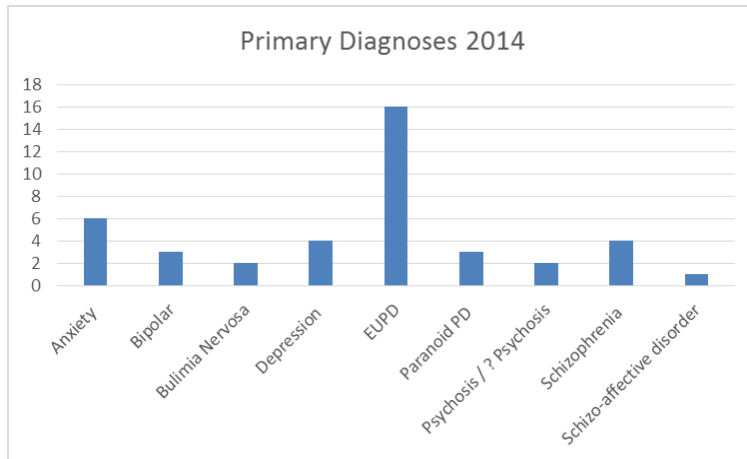
The team transferred to RiO approximately 6 months ago from their previous recording system.

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

At the time of the HNA there were 39 patients on the caseload and a snapshot of the primary and secondary diagnoses is illustrated below.

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Figure 27 In Reach Team Caseload - Primary Diagnoses 2014



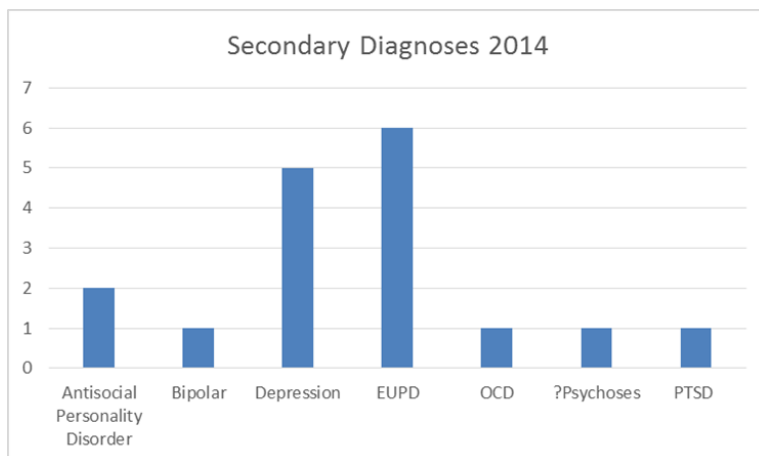
EUPD = Emotionally Unstable Personality Disorder

OCD = Obsessive compulsive disorder

PD = Personality Disorder

PTSD = Post Traumatic Stress Disorder

Figure 28 In Reach Caseload - Secondary Diagnoses 2014



The number of primary diagnoses exceeds the caseload number as a small number of patients have more than one primary diagnosis.

As can be seen from the tables above, personality disorders feature significantly in both primary and secondary diagnoses, and contribute very significantly to the caseload of the In Reach team.

Joint commissioning work has been undertaken between NOMS and the Department of Health to develop a personality disorder pathway to meet the needs of this group of women who sometimes have the most complex needs and vulnerabilities.

The programme is jointly commissioned and managed by NOMS and the Department of Health. Women at all stages of the criminal justice system can have access to the pathway. The Womens Custodial Review has made a number of recommendations regarding Personality Disorder Units, and in the strategic hub of women's prisons in the Midlands, HMP Foston hall has a specialist unit.

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32 (82%) of the 39 patients on the caseload had co-existing substance misuse issues.

The team record consultations on SystmOne to enable sharing of information with primary care colleagues. However, there is no local mental health READ code formulary and the team do not routinely READ code entries onto records.

A template for the recording data required to report Health & Justice Indicators of Performance (HJIPs) has been developed by the Dovegate team and is to be adopted by the In Reach Team with a view to adopting this across all seven of the prisons into which they provide.

The service delivery model is the same across six of the prisons into which the team deliver services, therefore the referral process and management is the same across these prisons.

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

New (routine) referrals are made through the TAG referral system. Unless there is a high level of concern from the outset, referrals are usually made to the Primary Mental Health Team, who undertake an initial mental health assessment and may then refer to the In-Reach Team.

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

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

Referrals accepted by the In Reach Team are discussed at the team MDT meeting and allocated a care coordinator as appropriate.

Urgent referrals are followed up within 2 days. Non-urgent referrals are seen within 35 days.

In the month preceding the HNA (December 2014), 7 patients had been referred to In Reach, all of whom had been accepted.

In December 2014 there were 39 patients on the In Reach Case Load. This equates to 12.4% of the population and is disproportionately high. The In Reach Provider report for January 2015 suggests that the limited primary care mental health nurse capacity appears to be impacting upon the secondary care caseload.

The minimum waiting time for routine referrals in December was 1 day, the maximum waiting time was 6 days and there were 3 patients on the waiting list at the time of the HNA.

Discharge data was not available due to the loss of historic reporting functionality described above, however, the team reported that they rigorously pursue communication with Community Mental Health Teams and CPA Co-Ordinators for all clients who are released from prison whilst on their caseload.

Locally the team have strong links with the Birmingham Discharge Coordinator for Offender Health, Wolverhampton Forensic Liaison, Raeside Community Services and other local Community Mental Health Teams, but will also pursue contacts out of area where required.

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The team stated that they had links with CAMHS regarding women transferring from the juvenile estate. However, in discussion it was acknowledged that a formal transition pathway would be beneficial and would assist continuity of care.

A member of the team attends pre-discharge meetings and Section 117 meetings for those returning to their care.

The team attend ACCT reviews where appropriate, but are not able to attend all ACCT reviews as they are not always present on site at the establishment when ACCT reviews are convened.

It was reported that this has occasionally resulted in frustration expressed by prison colleagues.

A CQUIN (Commissioning for Quality & Innovation) project aimed at increased family & carer involvement is underway and subject to quarterly audit.

Family and carer information packs have been developed and family and carer involvement in care sought and encouraged, but only pursued following express consent being given for this.

Where consent has been obtained, the team reported that family/ carer information provided had contributed positively towards building accurate client histories.

Service user feedback is collected on an ongoing basis. Feedback from service users and stakeholders about the In reach service (reported in Section 16) was exceptionally positive.

12.3 Transfers under Mental Health Act

In 2014 there were a total of 3 patients who were assessed under the provisions of the Mental Health Act 1983.

Of the 3 patients referred only one was accepted for transfer.

Data has been partially suppressed and actual dates are not provided to preserve confidentiality.

The patient accepted for transfer was assessed six days after the referral was made and transferred 5 days after assessment, falling well within the 14 days transfer target.

12.4 Recommendations: Mental Health

- It may be beneficial to monitor the significant resources required to meet the needs of patients with personality disorders in order that the personality disorder pathway can be effectively implemented and evaluated.
- The limited primary care mental health nurse capacity appears to be impacting upon the secondary care caseload. It is recommended that consideration of the advantages and disadvantages of a primary / secondary care model versus an integrated mental health model is undertaken, to determine the best service delivery model for HMP & YOI Drake Hall.

13. Learning Disabilities & Autistic Spectrum Disorders

The identification of patients with learning disabilities is identified as a gap in service provision by the Head of Healthcare, Prison In - Reach Lead and also by NOMs and HMPS colleagues.

The Bradley report suggests 'the proportion of people in prison who have learning difficulties or disabilities that interfere with their ability to cope with the criminal justice system has been estimated at 20 to 30%.'²⁷

NICE²⁸ states that 'A significant proportion of adults with autism across the whole autistic spectrum experience social and economic exclusion' and that 'there is a wide variation in rates of identification and referral for diagnostic assessment, waiting times for diagnosis, models of multi-professional working, assessment criteria and diagnostic practice for adults with features of autism. These factors contribute to delays in reaching a diagnosis and subsequent access to appropriate services'.

The QOF performance report 'How am I driving?' Indicator LD003, for this prison indicates that there are 2 patients with a learning disability. This is a significant under-representation.

A review of 'Autism: recognition, referral, diagnosis and management of adults on the autism spectrum' may provide tools upon which to conduct an analysis of need in this area.²⁹

13.1 Recommendations: Learning Disabilities and Autistic Spectrum Disorders

- The development of Local READ code formularies for both Primary Care & In reach services would improve data capture and collation regarding prevalence of learning disability and autistic spectrum disorders.
- It is recommended that a commissioner led steering group is formed to review current Learning Disability and Autism services and support across the West Midlands Prison Cluster.
- The Steering group should link with any existing multi-agency autism strategy groups to review, develop, implement and evaluate local care pathways.
- It is recommended that funding is identified to develop a regional resource to support further research, identification, signposting and support services for the West Midlands Prisons cluster.
- It is recommended that the regional resource will comprise an appropriate cohort of professionals who are able to develop care pathways for children, young people transferring from children's to adult services, and adults who have learning disabilities, ADHD or Autistic Spectrum Disorders.

²⁷ The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system; London, Department of Health April 2009

²⁸ NICE: 'Autism: recognition, referral, diagnosis and management of adults on the autism spectrum'
NICE Clinical Guideline 142, June 2012 available at www.nice.org.uk

²⁹ Autism: Recognition, referral, diagnosis and management of adults on the autistic spectrum at www.nice.org.uk/guidance/cg142- Accessed 23.01.15

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- It is recommended that the regional resource is commissioned to provide:
 - assessment, treatment and support and referral services for service users whilst in prison
 - education and awareness raising for healthcare staff and HMPS and NOMS colleagues
 - a through the gate service linking to Community Healthcare Teams, third sector agencies, peer support networks and Community Rehabilitation Companies to support resettlement on release

14. Substance Misuse

14.1 Service Delivery Model

An integrated Drug & Alcohol Recovery Service (DARS) is provided through a partnership between Lifeline & Delphi Medical.

Delphi provide clinical substance misuse services (assessment, pharmacological interventions, care planning and treatment) and Lifeline deliver a range of psychosocial support and interventions.

The multi-disciplinary teams are co-located and work together to provide a comprehensive and cohesive service.

40% of reviews are joint clinical and psychosocial reviews. There are bi-weekly psychosocial meetings, bi-weekly clinical meetings and additional bi weekly joint meetings between the two teams.

In addition there are regular operational meetings for the cluster and a Senior Practitioner Focus.

The model encompasses 1:1 and group work, peer led recovery and support, and family work and involvement. It is described as a recovery peer led holistic therapy programme and includes mental health and mindfulness, relaxation and acupuncture and has a focus on long-term recovery.

14.2 Current Need

At the time of the Health Needs Assessment there were 148 women accessing Lifeline psychosocial support and 55 on the Delphi clinical caseload.

Figure 29 Substance Use April 2013-April 2014 (Source: Adult Prisons Quarterly Treatment Report)

New receptions

Number of new receptions (based on healthcare screenings)	414
Number of new receptions beginning drug treatment episodes	214
Percentage of new receptions beginning drug treatment episodes	52%

New Treatment Entrants (individuals)

Total new treatment entrants	228	
Opiate users (OUs) - New treatment entrants		
Taken directly into custody at this prison and starting treatment within 3 weeks	0	0%
Transferred from another prison and starting treatment within 3 weeks	110	92%
Existing prisoners starting new treatment episode after 3 weeks in this prison	10	8%
Total OU new treatment entries	120	
Non Opiate users (Non-OUs) - New treatment entrants		
Taken directly into custody at this prison and starting treatment within 3 weeks	0	0%
Transferred from another prison and starting treatment within 3 weeks	29	73%
Existing prisoners starting new treatment episode after 3 weeks in this prison	11	28%
Total non-OU new treatment entries	40	
Primary Alcohol clients		
Taken directly into custody at this prison and starting treatment within 3 weeks	0	0%
Transferred from another prison and starting treatment within 3 weeks	53	78%
Existing prisoners starting new treatment episode after 3 weeks in this prison	15	22%
Total primary alcohol new treatment entries	68	

From April 2013 to April 2014 there was a total of 414 new receptions of whom 214 (36.7%) began treatment episodes at HMP & YOI Drake Hall.

Of the total 228 new treatment entrants at the prison 52.6% (n=120) were opiate users, 17.5% (n=40) were non-opiate new treatment entrants and 29.8% (n=68) were primary alcohol new treatment entrants.

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In comparison, NDTMS data from the previous year (April 2012- March 2013) reported a total of 107 new treatment entrants, of whom 71% were opiate users, 8% were non opiate users and 21% were primary alcohol client.

This suggests a 113% increase in new treatment entrants, with a decrease in the percentage of service users who were opiate users and a significant increase in non-opiate treatment and primary alcohol new treatment entrants. However, the 2013 HNA comments that 'practitioners at the multi-agency meeting felt that the percentage of prisoners starting a drug treatment episode recorded by NDTMS appeared low and may not be an accurate reflection of activity at the establishment'. This increase may be partially attributable to more accurate data recording rather than to actual fluctuations in numbers.

Of the opiate user treatment entrants 92% (n=78) had been transferred from other prisons and 8% (n=7) commenced treatment after at least three weeks in the prison.

Of the non- opiate user treatment entrants 73% had been transferred from other prisons and 28% commenced treatment after three weeks or more in the prison.

Of the primary alcohol user treatment entrants 78% had been transferred from other prisons and 22% commenced treatment after three weeks or more in the prison.

Over the 12 months reviewed Heroin was reported as the primary main drug by 44% of women (n=131), followed by alcohol (n=93). Crack was reported by 67 women as the most widely used secondary drug.

This is consistent with the previous 2013 HNA, where local performance data indicated that of prisoners in contact with DARs between November 2012 – June 2013 48 % reported heroin as the primary drug of use.

The number of women with a previous history of intravenous drug use at HMP & YOI Drake Hall is consistent with national trends. At HMP & YOI Drake Hall 44% of those for whom injecting status was recorded reporting having previously injected and 2% stating they were injecting at the time of coming into the prison. National NDTMS data³⁰ suggests that of all clients starting treatment in 2013 – 2014 (and where reported) 43% had previously injected.

The 2013 HMP and YOI Drake Hall Drug and Alcohol Needs Assessment comment that 'practitioners at the multi -agency meeting suggested that there was misuse of illicit drugs at the prison including Subutex, cannabis and stimulants, all of which have been found at the establishment. Heroin was believed to be used less commonly and it was felt that use of legal highs and steroids would be unusual'.

³⁰ Statistics for drug treatment in England 2013-14 from the National Drug Treatment Monitoring System (NDTMS)
<http://www.nta.nhs.uk/uploads/drug-treatment-statistical-bulletin-2013-14>

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Interviews with the DARS Lead and DARS Clinical Manager suggested that misuse of Subutex is still an issue, with anecdotal incidences of women placing cling film in their throats in order to catch Subutex tablets and regurgitate them at a later time.

It was stated that there was no evidence of prolific use of Black Mamba, but there had been three cases where women had become unwell and had to be sent to hospital and it was suspected that this may have been the cause.

Although use of mamba is not used to the same extent as within the mens prisons, there is nevertheless a high level of concern that its use will become more prevalent. There have been suggestions that some of the more vulnerable women have allegedly being tricked/bullied into testing mamba for others and being told “you’ve been mamba-d”.

59% of the client group reported being parents.

42% reported having no children living with them prior to coming in to custody, 35% had one or two children living with them and 12% three or four.

4% of the women had five or more children living with them immediately prior to coming in to custody.

The above statistics starkly highlight the need for drug and alcohol services to include families within their recovery work where this is possible, whilst remaining mindful of any safeguarding considerations or restrictions placed upon this through criminal justice processes.

With the consent of clients, DARS actively engage in family work. An example was given of how family work had been very successful in raising the self- esteem of a young woman with very low self- belief.

As is illustrated in the table below, the majority of women (77%) accessing drug and alcohol services at HMP & YOI Drake Hall during the period reviewed were released and referred to Criminal Justice Intervention Teams or other providers. Of this cohort 14 women were referred to community drugs teams for continuance of treatment.

Figure 30 Prison Exit Reason

Prison exit reason for individuals leaving this prison		
Transferred to another prison	18	13%
Released - referred to CJIT and / or treatment provider	111	77%
Released - no onward referral or not recorded	15	10%
Died	0	0%
Absconded	0	0%
Not recorded	0	0%
Total prison exits	144	100%

78 women accessing the service engaged in psychosocial therapy and 60 in structured intervention work.

3 women underwent opioid reduction and 34 were prescribed opioid maintenance regimes.

14.4 Stakeholder Feedback

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Only four questionnaire responses were received from DARS service users. These were from women who attended the service whilst the HNA team were on site. Questionnaires left on site to be completed were not returned.

All four of the respondents who completed the questionnaires were aged between 22 to 39 years old. All had received medication for opiate withdrawal and all four reported having received one to one support from the DARS team, as well as having taken part in group work and clinical and non-clinical reviews.

All four reported having received harm minimisation advice and support.

Comments included 'there is help for drug users if they really want it' and 'good to know that there is someone there to talk to anytime'.

Comments on how the service could be improved were 'the medicine queues' and 'getting help quicker and not to feel you've just been left'.

In interviews with the DARS Lead and Clinical Manager it was reported that space was at a premium and additional office and consulting room space was required to be able to effectively deliver the service.

DARS would like to offer a Drop-In Recovery Café but there is no available space for this.

There are only two clinical rooms with computers with access to SystemOne and it was reported that 'finding a room with SystemOne was like finding gold dust'.

The service has identified gaps in meeting the needs of substance misuse and domestic violence dual issues and feels that although they link with other agencies to address this, further work is required and more creative therapies needed. Group work with creative mood boards and work with a womens theatre group have been well received.

14.5 Recommendations Substance Misuse

- NDTMS data suggests a significant increase in women accessing the service between 2013 and 2014. Although the 2013 HNA suggests 2013 data may not be accurate, monitoring of this is required to ensure resources continue to meet need.
- The service will need to consider ways in which to resource support for the women who will reside in the open house, who may still require psychosocial support prior to resettlement back into the community.
- The service provider and recovery champions should explore innovative ways of developing and delivering a recovery drop in clinic, researching all available options for potential premises and locations.

15. Planned and Unplanned Secondary Care

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

With recent benchmarking exercises and the efficiencies required across all public sector services, it has become essential that this element of healthcare service provision is robustly managed and that

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innovations to reduce hospital escorts and bedwatches are considered, in order to continue to meet healthcare needs.

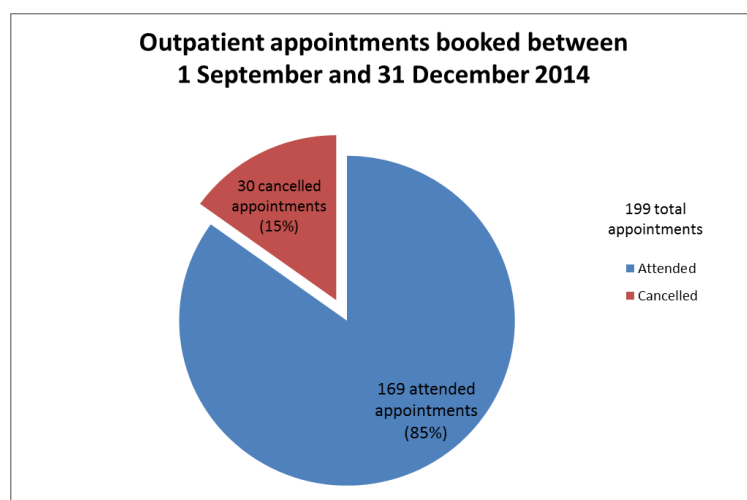
The healthcare department are currently allocated 2 appointment slots per day.

As part of the health needs analysis a detailed analysis of escorts for the four months from 1st September to 31st December 2014 was undertaken.

During this time 199 appointments were made and of these 30 (15%) were postponed or cancelled.

Without accessing each patient’s record individually, which would have been very time consuming it was not possible to determine how many appointments exceeded the 18 week NHS target for referral to appointment time.

Figure 31 Hospital Outpatient Appointments 1st September to 31st December 2014



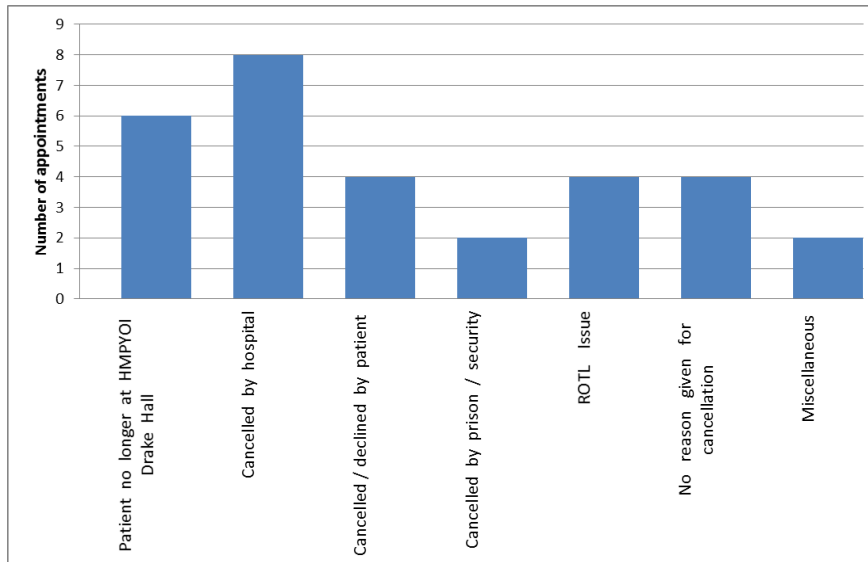
Out of the 199 appointments made, 11.8% (n=20) of patients were released on temporary licence to attend.

Allowing patients to attend hospital appointments under ROTL is good practice as it not only reduces the cost of escorts, but also increases patient ownership and responsibility for their health and from a dignity perspective allows patients to attend appointments in privacy and unaccompanied by prison officers.

Reasons for postponement and cancellation of appointments are illustrated in the table below.

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Figure 32 Reasons for Cancellation and Postponement of Hospital Appointments



The reallocation of appointments is time consuming, costly and frustrating for both providers and prison colleagues. Based on the information above, recommendations have been made that suggest ways in which cancellations and postponements may be reduced.

During this same time period (September –December 2014), there were 4 urgent (two week) referrals (or rapid access appointments) all of which we were informed met the two week referral to appointment time target. It was reported that the prison had been accommodating in providing escorts for these necessary appointments.

An analysis of appointments by speciality was undertaken and is summarised in the table below:-

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Figure 33 Appointments by Speciality

Speciality	No.
Antenatal	1
Breast surgery / breast care	7
Cardiology	1
Colorectal surgery	2
CT scan	4
Day surgery	4
Dermatology	8
EEG	4
ENT	4
Endocrinology	2
Endoscopy	2
Epilepsy clinic	6
Eye Clinic / ophthalmology	2
Gastroenterology	10
General Surgery	1
Gynaecology (including colposcopy x 9)	13
Infectious diseases	1
Medicine	1
MRI	12
Neuclear Medicine	1
Neurology	6
Oncology / chemotherapy	2
Opticians	4
Oral surgery	6
Orthopaedics / Trauma	11
Orthotics	2
Pre-assessment	12
Respiratory	4
Rheumatology	1
Spinal	1
Ultrasound Scan	18
Urology	1
X Ray	21
Appointment details not specified	7

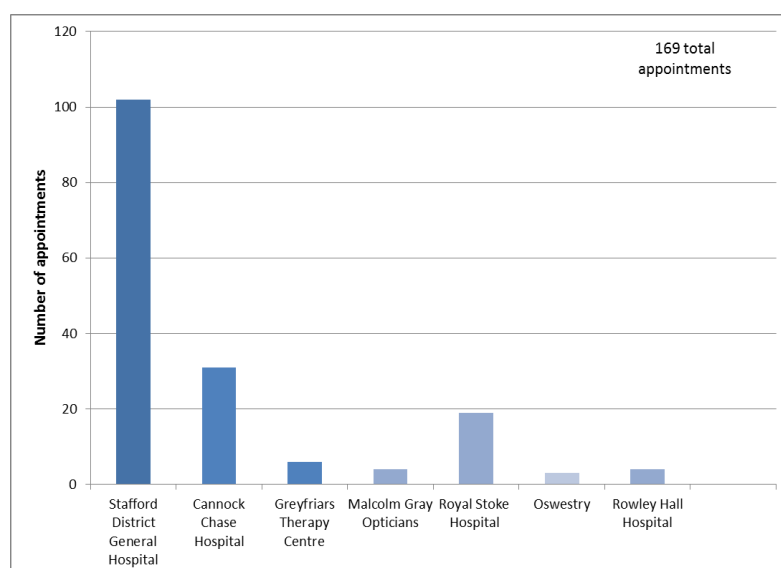
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- The highest number of outpatient appointments were for x ray (n=21), ultrasound scans (n=18) and gynaecology (n=13).
- Outpatient visits to these three most frequently accessed specialities combine to account for approximately 31% of all appointments.
- Based upon data for this four month period, it is estimated that up to 117 x-ray and ultrasound appointments per year could be saved if all of these appointments could be done on site. It is acknowledged that some appointments are urgent and patients would still need to attend hospital.
- 50% of x-ray and ultrasound scan appointments on site would equate to approximately 60 saved appointments per year.
- A mobile diagnostic unit with the capability to provide x-ray and sonography would have a significant impact on the number of escorts to outpatient appointments.
- 12 appointments were for pre- assessment appointments. Liaison with local hospitals to agree a shared care protocol to enable nurses at the prison to undertake pre-operative assessments would negate the need for most patients to go to hospital for this.
- Visiting gynaecology, orthopaedic and breast clinic consultants could further reduce escorts very significantly.

Developing strong links with local hospitals is key to enabling some of the actions required to reduce escorts and bedwatches.

Based upon the sample of escorts analysed, approximately 60% (n=102) went to Stafford District General Hospital, whilst a further 18% (n=31) attended Cannock Chase Hospital and the remaining 22% attended various other local hospitals and clinics.

Figure 34 Location of Hospital and Clinic Appointments



It would be beneficial for the Healthcare Department to develop strong links with Directorate Leads at Stafford District General Hospital and to develop ongoing dialogue to identify and address actions that can be taken to reduce the numbers of hospital escorts and duration of bedwatches.

15.1 Recommendations – Planned and Unplanned Secondary Care

- The potential to arrange visiting consultant appointments for most frequently accessed specialities (gynaecology, orthopaedics and breast clinic) should be explored.
- It is recommended that Commissioners undertake a regional cost benefit analysis for the commissioning of a mobile diagnostic unit (x-ray and ultrasound) to regularly visit HMP & YOI Drake Hall, which has the potential to reduce escorts substantially. This is further discussed in the regional analysis.
- Telemedicine has significantly reduced hospital escorts within the North East Cluster of prisons. It is recommended that Commissioners undertake a regional cost- benefit analysis for the introduction of telemedicine facilities. This is discussed further in the regional analysis. At HMP & YOI Drake Hall this may be specifically considered as an alternative to hospital visits for appointments across a range of specialities.
- A SystmOne template with background READ codes should be used to record all unscheduled hospital visits (escorts and bedwatches) to enable accurate future analysis.
- To reduce appointment cancellations and rescheduling, the SystmOne appointments ledger could be utilised to record external hospital appointments so that when women leave the establishment an automatic alert for any outstanding appointments can be generated.
- All GPs should be encouraged to consider release dates when making initial hospital referrals. Where referrals are none urgent and the expected date of release falls within NHS eighteen week target, and patient is likely to have a registered GP on release, consideration should be given to requesting hospital appointment for a date after release.
- Close liaison with OMU is required to ensure all opportunities to ROTL women for appointments are explored and that appointment cancellations or postponement due to ROTL issues are avoided.

16. Stakeholder Analysis

16.1 Methodology

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

Semi-structured face to face interviews were conducted with the Governor with responsibility for healthcare, Clinical Co-ordinator, In Reach Clinical Lead, Primary Mental Health Lead, and Drug & Alcohol Recovery Services (DARS) team leads. The Head of Healthcare was brand new in post, however, the deputy head of healthcare was very helpful in answering questions and supplying information requested.

A focus group was held with ladies waiting to attend appointments in the healthcare centre and with some of the healthcare champions.

15 service user questionnaires were distributed. A focus group was held and themes from these incorporated into the HNA, along with themes and comments from general field notes made during on-site activities.

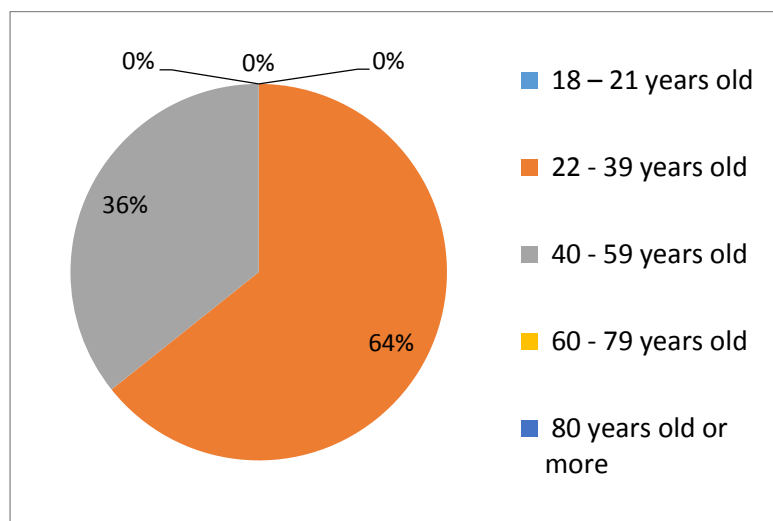
In addition, 6 visitors' questionnaires were completed by visitors visiting women on the day that the site visit took place

16.2 Questionnaires

15 general questionnaires were distributed and 14 returned, giving a response rate of 93%.

General questionnaire results are illustrated in the figures below.

Figure 35 General Questionnaires Age of Respondents



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Figure 36 General Questionnaires Length of Sentence of Respondents

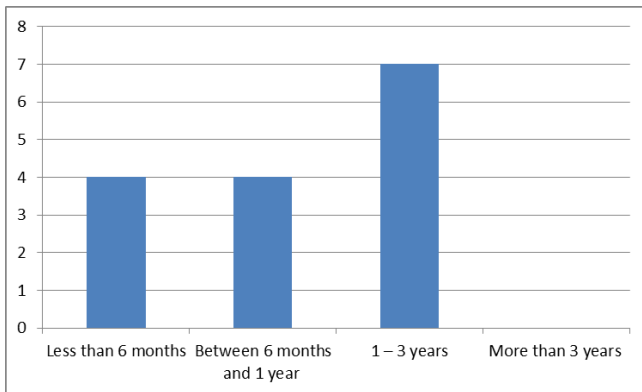


Figure 37 General Questionnaires Perception of Information Provided

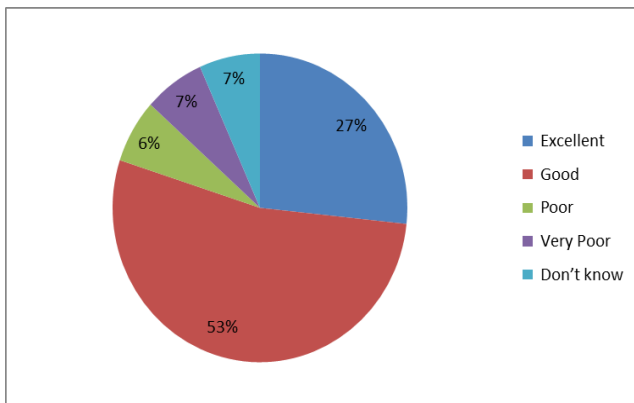
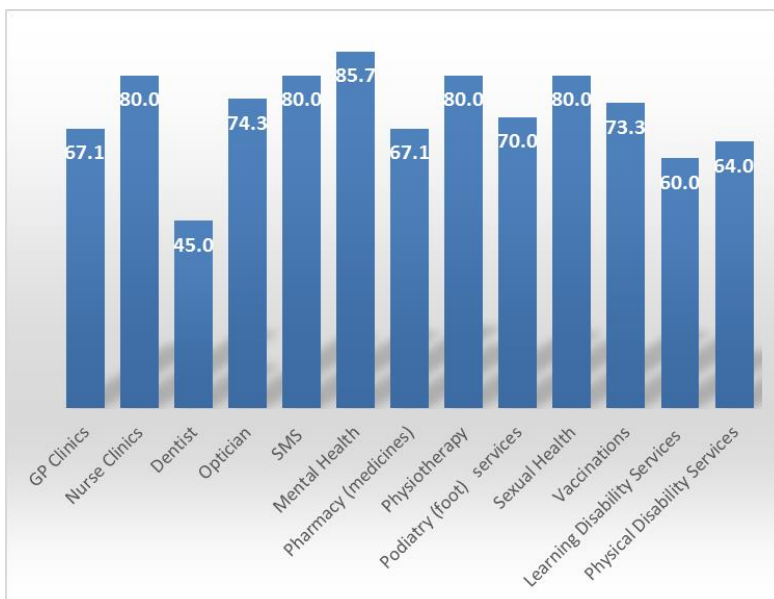


Figure 38 Perception of Quality of Services Delivered



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Figure 39 Comments from General Questionnaires

What are the best things about healthcare services in this prison?	Are there any things about healthcare services that you think could be improved?
Appointments (2 x comments)	The healthcare could be a bit better. All the running around you have to do when you're ill is not very good.
Appointments are regular except the dentist	Appointments could be a bit better – less waiting time
Mental health and DARS are brilliant	Waiting times (2 x comments)
You can have meds in possession on a monthly basis	Medication queue (2 x comments)
Nurse clinics	Medication times
Nurses	The nurses need to have a bit more time for prisoners because when we ask if we can have a word they always say they're busy There's nobody to talk to about mistakes without being out of bounds and you can't speak about it when you go for meds when mistakes are made about repeat prescriptions Attitudes of some staff
Mental health	
You get seen quickly (2 x comments)	
Staff are always helpful	
You do get seen eventually	
Healthcare team and reception staff very helpful	

The majority of respondents (64%) were aged between 22 and 39 years and most respondents were serving between one and three year sentences.

The perception of the quality of information provided about healthcare was better than in other prisons with 80% respondents rating information about services as excellent or good. This was further endorsed by the women in the focus group who were very positive about the information they received about healthcare.

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.

Mental health services were rated very highly and this was supported by textual comments and by feedback from the focus group and prison colleagues. Nurse clinics, sexual health services and Drug & Alcohol Recovery Services were also highly rated. Dental services appear to be viewed less positively.

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16.3 Family & Visitors Feedback

Figure 40 Family & Visitor Questionnaires

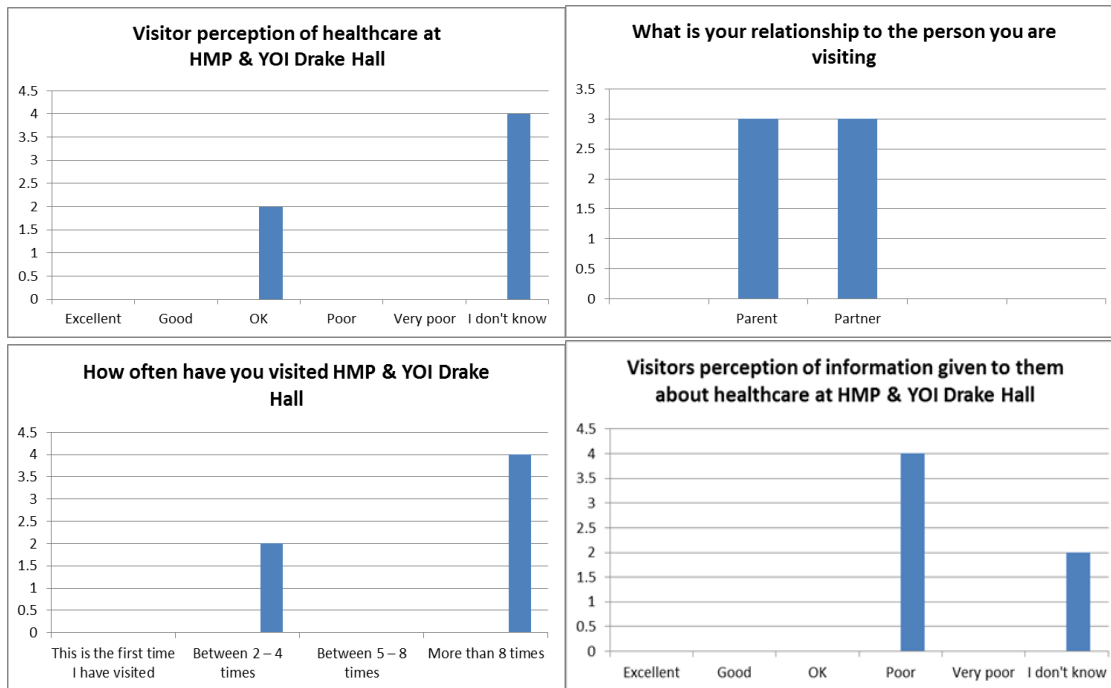


Figure 41 Family & Visitor Comments

Please tell us what health services you think are important to the women at this prison	Are there any other comments you would like to make about healthcare or the health needs of women at this prison?
<p>Women's stuff</p> <p>Weight maintenance</p> <p>Everything (2 x comments)</p> <p>Medicals</p> <p>To see a GP or nurse for general ailments should be quicker than my partner experiences and it can be very important – delays make problems worse</p>	<p>Eating good and healthy</p> <p>Mental health</p> <p>Everything (3 x comments)</p> <p>Being informed of issues may help!</p>

As can be seen from the feedback above, families and visitors knowledge of the healthcare services available at the prison was low. Information provided to visitors was regarded as poor. There is significant potential to improve family and visitor knowledge and involvement and to leverage this to

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support key health and wellbeing messages. Health Trainers could have a key role in developing a family involvement initiative.

16.4 Qualitative Feedback

Comments from the questionnaires are summarised above.

An interview was undertaken with the governor with responsibility for healthcare who was very positive about healthcare services provide and again particularly praised the In reach service provision, commenting on how responsive and supportive the service is and how the staff in the team ` help officers to see things differently'. It was also mentioned that mental health training had been offered to officers and that this was appreciated. Some concerns were expressed at staffing levels and use of agency staff and of not having had a Head of Healthcare prior to the recently filled vacancy, however, the prison were extremely positive in feedback regarding the deputy healthcare manager, who had recently transferred to HMP Drake Hall from another prison and has built confidence with the prison. It was felt that with the new Head of Healthcare in post as well staffing issues would be stabilised.

It was felt that there was appropriate representation from Delphi and In Reach staff at prison meetings but that the staffing problems described had resulted in there not always being primary care representation. However, it was acknowledged and appreciated that despite recent staffing issues, the prison had continued to have healthcare support for ACCT reviews; Care & Separation Unit checks and algorithms and attendance at incidents to complete F213 & F213 SH forms (prison documents completed by healthcare staff after incidents where injures have been sustained).

The benchmarking process was raised and the importance of managing escorts and bedwatches rigorously and also ensuring efficient and timely administration of medicines was discussed. Frustrations were expressed that nursing staff did not suture or glue wounds and that this sometimes resulted in avoidable escorts to hospital.

16.5 Recommendations: Stakeholder Feedback

- There is significant potential to improve family and visitor knowledge and involvement and to leverage this to support key health and wellbeing messages. Health Trainers could have a key role in developing a family involvement initiative.
- A training needs analysis should be undertaken and training identified (minor injury and illness assessment, wound closure – suturing and gluing etc.) to support on site management and reduce avoidable escorts to Accident & Emergency.
- A comprehensive review of medicines administration should take place to identify any efficiencies that can be made to reduce medicines administration time whilst maintaining all aspects of safe administration practice.

17. Independent Scrutiny

During an announced inspection in March 2013, HMIP reported that ‘prisoners were generally satisfied with health care services. Clinical governance arrangements were reasonable, although some areas needed development. Waiting times for clinics were short, but access to a female GP was limited. Health care staffing shortages had affected some services. Stop smoking services were good and the team included a prisoner health trainer, an excellent initiative. Pharmacy services were reasonable but drug administration was not private. Secondary mental health services were impressive. Overall health care services were reasonably good’³¹.

HMPYOI Drake Hall was inspected against the following CQC outcomes in May 2013

- Outcome 1 People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run
- Outcome 4 People should get safe and appropriate care that meets their needs and supports their rights
- Outcome 6 People should get safe and coordinated care when they move between different services
- Outcome 14 Staff should be properly trained and supervised, and have the chance to develop and improve their skills
- Outcome 16 The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The service was assessed as meeting all standards. The CQC report states that prisoners at HMPYOI Drake Hall ‘were positive about the standard of care and treatment they received’³².

The Annual IMB report commented that ‘despite difficulties which have presented during the year, the Board is happy that prisoners continue to receive an excellent standard of healthcare at Drake Hall’³³.

³¹ HMPYOI Drake Hall Announced Inspection by HMIP, 4th-15th March 2013, p35

³² HMPYOI Drake Hall CQC Inspection Report 8th May 2013, <http://www.cqc.org.uk/location/1-473611944>

³³ HMPYOI Drake Hall The Annual Report of the Independent Monitoring Board, 1st November 2011-31st October 2012, p8

18. Compliments and Complaints

From October 2013 to September 2014 there were a total of 42 complaints, three were made directly to the provider and 39 were made via the PALS (Patient Advice and Liaison Service)

Figure 42 Complaints October 2013 to September 2014

Subject of complaint	No. of Complaints
Access to services	3
Aids. Appliances / equipment	2
Pain relief/ management	5
Patient Information	2
Patient property	1
Quality of care	9
Waiting times	1
Staff attitude	2
Alleged discrimination	1
Communication	4
Other (unclassified)	12
Total	42

In the same time period there is one compliment recorded. It is suspected from the positive feedback received at focus group meetings that compliments are under reported and it would be a positive step to record all compliments to provide an accurate balance of commentary on service delivery.

19. Incidents & Serious Untoward Incidents

In December 2014 a prisoner was released on license and died 10 days later. This was treated as a serious untoward incident by the provider trust but we are told is not being regarded as a death in custody.

A total of 64 incidents were reported over the twelve month period between October 1st 2013 and September 30th 2014. There were no 'never events' reported in this reporting period.

Figure 43 Incidents October 2013 to September 2014

Incident type	No. of Incidents
Communication issue	1
Discharge / transfer	1
Equipment	2
HR / Workforce	7
Infection control	1
Information Technology	3
Medication	14
Patient deterioration	1
Patient non- compliance	4
Self harm	11
Slips/ trips/falls	1
Unexpected death	1
Violence / aggression	9
Other (unclassified)	8
Total	64

20. Deaths In Custody

There has been one death in custody at HMP & YOI Drake Hall in September 2014. The death was from natural causes. The Prisons & Probation Ombudsman (PPO) report has not yet been published and therefore any recommendations are not yet known.

21. Local Summary and Gap Analysis

At HMP & YOI Drake Hall a range of healthcare services and interventions are delivered to meet the complex needs of the population. Reception and screening processes are very thorough, and women are referred appropriately to clinics and services to meet their individual health needs.

The Health Trainer programme is an excellent initiative and has the potential to be extended significantly to the benefit of women and their families.

Gap analysis suggests:

- There is scope to improve womens awareness and uptake of national screening programmes, and in particular bowel cancer and CVD risk screening.

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- Identification, referral, assessment, diagnosis and support for those with learning disabilities and autistic spectrum disorders and conduct disorders requires improvement
- A number of actions could be taken to reduce the number of escorts for hospital appointments.

The reader is referred to the synopsis of findings in the executive summary at the beginning of the report and to the list of recommendations below for a full summary.

22. Local recommendations

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

No.	Area	Recommendation
1	Reception & Screening	The creation of a strategic hub between HMPs Styal, Foston Hall and Drake Hall provides an opportunity for enhanced liaison between healthcare providers to develop shared care pathways, streamline sharing of healthcare information and promote efficiencies in the transfer process to support continuity of care.
2	Reception & Screening	As only approximately 5% of the population are serving sentences of less than 12 months, there is an excellent opportunity to foster engagement with healthcare services, promote personal responsibility for health and develop a culture that seeks to consistently support and prepare women for discharge and resettlement throughout their term of imprisonment.
3	Reception & Screening	As HMP & YOI Drake Hall is a designated resettlement prison, healthcare providers will need to build links with community providers and with Community Rehabilitation Companies to support 'through the gate initiatives' and continuity of care on resettlement.
4	Facilities	A solution should be sought as soon as possible to women waiting outside to queue for medicines.
5	Primary Care	A review of primary care staffing levels and skill mix may be beneficial, with consideration of how health care assistants and associate practitioners could compliment qualified nursing staff to provide the optimal staffing structure.
6	Primary Care NHS Screening Programmes	A referral process review is required to ensure that all eligible women are afforded the opportunity to take part in national screening programmes.
7	Primary Care NHS Screening Programmes	With reference to HJIP indicators A01K04 (NHS CVD Screening) and A02K03 (Bowel Cancer Screening) a SystemOne READ code formulary should be developed incorporating the suggested READ codes for national screening programmes. All offers of screening and screening uptake should be appropriately coded to enable accurate reports for screening against national targets to be generated.
8	Primary Care Clinics	The highly effective joint prison and healthcare provider approach to management of DNA should be shared for consideration and discussion with other HMPS and healthcare providers across the cluster.

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No.	Area	Recommendation
9	Primary Care Clinics	The introduction of female GP sessions since the last HMIP inspection is very positive, however, requests to see a female GP are high and an additional female session per month would be advantageous.
10	Primary Care Clinics	Providers and commissioners may wish to consider routinely capturing the number of appointments per opticians and physiotherapy clinic session, including the number of women called up to appointments and actual attendance numbers for future reporting against HJIP indicators A13K10 – A13K12 and A09K05.
11	Primary Care Clinics	Over the 12 months reviewed, on average less than a quarter (24%) of women saw the optician within the 6 week target date. A review of patients accessing the service should be undertaken to separate need from demand.
12	Primary Care Clinics	Training of nurses to undertake ocular triage (supported by ocular triage protocols) may assist in management of the optician waiting list.
13	Sexual Health	Prevalence data was not available for this HNA due to the sexual health nurse leaving. It is therefore recommended that this is an area of focus when the next HNA/ HNA refresh is undertaken.
14	Sexual Health	Arrangements should be made for continuance of sexual health services at the prison as soon as possible.
15	Social Care	A question regarding previous `Looked After` status should be added to the reception screening template to ensure appropriate healthcare contribution to leaving care pathways on release from prison.
16	Mental Health	It may be beneficial to monitor the significant resources required to meet the needs of patients with personality disorders in order that the personality disorder pathway can be effectively implemented and evaluated.
17	Mental Health	The limited primary care mental health nurse capacity appears to be impacting upon the secondary care caseload. It is recommended that consideration of the advantages and disadvantages of a primary / secondary care model versus an integrated mental health model is undertaken to determine the best service delivery model for HMP & YOI Drake Hall.
18	LD & Autistic Spectrum Disorder (ASD)	It is recommended that a Commissioner led Steering Group is formed to review current Learning Disability and Autism support across the West Midlands Prison Cluster.
19	LD & ASD	The above Steering Group should link with any existing multi-agency autism strategy groups to review, develop, implement and evaluate local care pathways.

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No.	Area	Recommendation
20	LD & ASD	It is recommended that the Steering Group consider funding for the development of a regional resource to support further research, identification, signposting and support services for Learning Disabilities and Autistic Spectrum Disorders for West Midlands Prisons cluster.
21	LD & ASD	It is recommended that the above regional resource comprises an appropriate cohort of professionals who are able to develop care pathways for children, young people transferring from children's to adult services and adults who have learning disabilities, ADHD or Autistic Spectrum Disorders.
22	LD & ASD	It is recommended that the regional resource is commissioned to provide: <ul style="list-style-type: none"> • assessment, treatment and support and referral services for service users whilst in prison • education and awareness raising for healthcare staff and HMPS and NOMS colleagues • a through the gate service linking to Community Healthcare Teams, third sector agencies, peer support networks and Community Rehabilitation Companies to support resettlement on release
23	LD & ASD	The development of Local READ code formularies for both Primary Care & In Reach services would improve data capture and collation regarding prevalence of learning disability and Autistic Spectrum Disorders.
24	Drug & Alcohol Recovery Services	NDTMS data suggests a significant increase in women accessing the service between 2013 and 2014. Although the 2013 HNA suggests 2013 data may not be accurate, monitoring of this is required to ensure resources continue to meet need.
25	Drug & Alcohol Recovery Services	The service will need to consider ways in which to resource support for the women who will reside in the open house and who may still require psychosocial support prior to resettlement back into the community.
26	Drug & Alcohol Recovery Services	The service provider and recovery champions should explore innovative ways of developing and delivering a recovery drop in clinic, researching all available options for potential premises and locations.

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No.	Area	Recommendation
27	Hospital Appointments	The potential to arrange visiting consultant appointments for most frequently accessed specialities (gynaecology, orthopaedics and breast clinic) should be explored.
28	Hospital Appointments	It is recommended that Commissioners undertake a regional cost benefit analysis for the commissioning of a mobile diagnostic unit (x-ray and ultrasound) to regularly visit HMP & YOI Drake Hall. This has the potential to reduce escorts substantially and is further discussed in the regional analysis.
29	Hospital Appointments	Telemedicine has significantly reduced hospital escorts within the North East Cluster of prisons. It is recommended that Commissioners undertake a regional cost-benefit analysis for the introduction of telemedicine facilities. This is discussed further in the regional analysis. At HMP & YOI Drake Hall this may be specifically considered as an alternative to hospital visits for appointments across a range of specialities.
30	Hospital Appointments	A SystmOne template with background READ codes should be used to record all unscheduled hospital visits (escorts and bedwatches) to enable accurate future analysis.
31	Hospital Appointments	To reduce appointment cancellations and rescheduling, the SystmOne appointments ledger could be utilised to record external hospital appointments so that when women leave the establishment an automatic alert for any outstanding appointments can be generated.
32	Hospital Appointments	All GPs should be encouraged to consider release dates when making initial hospital referrals. Where referrals are none urgent and the expected date of release falls within NHS eighteen week target, if the patient is likely to have a registered GP on release, consideration should be given to requesting hospital appointment for a date after release.
33	Hospital Appointments	Close liaison with OMU is required to ensure all opportunities to ROTL women for appointments are explored and that appointment cancellations or postponement due to ROTL issues are avoided.
34	Families & Visitors	There is significant potential to improve family and visitor knowledge and involvement and to leverage this to support key health and wellbeing messages. Health Trainers could have a key role in developing a family involvement initiative.
35	Training	A training needs analysis should be undertaken and training identified (minor injury and illness assessment, wound closure – suturing and gluing etc.) to support on site management and reduce avoidable escorts to Accident & Emergency.
36	Medicines Administration	A comprehensive review of medicines administration should take place to identify any efficiencies that can be made to reduce medicines administration time whilst maintaining all aspects of safe administration practice.

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