



Public Health
England

Protecting and improving the nation's health

Health and social care needs assessments of the older prison population

A guidance document

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Glossary

| | |
|-------------------|--|
| ACE-III | Addenbrooke's Cognitive Examination-III |
| ADASS | Association of Directors of Adult Social Services |
| ADL | Activity of Daily Living |
| BMI | Body Mass Index |
| BNF | British National Formulary |
| DNA | Did Not Attend |
| DoH | Department of Health |
| DNACPR | Do Not Attempt Cardio-Pulmonary Resuscitation |
| HJIPs | Health and Justice Indicators of Performance |
| H&SCNA | Health & Social Care Needs Assessment |
| HNA | Health needs assessment |
| HMP | Her Majesty's Prison |
| HMPPS | Her Majesty's Prison and Probation Service |
| KPI | Key Performance Indicator |
| LA | Local authority |
| MoJ | Ministry of Justice |
| NDTMS | National Drug and Treatment Monitoring Service |
| NICE | National Institute for Health and Care Excellence |
| NOMS | National Offender Management Service (now called HMPPS- see above) |
| P-NOMIS | Prison National Offender Management Information System |
| PADLs | Prison Activities of Daily Living |
| PHE | Public Health England |
| PPO | Prison and Probation Ombudsmen |
| PRT | Prison Reform Trust |
| PSI | Prison Service Instruction |
| RECOOP | Resettlement and Care for Older Ex-Offenders and Prisoners |
| RPS | Royal Pharmaceutical Society |

| | |
|------------|------------------------------|
| SOP | Standard Operating Procedure |
| SPS | Scottish Prison Service |

Executive summary

The number and proportion of people in prison who are aged over 50 has been steadily increasing. This trend is projected to continue for the next 5 years and beyond. Older people in prison have a variety of needs; high prevalence of long-term chronic disease, disease risk factors, reduced mobility levels, and sensory impairment are just some of the needs this population group have. Prison services, regimes and the physical estate have not historically been designed around such needs and effectively responding to them can be challenging. Much has already been done in recent times to improve the health and wellbeing of this group, but further action is required if this is to be improved further and meet equivalence with age- matched community peers.

An initial and fundamental step in the process of improving health and wellbeing of older people in prison is to fully ascertain the nature and level of need that exists among that cohort within a specific prison establishment. This is not necessarily a static phenomenon for an individual prison due to prisoner churn, prison re-rolling and the prison reconfiguration programme. However, undertaking a formal Needs Assessment at a prison level is an evidence-based way to fully characterise the needs of this group. When this approach covers the key themes outlined in this document, detailed insight into the nature and extent of need can be generated. In turn, this understanding of need should then inform the commissioning and delivery of services to meet the identified need. At the very least, this involves health and social care to be considered together in a holistic way and requires collaboration from a number of partner organisations.

This document aims to provide guidance to those commissioning or undertaking Health and Social Care Needs Assessments of the older prison population. It has been written by Public Health England's Health and Justice Team, with significant input from partner organisations from across the health and justice system, including input from service users. The document is structured around 13 chapters which each address a key theme that should be considered when undertaking a needs assessment of older people in prison. Each chapter has a common structure to it, to guide the reader systematically through the document and the process of undertaking a needs assessment.

This document should provide an important contribution to improving the health and wellbeing of older people in prison.

1. Introduction

1.1 Purpose

The aim of this document is to provide evidence based guidance on undertaking Health and Social Care Needs Assessments (H&SCNAs) of older people within prisons. A definition of needs assessments is given below. The intended audience include commissioners and providers of prisons and prison health services (eg NHS England, HM Prison & Probation Service, Ministry of Justice) and commissioners & providers of social care services (eg Local authority Directors of Adult Social Services, Directors of Public Health).

1.2 Background and policy context

This document has been developed by Public Health England's (PHE) Health and Justice Team, in response to both the increasing numbers of older people in prisons in England and recent changes in the role of Local Government in the provision of social care to people in prison¹. Furthermore, recent reforms in the commissioning of prison healthcare services, outlined in the White Paper on Prison Safety and Reform², have created new opportunities for co-commissioning by prison governors and NHS England to better meet the needs of their populations and take a 'whole prison approach' to the design and delivery of health & social care services.

The Prison Reconfiguration Programme is currently being developed in England and Wales. In summary, this will involve all prisons being classified as primarily for Reception, Training or Resettlement. These 3 designations reflect the distinct stages of the journey through the prison system an incarcerated person will take. This has relevance to needs assessments because health needs in reception prisons will be different to training and resettlement prisons due to the nature of population, duration of incarceration and stage of rehabilitation. This pathway approach to supporting people in prison underpins this document and is discussed in more detail in section 1.6 and in chapter 12. Running concurrently with this reconfiguration, is the Prison Rebuild Programme. This will provide purpose built replacement to the 10,000 oldest or least suitable prison places. Chapter 3 on the physical environment of a prison will support this development.

At the same time as these policy developments, the number of deaths in prisons has been steadily rising year-on-year. Recent data from 2017 shows a downward trend from previous

¹ The Care Act (2014) *The Care Act*. TSO: London. Available at: <http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>

² MoJ (2016) *Prison safety and reform*. HMSO: London. Available at: <https://www.gov.uk/government/publications/prison-safety-and-reform>

years³. In a Prison and Probation Ombudsmen (PPO) report this year⁴, the challenge of an ageing prison population was summarised thus: “prisons designed for fit, young men must adjust to the largely unexpected and unplanned roles of the care home and the even hospice”.

1.3 Demographic changes

Her Majesty’s Prison and Probation Service (HMPPS) define people aged 50 years or more in prison as older, and this is a definition used by other prison systems internationally. Although this is not consistent with definitions used elsewhere in health and social care (where those aged 60 or 65 are classified as older), it is an increasingly accepted threshold for those in prison. This is because of the accelerated ageing process experienced by those in prison, due to their exposure to a variety of social and environmental factors prior, during and after detention in prison. For example, Hayes et al (2012)⁵ successfully demonstrated that the burden of ill-health is not significantly different between those aged 50 to 54 and any other older 5 year age groups.

Since 2002 the proportion of people in prison aged 50 or older has increased by 150%⁶ making it the demographic group increasing fastest in the prison estate. As demonstrated in the table below, there is a projected growth in this age group, which by June 2021 will represent 16.9% of the population⁷. This number is expected to increase in both real terms and as a proportion of the whole prison population over the next 4 years.

Table 1- Projected over 50, 60 and 70 year old prison population (end of June figures)⁸

| | Total prison pop | 50-59 | 60-69 | Over 70 | Total aged 50+ | % 50+ |
|-----------|-------------------------|--------------|--------------|----------------|-----------------------|--------------|
| June 2017 | 85,863 | 8,564 | 3,213 | 1,599 | 13,376 | 15.6% |
| June 2018 | 86,400 | 8,700 | 3,400 | 1,700 | 13,800 | 16.0% |
| June 2019 | 86,500 | 8,700 | 3,500 | 1,800 | 14,000 | 16.2% |
| June 2020 | 86,800 | 8,800 | 3,700 | 1,900 | 14,400 | 16.6% |
| June 2021 | 87,400 | 8,900 | 3,800 | 2,100 | 14,800 | 16.9% |

³ See MoJ (2017) Safety in custody statistics. Available at; <https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-march-2017>

⁴ Prison and Probation Ombudsmen (2017) Learning from PPO Investigations: older prisoners. Available at <http://www.ppo.gov.uk/document/learning-lessons-reports/>

⁵ Hayes et al (2012) The health and social care needs of older male prisoners. *International Journal of Geriatric Psychiatry* 2012; 27: 1155–1162.

⁶ House of Commons Briefing Paper No. SN/SG/04334 July 4, 2016

⁷ MoJ (2017) *Prison population projections* MoJ. Available at; <https://www.gov.uk/government/statistics/prison-population-projections-ns>

⁸ Ibid

NB All projection figures are rounded to the nearest 100.

While the ageing population in England might partly explain this phenomenon, it is more directly a result of other factors. These include: historical sentencing practices (such as the use of Imprisonment for Public Protection sentences), and the increase in late-in-life prosecutions, often for historic sex offences.

1.4 Health and social care needs of older people in prison

There is strong evidence that the older population in prison experience a high burden of physical and mental health problems. Up to 90% have at least one moderate or severe health condition⁹, with more than 50% having 3 or more¹⁰. Their health outcomes are worse than those of the same age in the community and worse than their younger peers in prison¹¹. The need for social care within prisons is increasing with the typical older person in prison having on average almost 6 separate health or social care needs¹². Often the presence of such long-term and complex health conditions makes effective management difficult in any individual, but this is especially the case when care is being delivered in a prison context. The very nature of the prison built environment may pose particular challenges to this cohort, as up to half of this group experience sensory impairment and/ or reduced mobility.

1.5 What is an H&SCNA?

A Health Needs Assessment (HNA) is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities¹³. Previous guidance has been produced for undertaking HNAs in a PPD context which is available at:

<https://www.gov.uk/government/publications/prescribed-places-of-detention-health-needs-assessment-toolkit>.

For the reasons stated above, this older person document builds upon this prior guidance by providing more detailed guidance on undertaking HNAs specifically for older people in prison. This document deliberately addresses health and social care need together. This is because it is often not possible (or desirable) to attempt to fully distinguish between the two and, when considering an ageing and increasingly frail population, it is only possible to maximise health and wellbeing when a holistic approach is taken.

⁹ Williams, BCA and Greifinger R (2014), *The older prisoner and complex chronic medical care*, in *Prisons and Health*, L.M. Stefan Enggist, Gauden Galea and Caroline Udesen, Editor. 2014, World Health Organisation Regional Office for Europe: Copenhagen, Denmark

¹⁰ Hayes et al (2012) *The health and social care needs of older male prisoners*. *International Journal of Geriatric Psychiatry* 2012; 27: 1155–1162.

¹¹ Fazel et al (2001) *Health of elderly male prisoners: worse than the general population, worse than younger prisoners*. *Age and ageing*, 30 (5): 403-7

¹² Hayes et al (2013) *Social and custodial needs of older adults in prison*. *Age and Ageing* 2013; 42 (5): 589-593

¹³ NICE (2005) *Health Needs Assessments: A practical guide*. NICE. Available at; https://www.k4health.org/sites/default/files/migrated_toolkit_files/Health_Needs_Assessment_A_Practical_Guide.pdf

Undertaking an H&SCNA should be a collaborative effort and draw on knowledge, resources and information of all relevant partner organisations. Therefore, it is considered good practice that at the start of the process the lead agency establishes and chairs an H&SCNA working group. In the case of adult prisons, this would usually be NHS England and or the Local authority (LA). They would oversee the development and delivery of H&SCNA recommendations for all prisons in their area. Membership of the working group should include all the relevant stakeholders relevant to the prison or cluster of prisons in question.

Consideration of health and social care needs is not limited to the prison setting alone but the total care pathway should be taken into account, from reception to discharge. This allows the work to adequately reflect continuity of care needs which are often more challenging in older people which multiple complex health and social care needs. This issue is discussed further in chapter 12 of this document.

It is usual practice for needs assessments to have a comparative element. Within the context of an H&SCNA for the older prison population comparisons can be made with: younger cohort of people in prison, or community peers of the same age, or data from other establishments on the same-aged cohort, and are included in the national data where available. Comparisons can be helpful in this case for example in informing difference of health care provision for older people between community and prison settings and within prisons for older and younger people in prison. Caution is, however, required as different demographics within these cohorts and the different service models between settings can also play a factor in the differences identified.

1.6 Structure of this guidance and how to use it

The following chapters of this document are structured around the key themes or sections that would usually be captured by a standard needs assessment for a population of any age. However, to ensure issues specific to older people in prison are considered within each theme, the chapters are structured around the following four headings:

Health and social care issues specifically relevant to the older prison population: The figure below illustrates some of the specific and overlapping health & social care needs relevant to older people in prison. This initial section of each of the chapters will highlight what the specific considerations for older people in prison should be within the theme being discussed in that chapter.

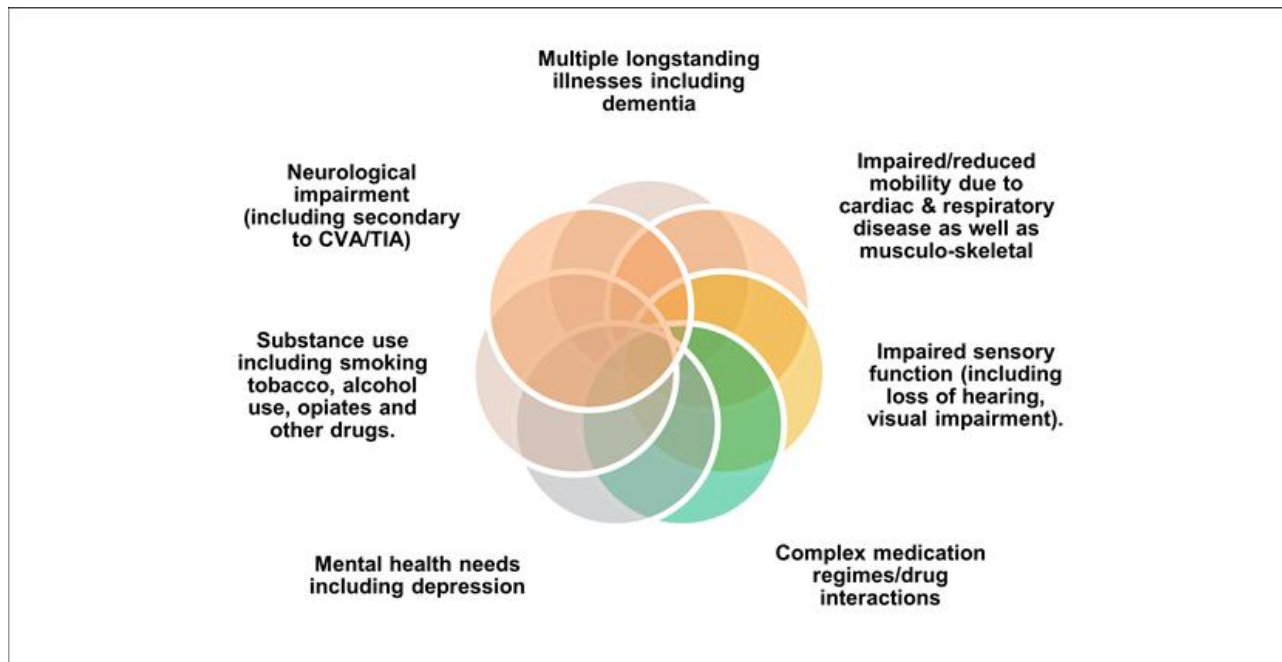


Figure 1- Illustration of multiple complex health and social care needs of older people in prisons to be considered in formal HSCNA process¹⁴

National level data (where it exists) on the issue being addressed, including published datasets from health and justice providers eg PHE Fingertips tool (<https://fingertips.phe.org.uk>), Ministry of Justice (MoJ) statistical publications. (<https://www.gov.uk/government/organisations/ministry-of-justice/about/statistics>) and relevant Local Government publications. Published research papers may also provide useful data which can be applied to local prison populations. (For example, the overall proportion of people over the age of 50 in prison with hypertension). At some points international research data is presented if there is not UK based published literature on the topic. There are some inherent challenges in using such data. It is not included to make direct comparisons against, but rather to give a feel for how common a particular issue is in some form of prison setting.

Local level data and intelligence resources eg health system data (Health & Justice Indicators of Performance (HJIPs); SystmOne READ codes; healthcare provider performance data provided to NHS England commissioners; pharmacy dispensing logs for medicines & vaccines etc.) or prison system data (eg Prison National Offender Management Information System (P-NOMIS) data on prison population numbers, age and sex structure, etc.). Qualitative data sources should also be considered eg feedback from those in prison including complaints or outputs from surveys or focus group work.

Examples of practice locally, regionally or nationally: these examples include case-studies from specific prisons or regions, as well as resources that have been developed and can be used to support practice. (For example, the development of local standard operating

¹⁴ O'Moore, E.J (2016) Personal correspondence

procedures in prisons in the Thames Valley to implement national screening programmes in detained settings, or the RECOOP (Resettlement and Care for Older Ex-Offenders and Prisoners) charities toolkit for assessment of the physical environment of a prison and how it affects access for older people)

Two of the final sections of this document depart from the above structure. They are chapter 10 on User engagement and chapter 12 on Planning for release and continuity of care. The reason for this is that they are both “cross cutting themes” that underpin much of the H&SCNA process. For example, engaging the user voice is referred to as a useful data source in many of the following chapters, not just in chapter 10. In regard to continuity of care, it is important to acknowledge the needs of an individual, and a population as a whole, will be different from reception, through training and then upon release. Understanding the churn of this older cohort and where individuals are at on this pathway is therefore relevant when assessing the level of need.

This document should be used in establishments with a larger older population. It can be used as a standalone document, or as an aid to fully assessing need of the older population when using the existing PHE HNA toolkit

(<https://www.gov.uk/government/publications/prescribed-places-of-detention-health-needs-assessment-toolkit>) for a full prison HNA. As a minimum it should be used on the usual 3 yearly cycle, when contracts are being re-procured , or when a prison is re-designated if this leads to a rapid increase in the number of older people within the prison.

2. Demographics of population

2.1 Specific considerations for older people

The number of older people in prison is not evenly distributed around the estate. The proportion of a prison population in the 50 years-old and older cohort will be influenced by factors such as the security category of the prison, its designated function and the services provided in the establishment. It is therefore important to obtain a local population profile of the prison in question when undertaking the H&SCNA. In section 1.2, the Prison Reconfiguration Programme was outlined. It is anticipated that as this programme is rolled out the demographics of a prison will be largely determined by whether it is predominantly a reception, training or resettlement establishment.

In addition, it is also important to consider the length of incarceration of the older cohort of older people in prison. There is some evidence that length of time in prison is also a determinant of health (as well as age) with those in prison for longer periods experiencing worse health than those of the same age incarcerated for shorter periods¹⁵. This reflects the phenomenon described in Section 1, that older people in prison should not be considered a homogenous group as some have been in prison for long periods, others frequently in and out of prison throughout life, while others are sentenced to their first custodial sentence once over the age of 50.

2.2 National level data

As of October 2017, there are 13,376 people in prison in England and Wales who are aged 50 years-old or older. This represents 15.6% of the whole prison population¹⁶. The MoJ project this to rise over the next 4 years to 14,800, which would equate to 16.9% of the prison population¹⁷. This growth will occur in the context of a substantial increase in the number of older people in prison, already seen in the last decade or more, outlined in Section 1.

¹⁵ Wangmo et al (2015) Ageing Prisoners' Disease Burden- is being old a better predictor than time served in prison? *Gerontology* 61:116–123. Available at; <https://www.karger.com/Article/PDF/363766>

¹⁶ MoJ (2017) *Prison population projections* MoJ. Available at; <https://www.gov.uk/government/statistics/prison-population-projections-ns>

¹⁷ Ibid

2.3 Data sources and indicators

| Indicator | Source | Comment |
|--|--|--|
| The number and proportion of people in prison aged 50 years-old or older at a specific point in time, out of the prison's whole population | p-NOMIS | As prison populations are in a constant state of flux a single data should be used to obtain a "snap shot" in time. If calculating trend data then the same time point for each year should be used to avoid seasonal variations affecting the data |
| As above but comparing information held on SystmOne with p-NOMIS | p-NOMIS and SystmOne | Comparison could contribute to understanding of 'churn'- i.e. everyone should be seen by healthcare services so in theory numbers should be equal- however, often disparity reflecting turnover and throughput of people in prison especially those on remand. This will increase in new reception prison. |
| The number and proportion of those 50 years-old or older who have been in prison for more than 5 years out of the whole older prison population | p-NOMIS | A different cut-off to 5 years can be used if desired |
| The number and proportion of those 50 years-old or older who have been in prison for less than 5 years out of the whole older prison population | p-NOMIS | |
| Operational capacity of prison | Local data or HMPPS | This is the number of places at any one point in time |
| First receptions | MoJ Offender management statistics quarterly | The number of people newly sentenced and on remand each year which will increasingly be effected by prison category (reception/ training/ resettlement) |

| | | |
|---|--|---|
| Turnover (churn) | MoJ Offender management statistics quarterly | The number of times each place is used per year- the ratio of first receptions to operational capacity |
| Receptions | Local data/p-NOMIS or HMPPS | The number of people entering the prison each year – will be higher than the number of first receptions as it will include people returning from elsewhere such as hospital |
| % and number of the prison population released to community each year | Local data/ p-NOMIS or HMPPS | The release rate into the community. |
| The number and proportion of people age 50 and over registered as having a disability | Local data/p-NOMIS | Some prisons have disability liaison officers. Some disability can be self-reported by those in prison themselves |
| Ethnicity profile of 50 years and older cohort | Local data/p-NOMIS | The ethnic profile of people in prison can determine the cultural and social needs of the population which often impact on health needs |
| LA of residence | HMPPS | This will provide information about where after care should take place following release |

3. Review of physical environment

3.1 Specific considerations for older people

To ensure the H&SCNA fully assess need it is important to review the physical environment people are incarcerated in. This is because much of the prison estate was not designed with the needs of older people in mind. As a result various elements of prisons such as steep metal stair cases, lack of lifts, narrow cell doors or corridors, cramped cells, bunk beds, steps in/out of showers, lack of grab rails or shower seats, can all provide challenges to the older people in prison if they have even small levels of mobility impairment¹⁸. Many of these issues would either not exist or be easily adapted if individuals were dwelling in their own home in the community.

As a result of this, reports of older people in prison missing key elements of day to day life are not uncommon. For example missing out on educational sessions, not engaging in social activity, or not being able to shower (see the “Who Cares”? report on the lived experience of older people in prison in Scotland¹⁹).

Issues around sensory impairment should also be considered within this section. It is well understood that those aged 50 years and older have a higher level of visual and hearing impairment than their younger peers (see chapter 5). Therefore elements of the prison environment such as signage, notice boards and posters need to be considered as well as hand rails and sensory cues in the environment. Equally, the background noise of the prison environment can disadvantage hearing aid users and make hearing verbal instruction more difficult.

3.2 National level data

No single figure exists of the number of older people in prison who might find the physical environment within which they are detained restrictive in some form or other. However, the following data is available;

- Hayes et al (2012)²⁰ identified that 49% of older people in prison in North West England over the aged of 50 reported some form of sight or hearing impairment

¹⁸ RECOOP (2017) *Chapter 4 Physical environment. In: Working with older prisoners good practice guide*. RECOOP. Available at; <http://www.recoop.org.uk/dbfiles/pages/54/FINAL-Older-Prisoners-Good-Practice-Guide-2017.pdf>

¹⁹ HMIPS (2017) “Who Cares”? The Lived Experience of Older Prisoners in Scotland’s Prisons. HMIPS. Available at; <https://www.prisoninspectorescotland.gov.uk/news/who-cares-lived-experience-older-prisoners-scotland%E2%80%99s-prisons>

²⁰ Hayes et al (2012) The health and social care needs of older male prisoners. *International Journal of Geriatric Psychiatry* 2012; 27: 1155–1162.

- Williams et al (2014)²¹ reports that 34% of older people in prison in California require walking aids such as walking sticks, “walkers” or wheel chairs
- the Scottish Prison Service (SPS) estate wide social care needs assessment (SPS 2017)²² found that 46% of those undergoing assessment for potential social care need were either “not confident” or “partially confident” getting around the prison

3.3 Data sources and indicators

The following data should be collected to ascertain what the needs are of the older person in prison in regard to the physical prison environment:

| Indicator | Source | Comment |
|---|---|---|
| The number and proportion of older people in prison designated as “locate flat/ locate low” | p-NOMIS | Available if a locate flat/ low procedure is in operation at the prison |
| Physical environment review | “walk-around” conducted around premises with a person in prison with physical or sensory impairment | See practice example comment below |
| Adaptation review | As above | Should consider availability of suitable adaptations to enable Activities of Daily Living (ADL) eg ground floor accommodation, access to private showers/toilets; availability of hoists, handrails |
| Self-reported disablement due to physical environment | Older person in prison survey | Questions on the physical environment can easily be incorporated |

²¹ Williams et al (2014) Pain behind bars: the epidemiology of pain in older jail inmates in a county jail. *Journal of palliative medicine*. 17 (12),1336-43

²² Scottish Prison Service (2017) An Estate wide social care needs assessment. SPS: Available at <http://www.sps.gov.uk/Corporate/Publications/Publication-4941.aspx>

3.4 Examples of practice

Undertaking a review of the physical environment in conjunction with someone in prison who has a physical or sensory impairment is an example of practice. This can be supported by utilising a check-list (RECOOP 2017²³) developed by the RECOOP charity which is available online at <http://www.recoop.org.uk/pages/services/index.php>

HMP Whatton, which has a significant proportion of older offenders, has responded to the challenges faced by those with sensory impairment. It has developed a cell with simple adaptations such as soft lighting, large clock, brail signage which can be used by those with visual impairment, as well as those with dementia. In addition, it has a ground floor wing with wider access, corridors and cells where those who need mobility aids such as walkers/ Zimmer frames or wheel chairs can be located. In addition Whatton was awarded a charter mark from the Royal Association for the Deaf in 2017, in acknowledgement of its efforts to support people in prison with hearing impairment. For more information please contact health-justice@phe.gov.uk.

Pathway to care for Older Offenders (DoH 2007)²⁴ contains a very useful list of questions and criteria to be auditing against in regard to the prison environment (see pages 16-20), available at:

http://webarchive.nationalarchives.gov.uk/20130123192716/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079928

For prisons looking to develop the physical environment to be “older friendly” the NARCO resource pack (NACRO 2009)²⁵ (see particularly page 32-33, available at: <http://www.changinglivesogether.org.uk/wp-content/uploads/2014/01/A-resource-pack-for-working-with-older-prisoners.pdf>) offers some useful practical ideas of simple changes or adaptations that can be made which make a significant difference for older people in prison.

²³ RECOOP (2017) *Chapter 4 Physical environment. In: Working with older prisoners good practice guide*. RECOOP. Available at; <http://www.recoop.org.uk/dbfiles/pages/54/FINAL-Older-Prisoners-Good-Practice-Guide-2017.pdf>

Department of Health (2007)²⁴ *Pathway to care for Older Offenders*. DoH. Available at; http://webarchive.nationalarchives.gov.uk/20130123192716/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079928

²⁵ NACRO (2009) *A resource pack for working with older prisoners*. NARCO. Available at: <http://www.changinglivesogether.org.uk/wp-content/uploads/2014/01/A-resource-pack-for-working-with-older-prisoners.pdf>

4. Risk factors for disease

4.1 Specific considerations for older people

A risk factor for disease is “any attribute, characteristic or exposure of an individual that increases the likelihood of developing a disease or injury”²⁶. A variety of risk factors for disease are likely to be found in any prison population. Within an older prison population, many of these are the same and issues such as; smoking, excessive alcohol use, substance misuse, poor diet, excess weight and physical in-activity. All of these need careful consideration. However, as is highlighted below, it is expected that older people in prison will have a slightly different profile of risk-factors than their younger peers. In summary the most prevalent risk factors to focus on are high alcohol use, being overweight and low levels of physical activity.

4.2 National level data

Bridgwood and Malbon’s (1994)²⁷ survey of “the physical health of prisoners” remains the most comprehensive review of disease risk factors across the English prison estate. It identified the following trend in the reasonably small number of people in prison aged 45 and over (12% of the total sample):

- **Cigarette smoking**- 66% prevalence in the 45 and over group compared to an overall 80% prevalence across the population as a whole.
- **Alcohol use**- the aged 45 and over group were the most likely age group to report drinking every day or nearly every day prior to imprisonment.
- **Substance misuse**- 25% of men aged 45 and over had used drugs in the previous 12 months compared with 82% of men under the age of 21.
- **Physical activity**- 40% of men aged 45 and older had participated in sporting activity in the prior 4 weeks, where as 97% of younger men had.
- **Diet**- the 45 and older group were the most likely age-group to eat at least one vegetable (45%) or piece of fruit (32%) per day.
- **Weight**- with an average of 26.3, the 45 and over group had the highest average Body Mass Index (BMI) out of all the age groups surveyed.

Binswanger (2009)²⁸ undertook a comprehensive survey of older people in prison in American and identified 50% and 26% of those aged 50-65 were over-weight and obese respectively.

²⁶ WHO (2017) *Health Topics- risk factors*. WHO. Available at: <http://www.who.int/topics/en/>

²⁷ Binswanger (2009) Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population. *Journal of epidemiology and community health*, 63 (11) 912-9

²⁸ Bridgwood and Malbon (1994) *Survey of the physical health of prisoners*. HMSO: London.

Data from the National Drug Treatment Monitoring Service (NDTMS) for 2015-16²⁹ demonstrate that; of all the 2,214 adults aged 50 and over commencing some form of drug or alcohol treatment, 67% were for alcohol dependency only, compared to 50% of people in prison from all-age groups. When the 60+ population alone is considered, the equivalent proportion rises to 84%. At the same time the proportion of those in prison aged 50+ commencing treatment for non-alcohol drug dependency remains consistently below the average figure for all age groups, regardless of the drug in question.

This suggests the trend identified above by Bridgwood and Malbon (1994) persists and the most important risk factors for disease in the 50 years and older group continue to be: alcohol dependency, obesity and physical in-activity.

From 2016, prisons in England started the phased process of becoming smoke free. This fundamentally changes the way people in prison access tobacco products and will affect smoking prevalence. Although it was noted above that smoking prevalence is not as high in the older population when compared to older groups, it is important to note this change, especially when calculating trend data over time on smoking prevalence.

4.3 Data sources and indicators

The following data should be obtained to ensure as full a picture as possible is obtained of the risk factor profile of the older people in the prison in question:

| Indicator | Source | Comment |
|--|--|---|
| Number and proportion of people aged 50 years-old and older who are in treatment for alcohol dependency out of the whole older person cohort. | NDTMS- quarterly report available via Health and Justice commissioners | This report provides data at individual prison level. This report now incorporates age-stratified data on those in contact with drug and alcohol services by the following sub groups; <ul style="list-style-type: none"> - opiate user - non-opiate user only - non-opiate user and alcohol - alcohol only |

²⁹ NDTMS (2016) *Secure setting statistics from the NDTMS: financial year ending March 2016*. NDTMS. Available at; <https://www.gov.uk/government/statistics/secure-setting-statistics-from-the-ndtms-financial-year-ending-march-2016>

| | | |
|---|--|---|
| <p>Number and proportion of people aged 50 years-old and older who are in treatment for non-alcohol drug dependency out of the whole older person cohort.</p> | <p>NDTMS- quarterly report available via H&J commissioners</p> | <p>As above</p> |
| <p>Alcohol screening- the number and proportion of people aged 50 years-old and older who have been screened with the AUDIT scale out of the whole older person cohort.</p> | <p>HJIPs- KPI A07K03-A07K06</p> | |
| <p>Alcohol screening- the number and proportion of people aged 50 years-old and older in the following 3 AUDIT score groups;</p> <ul style="list-style-type: none"> - 8-15 - 16-19 - 20+ | <p>HJIPs- KPI A07K03-A07K06</p> | |
| <p>Number and proportion of people aged 50 years-old and older who have a BMI 30 or higher (obese) out of the whole older person cohort.</p> | <p>SystemOne</p> | |
| <p>Number and proportion of people aged 50 years-old and older who have a BMI between 25 and 29 (overweight) out of the whole older person cohort.</p> | <p>SystemOne</p> | <p>BMI should be recorded at second stage health assessment and also at physical health checks appointment (see health promoting services chapter or in chronic disease clinics</p> |
| <p>Smoking prevalence- Number and proportion of 50 year-olds and older who are smokers at reception</p> | <p>HJIP- KPI A17K01</p> | |

| | | |
|--|-------------------------------|--|
| Smoking cessation- Number and proportion of 50 year-old and older smokers who take part in regular smoking therapies | HJIP- KPI A17K02 | Data also relevant to chapter 8 on Promoting Health and Wellbeing; addressing wider determinates of health |
| Smoking quitters- - Number and proportion of 50 year-old and older smokers who are smoking quitters on discharge from prison | HJIP- KPI A17K03 | Data also relevant to chapter 8 on Promoting Health and Wellbeing; addressing wider determinates of health |
| Self-reported frequency of physical activity in its variety of forms | Older person in prison survey | Can be asked in a variety of ways via questionnaire – see later section on user engagement |

4.4 Examples of practice

A recent HNA undertaken in HMP Northumberland (Hamoodi and Christie 2013³⁰) sought views of stakeholders by utilising surveys. This identified what the priorities were for people in prison themselves (for example requesting the availability of scales on the wing to allow convenient opportunity to weigh themselves, additional help to stop smoking) and for prison officers (who identified the need for older person specific exercise opportunities) to address disease risk factors. For more information on this approach contact health-justice@phe.gov.uk

³⁰ Hamoodi and Christie (2013) HMP Northumberland; Health Needs Assessment. *Personal Correspondence*

5. Prevalence of disease

5.1 Specific considerations for older people

It is well documented that people in prison experience a heavy burden of disease³¹. In addition most diseases become more prevalent as people age and hence, as demonstrated by Fazel et al (2001)³², chronic diseases are more prevalent in older people in prison than both their age-matched community peers and younger people in prison.

Furthermore, as a result of the high level of disease prevalence they experience, many older people in prison have more than one chronic disease that requires ongoing management. Baillargeon et al (2000)³³ identified that almost two thirds of those aged 50 years-old or older had at least two chronic diseases. It should be noted that presence of some diseases can compound the prevalence of others. For example, Murdoch et al (2008)³⁴ found that chronic physical ill-health was strongly related to depression scores in elderly people in prison sentenced to life in prison.

5.2 National level data

This section of an H&SCNA should be broken down into different groups of diseases as follows. Included in each bullet point is prevalence data for those aged 50 years-old and over, drawn from a variety of sources (see footnotes for references).

Non-communicable chronic diseases such as; cardiovascular diseases, asthma, COPD, diabetes, cancer, musculoskeletal, liver and kidney disease. A systematic review of disease prevalence in older people in prison has found the following rates in key diseases³⁵:

- Cancer (any site) 9%
- Cardiovascular disease (any disease) 38%
- Hypertension 40%
- Ischaemic heart disease 21%
- Stroke 6%
- Diabetes 15%

³¹ Fazel and Baillargeon (2010) The health of prisoners. *Lancet*. 377: 956–65

³² Fazel et al (2001) Health of elderly male prisoners: worse than the general population, worse than younger prisoners. *Age and ageing*, 30 (5): 403-7

³³ Baillargeon et al (2000). The disease profile of Texas prison inmates. *Annals of Epidemiology*. 10 (2):74–80.

³⁴ Murdoch et al (2008). Depression in elderly life sentence prisoners. *International Journal of Geriatric Psychiatry* 23: 957–962

³⁵ Munday et al (in press). The prevalence of non-communicable disease in older people in prison globally: a systematic review and meta-analysis

- Asthma 7%
- COPD 8%
- Arthritis 34%

It is important the prevalence of issues not always defined as medical disease are included in this section. They include conditions like; chronic pain (up to 52% of people in prison on analgesia for chronic non-cancer pain and up to 34% on continuous analgesic therapy)³⁶, sensory impairment (particularly sight and hearing loss 65% and 28% prevalence respectively³⁷) and incontinence. A pilot study of a chronic non-cancer pain clinic in Gloucestershire found the average age of male attendees (48 years-old) was higher than the average age of people in prison generally³⁸. This suggests that chronic pain is likely to affect an older population to a greater extent than a younger population.

Communicable diseases such as; latent TB infection (prevalence 30%*), active TB infection (0.12%*), Hep C infection (12.9%*), Hep B infection (1.7%), HIV/AIDS (1.2%), syphilis (1.1%*)³⁹

*represents statistically significantly higher prevalence than those aged under 50 years

Mental health illnesses such as; depression (prevalence 8-52%), schizophrenia psychoses (3-12%), bipolar disorder (5%), dementia (1-5%), cognitive impairment (7-19%), personality disorder (16-30%), anxiety disorders (13-39%), post-traumatic stress disorder (6-9%)⁴⁰.

Oral health. The average number of Decayed, Missing or Filled Teeth (DMFT) per person in prison aged over 55 and over 60 respectively is estimated to be between 11.441 and 22.542. However, it should be noted that both studies were conducted in countries less resource rich than England, which might make direct comparisons with English prison population difficult.

³⁶ Croft et al (2015) Prevalence of chronic non-cancer pain in a UK prison environment. *British Journal of Pain* 9 (2) 96–108

³⁷ Munday et al (in press). The prevalence of non-communicable disease in older people in prison globally: a systematic review and meta-analysis

³⁸ PHE (2016) Development of a chronic non-cancer pain clinic in South Gloucester prisons: an exploratory study. London: Crown copyright. Available at: <http://www.nta.nhs.uk/uploads/pain-management-clinic-final-report.pdf>

³⁹ Baillargeon et al (2004) The infectious disease profile of Texas prison inmates. *Preventive Medicine*. 28: 607–612.

⁴⁰ Di Lorito et al (2017) Psychiatric disorders among older prisoners: a systematic review and comparison study against older people in the community. *Aging & Mental Health*. Feb 2017: 1-10. Available at; <http://www.tandfonline.com/doi/full/10.1080/13607863.2017.1286453>

⁴¹ Bansal (2012) Dentition status and treatment needs of prisoners of Haryana state, India. *International journal of prisoner health* 8 (1) 27-34

⁴² McGrath (2002) Oral health behind bars: a study of oral disease and its impact on the life quality of an older prison population. *Gerodontology* 19 (2): 109-14

5.3 Data sources and indicators

The number of people in prison with a diagnosis of a specific disease is likely to under-represent the true prevalence of that condition. This is because some individuals with a disease may be asymptomatic or because of barriers (perceived or structural) to accessing diagnosis and treatment. Some diseases are often under-diagnosed in the community and within a prison context this phenomenon is likely to be exacerbated. Diabetes and dementia are both examples of this.

In addition to the sources of data listed below, prescribing data can also be used. This data can be hard to validate, its quality is reliant on the quality of data initially inputted into pharmacy systems and is not always possible to determine what specific disease a medicine was prescribed to treat. Historical prescribing data can be useful when comparing it with the current picture to conduct a trend analysis. However such analysis would need to be adjusted for changes to the underlying demographic in that time (i.e. an increase in older people).

The following table provides a guide as to what forms of prevalence data to draw from and where to obtain it from:

| Indicator | Source | Comment |
|--|---|---|
| Number and proportion of older people with a diagnosis of a key communicable diseases, out of the whole older prison population (produce a % for each disease separately) -Tuberculosis (pulmonary or extra pulmonary) -Herpes zoster (shingles) -Varicella zoster (chickenpox) -Staphylococcus aureus/ panton valentine leucocidin -Invasive Group A Streptococcus (iGAS) -Hepatitis B (acute or chronic) -Hepatitis C -HIV -E.coli 0157, Salmonellosis or other GI infections (Shigella etc.) | -PHE Health and Justice Surveillance -Local BBV screening results -SRHAD (Sexual and reproductive health activity dataset) - GUMCADv2 (Genitourinary Medicine Clinic Activity Dataset) -SystemOne | SRHAD has replaced the KT31 return by the Department of Health to capture contraception and other sexual and reproductive health activities. SRHAD, together with GUMCADv2 form the basis for a standardised sexual health dataset collected from clinical settings across England. For further details visit the SRHAD website . |

| | | |
|--|---|--|
| <p>Number and proportion of older people with a diagnosis of a chronic disease, out of the whole older prison population (produce a % for each disease or disease group separately). Most common chronic diseases groups include:</p> <ul style="list-style-type: none"> -Cardiovascular disease -Respiratory disease -Diabetes -Cancer -Musculoskeletal disease -Chronic pain -Motor impairment -Sensory impairment (esp. visual and auditory) -Incontinence (urinary or faecal) | <p>SystmOne</p> <p>Or</p> <p>Number of people recorded on the relevant chronic disease register for the prison</p> <p>Or</p> <p>Numbers reported by healthcare team to QOF system</p> | <p>Most data in SystmOne is populated by the use of read codes. Therefore, data can be extracted via SystmOne reporting module by sign the relevant codes.</p> |
| <p>Number and proportion of older people with a diagnosis of mental health condition, out of the whole older prison population (produce a % for each disease or disease group separately). Most common mental health conditions are:</p> <ul style="list-style-type: none"> -depression -anxiety disorders -schizophrenia -bipolar disorder -dementia/cognitive impairment -personality disorder -post-traumatic stress disorder | <ul style="list-style-type: none"> - SystmOne data - HJIPs A05K01/02 - HJIPs A05K06/07 - HJIP A05K10 | <ul style="list-style-type: none"> - See appendix B of HJIPs 206/7 user guide for list of relevant read codes - Proportion of people entering or starting in prison a Care Programme Approach (CPA) gives an estimate of over-all level of mental health disease - Proportion of people on individual/ group therapy is also an estimate of prevalence. As with CPA data this may under represent less engaged people - Proportion of people undergoing psychiatric assessment for secure transfer is a proxy for prevalence of more acute disease |

| | | |
|---|---|---|
| <p>-self-harm -suicide</p> | <p>- HJIP A05K18</p> <p>Quarterly Safety in Custody Statistics, MoJ</p> | <p>- May under estimate prevalence of self-harm or suicidal ideation as not all people may present</p> <p>Quarterly statistical bulletins on deaths, self-harm and assaults in prison custody https://www.gov.uk/government/collections/safety-in-custody-statistics</p> |
| <p>Number and proportion of older people with oral disease requiring dental treatment</p> | <p>HJIPs- A06K01-A06K04</p> | <p>Stratifying data into the 4 separate bands of treatment may provide insight into severity of dental disease. May miss patients not assessed by dentist/ not started on a treatment plan</p> |
| <p>Self-reported disease prevalence</p> | <p>Older person survey</p> | <p>Use of a framework such as the Burvill Grid asks participants about acute and chronic disease per major body system</p> |

5.4 Examples of practice

HMP Bronzefield undertook a pilot to improve diagnosis of dementia. They offered (Addenbrooke's Cognitive Examination-III) ACE-III cognitive screening to everyone detained in prison aged over 55 years. Of those screened a quarter received a provisional diagnosis of dementia for the first time, whilst risk factors for the development of dementia were noted in several others. For more information on this approach please contact health-justice@phe.gov.uk

Good practice in measuring disease prevalence often involves not simply relying on one source of data, but triangulating it from a number of available sources. For example, while current data on the prevalence of BBVs in prison is lacking, by looking at testing positivity rates from available sources such as PHE Sentinel Surveillance, HJIPs and information from PHE Dried Blood Spot testing, one can obtain a proxy measure for BBV prevalence in prisons. For further information please contact health-justice@phe.gov.uk

6. Medicines optimisation

6.1 Specific considerations for older people

Medicines optimisation is defined as “a person centred approach to safe and effective medicines use, to ensure people obtain the best possible outcomes from their medicines. Medicines optimisation applies to people who may or may not take their medicines effectively”⁴³. Pharmacy services in prisons include the provision of clinical pharmacy services that support both staff and people in prison with accessing and using medicines safely.

Many of the chronic conditions, identified in previous chapters as being of high prevalence in the older prison population, require the regular administration of medicines to manage or treat effectively. At the same time, the older prison population are at more likely to require support with the safe and effective administration of their medication than younger people in prison or age-equivalent community peers. This can be for a number of reasons, including sensory impairment, cognitive issues, or prison policy (such as “in possession” policy).

Medicines optimisation in this context is therefore about making sure that any decision that is made about medicines is best for the patient and their particular circumstances⁴⁴. When considering older people in prison’s need in this regard, it is helpful to consider the whole medicines pathway from initial diagnosis where a treatment might be first prescribed, through to administration of the medicine. Need could therefore exist in a variety of forms such as; understanding the indication of the medicine, having information about side effects in an accessible or suitable form, supply of or access to medication (especially if it involves queuing for long periods), taking it at the appropriate time or in the appropriate way, which would in turn inform appropriate medicines provision .

6.2 National level data

Prescribing activity within prisons is not centrally collected at a national level. It is therefore difficult to provide an overall picture of the potential level of need within England’s older prison population. However, 44% of the whole prison population

⁴³ NICE (2015) Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. NICE. Available at: <https://www.nice.org.uk/guidance/ng5>

⁴⁴ Specialist Pharmacy Service (2017) Supporting older people in the community to optimise their medicines including the use of multi compartment compliance aids. Available at; <https://www.sps.nhs.uk/wp-content/uploads/2013/06/MCA20toolkit.pdf>

reported taking medication (House of Commons Justice Committee 2013)⁴⁵, whilst in female people in prison Plugge (2006)⁴⁶ reports 73% were taking medication. When looking specifically at the 60 years and over prison population, Fazel et al (2004)⁴⁷ identified that 75% were prescribed at least one medication.

This data does not, however, give an indication of the proportion of people prescribed regular medication that require some level of support to effectively and safely take it. This is often in the form of monitored dosage systems of varying kinds.

6.3 Data sources and indicators

| Indicator | Source | Comment |
|--|--------------|--|
| The number and proportion of people aged 50 years-old and older who have been assessed to hold medication 'in-possession' | HJIP- A08K01 | If possible, stratify data into older (50 and over) and younger (< 50) age groups. |
| The number and proportion of people aged 50 years-old and older of who Did Not Attend (DNA) for supervised medication | HJIP- A08K02 | As above |
| The number and proportion of people aged 50 years-old and older who did not receive their prescribed medication. (excluding DNA's) | HJIP- A08K03 | As above |

⁴⁵ House of Commons Justice Committee (2014) Older prisoners: fifth report of session 2013-14

⁴⁶ Plugge E, Douglas N, Fitzpatrick R. 2006. The Health of women in prison: study findings. Dept Public Health. University of Oxford

⁴⁷ Fazel (2004) Unmet treatment needs of older prisoners: a primary care survey. *Age and Ageing* **33**: 396–398. Available at; <https://academic.oup.com/ageing/article-lookup/doi/10.1093/ageing/afh113>

| | | |
|---|----------------------|---|
| <p>Prescription rate per drug category (as per British National Formulary (BNF) chapters) for the aged 50 and older cohort.</p> | <p>SystemOne</p> | <p>Prescription data alone is a poor indicator of prevalence and needs to be triangulated with other sources of prevalence data (as outlined in previous chapter).</p> <p>It may provide useful information on time-trends of prescribing practice, although differences noted may simply be due to changes in recording practice</p> |
| <p>Establishment of pharmacy staff</p> | <p>Pharmacy team</p> | |
| <p>The number and proportion of older people in prison who are in receipt of a monitored dosage system, or other forms of support (eg medication reminder charts, large print labelling etc.) out of the whole older person cohort.</p> | <p>Pharmacy team</p> | <p>An indication of the level of need already identified within the prison. Report on each form of support separately.</p> |
| <p>The number of older people who have been risk assessed as not being able to have their medicines in-possession</p> | <p>SystemOne</p> | <p>Another way of ascertaining the number of people who need support to take medication appropriately</p> |
| <p>Summary of access to over the counter paracetamol or ibuprofen by older people vs younger people-</p> | <p>SystemOne</p> | <p>Prison providers have a variety of models for accessing over the counter medication. The report would enable any unmet health need to be identified for older people.</p> |

| | | |
|--|-------------------------|---|
| <p>Frequency of medicines review for older people on 4 or more medicines and/ or those on sedating medication</p> | <p>SystemOne</p> | <p>Older people are more likely to have polypharmacy and reduced renal function, reduced adherence to medicines and mobility that may increase adverse effects from medicines. These reviews could be medicines use reviews completed by the pharmacy team (equivalent to those provided in the community) or full clinical medication reviews.</p> |
| <p>The number and proportion of older people at risk of adverse events such as unplanned hospital admission due frailty or inappropriate polypharmacy by using the electronic frailty index (eFI) available on SystemOne</p> | <p>eFI on SystemOne</p> | <p>See National Institute for Health and Care Excellence (NICE) guidance on multi-morbidity use of number of meds and eFI. Note that frailty and polypharmacy are often linked issues</p> |

6.4 Examples of practice

There are different models of delivery of pharmacy services within the prison estate in England. Some prisons have a dispensing pharmacy on site, whilst others use the service of a community pharmacy. It is more important to ensure the service is of sufficient quality than aim for a particular delivery model.

To that end, the Royal Pharmaceutical Society (RPS) have published Professional Standards for optimising medicines for people in secure environments (RPS 2017)⁴⁸ which outlines 23 standards that should be adhered to. Among them are recommendations about; supporting those with long-term conditions to self-manage their medication, supplying medication in containers and with labels that meet people’s additional needs, and holistic support of individuals who require “step up” or “step down” of medication to best manage their long-term condition. The standards are available at: <https://www.rpharms.com/resources/professional-standards/optimising-medicines-in-secure-environments>

⁴⁸ RPS (2017) *Professional Standards for optimising medicines for people in secure environments*. Available at: <https://www.rpharms.com/resources/professional-standards/optimising-medicines-in-secure-environments>

The NHS England Specialist Pharmacy Services⁴⁹ provide resources and networks that facilitate optimising medicines for older people that are relevant for delivering services to older people in prisons.

⁴⁹<https://www.sps.nhs.uk/articles/what-is-the-evidence-to-support-the-use-of-nefopam-for-the-treatment-of-persistent-chronic-pain/>

7. Prevalence of social care need

7.1 Specific considerations for older people

People of any age can require some form of social care support; however, the likelihood of this increases as people age. Various definitions of social care exist, but for the purpose of this document the following guidance, taken from National Offender Management Service (NOMS -now called HMPPS) Prison Service Instruction (PSI) on Adult Social Care⁵⁰ is used. This is taken directly from The Care Act 2014 Statutory Guidance⁵¹ and is therefore the definitive definition for England.

PSI for Adult Social Care (2015)

An individual may be eligible for care and support services if the adult's needs arise from, or are related to, a physical or mental impairment or illness and as a result of the adult's needs the adult is unable to achieve two or more outcomes set out in regulations, and as a consequence there is, or is likely to be, a significant impact on the adult's wellbeing.

These outcomes include:

- managing and maintaining nutrition
- maintaining personal hygiene
- managing toilet needs
- being appropriately clothed
- being able to make use of the adult's home (in this case, the prison) safely
- maintaining a habitable home environment (in this case, the prisoner's cell)
- developing and maintaining family or other personal relationships
- accessing and engaging in work, training, education or volunteering
- making use of necessary facilities or services in the local community (that is prison services and any required community services during temporary release) including public transport, and (prison) recreational facilities or services
- carrying out any caring responsibilities the adult has for a child

⁵⁰ National Offender Management Service (2015) PSI 12/2015 Adult Social Care. Available at: <https://www.justice.gov.uk/downloads/offenders/psipso/psi-2015/psi-15-2015-adult-social-care.pdf>

⁵¹The Care Act (2014) *The Care Act*. TSO: London. Available at: <http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>

It is helpful to view the whole prison establishment as a provider of social care. For example, meal provision, laundry services, educational activities, exercise facilities all contribute to supporting people living there. Therefore social care support for people in prison is provided jointly by health services, social services and prison services. Formal or informal peer support systems in prisons (sometimes called “buddy systems”) can provide low levels of social care support and can prevent, reduce or delay referrals to local social care teams for assessments and support.

Some of the issues to be considered in terms of release planning are discussed in chapter 12. However, it is worth noting that the nature of services and support in prison described above can mask social care need which will exist upon release from prison. Therefore, it is particularly important to obtain information on anticipated social care needs upon release so that LAs can plan and deliver effective services to meet this need.

Activities of Daily Living (ADLs) are defined as: “routine activities that people tend to do every day without needing assistance”. The 6 basic ADLs are; eating, bathing or showering, personal hygiene or grooming, dressing, toileting, and mobility. Much of the social care support provided by LAs is aimed at supporting these activities. In addition, Williams et al (2006)⁵² introduced the concept of “prison ADLs” or PADLs. They define these as “daily physical activities that are unique to prison life and are necessary to independent functioning while in prison”. They include the following activities; dropping to the floor for alarms, standing for count, getting to meals, hearing orders, and climbing onto the top bunk. Therefore the prison environment poses unique challenges to the older person that might not be present in life in the community. The need for support with such PADLs, along with more regular ADLs, should be included within this section of the needs assessment.

It should also be noted that there is not a clear distinction between health and social care need. One area often affects the other- for example in the SPS estate wide social care needs assessment (SPS 2017)⁵³ 90% of those assessed reported a physical health problem which made it harder for them to take care of themselves.

The Care Act (2014)⁵⁴ clarified that Local Authorities are responsible for delivering social care to people with eligible need (see definition in section 7.3 below) residing in prisons that are within their geographical boundary. Social Care Team’s within LAs therefore need to have processes in place to respond to referrals, undertake

⁵² Williams et al (2006) Being old and doing time: functional impairment and adverse experiences of geriatric female prisoners. *Journal of the American Geriatrics Society*. **54**: 702–707.

⁵³ Scottish Prison Service (2017) An Estate wide social care needs assessment. SPS: Available at <http://www.sps.gov.uk/Corporate/Publications/Publication-4941.aspx>

⁵⁴ The Care Act (2014) The Care Act. TSO: London. Available at: <http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>

assessments and deliver care for those in a prison setting. It is beyond the scope of this guidance document to discuss the various potential models of delivery of such a service. However, the Association of Directors of Adult Social Services (ADASS) has developed a Care and Justice Network to enable collaboration between LA teams working in this area. More information can be found at:

<https://www.adass.org.uk/invitation-to-join-the-new-adass-care-and-justice-network>

7.2 National level data

No single estimate of the degree of social care need that exists within England's prisons has been made. However, the following data gives a sense of the level of need identified by a range of surveys, which broadly would be expected to be replicated at an English national level:

In advance of the implementation of the 2014 Care Act, the Department of Health (DoH) undertook an impact assessment of the introduction of the act. This estimated that 8.28% of people in prison aged 50 years or older would be in need of social care⁵⁵.

Based on an estate wide social care needs assessment SPS (2017)⁵⁶ calculated approximate rates of social care need (requiring re-enablement or personal care support). It is estimated that approximately 0.8% of those in prison aged under 50 and 8.5% of those aged over 50 in prison in Scotland have social care needs.

Canadian data on older male⁵⁷ and female⁵⁸ new receptions found a prevalence rate of social care need between 9% (male) and 12% (female) at initial reception assessment.

Hayes et al (2012)⁵⁹ undertook a research study in the North West of England, prior to the implementation of The Care Act. It included an assessment of the social care needs of older people in prison. They found that when measured on a 25 domain scale (CANFOR-S)⁶⁰, the average number of social care needs per older person in prison was 5.7, with the majority of these not currently being met.

⁵⁵ DoH (2014) The Care Act 2014: Regulations and guidance for implementation of Part 1 of the Act in 2015/16. Available at http://www.legislation.gov.uk/ukia/2014/407/pdfs/ukia_20140407_en.pdf - page 81

⁵⁶ Scottish Prison Service (2017) An Estate wide social care needs assessment. SPS: Available at <http://www.sps.gov.uk/Corporate/Publications/Publication-4941.aspx>

⁵⁷ Stewart et al (2014) *Self-Reported Physical Health Status of Newly Admitted Federally-Sentenced Men Offenders*. Correctional Service of Canada. Available at; <http://www.csc-scc.gc.ca/research/005008-0314-eng.shtml>

⁵⁸ Nolan and Stewart (2014) *Self-Reported Physical Health Status of Incoming Federally-Sentenced Women Offenders*. Correctional Service of Canada. Available at; <http://www.csc-scc.gc.ca/research/005008-r332-eng.shtml>

⁵⁹ Hayes et al (2013) Social and custodial needs of older adults in prison. *Age and Ageing* 2013; 42 (5): 589-593.

⁶⁰ Thomas S, Harty MA, Parrott J, et al. 2003. *CANFOR: Camberwell Assessment of Need – Forensic Version*. Gaskell: London.

Although it is hoped the introduction of The Care Act will have reduced the number of unmet needs, the variation in how it has been implemented nationwide is likely to mean unmet social care needs still persist

An HNA of HMP Northumberland (Hamoodi and Christie 2013)⁶¹ identified that 40% of people in prison over the age of 50 self-reported impairment of their ADL's due to a health condition or general "old age".

7.3 Data sources and indicators

Before trying to quantify the level of need within a prison, it is helpful to draw a distinction between "need" and "statutory need" as described in the box below. This is also taken from PSI for Adult Social Care (2015)⁶²

PSI for Adult Social Care (2015)

Not all needs which a prisoner may have will be eligible for local authority support, but local authorities have responsibilities to complete assessments, to prevent escalation of needs, to provide information and advice to aid wellbeing and services such as aids to daily living that will prevent, reduce or delay increased care needs developing. The level of need which triggers eligibility for local authority services is set out in regulations and is applicable to all local authorities in England.

There is no single source of data that prevalence of social care need can be drawn from Available options are as follows and because all have the potential to miss-represent the true level of need, data should be triangulated from as many of these sources as possible:

| Indicator | Source | Comment |
|--|---------|---------|
| Number, and proportion, of older people in prison referred for LA social care assessment in the last year as recorded by prison. | p-NOMIS | |

⁶¹ Hamoodi and Christie (2013) HMP Northumberland; Health Needs Assessment. *Personal Correspondence*

⁶² National Offender Management Service (2015) PSI 12/2015 Adult Social Care. Available at: <https://www.justice.gov.uk/downloads/offenders/psipso/psi-2015/psi-15-2015-adult-social-care.pdf>

| | | |
|---|-------------------------------------|---|
| Number, and proportion, of older people in prison referred for LA social care assessment in the last year as recorded by the LA. | LA Adult Social Care Team | Availability of this will depend on how/ if LAs capture this activity data. May not be accurate measure of need because of peer support or barriers to referral |
| Number, and proportion, of older people in prison in receipt of social care support, taken as a snap shot in time. | p-NOMIS or SystemOne | |
| Number, and proportion, of older people in prison who receive some form of buddy system or peer-based support for any form of social care need. | p-NOMIS | Availability dependant on whether a “buddy system” is in place in the prison or not |
| Number, and proportion, of older people in prison who are registered as having a disability | p-NOMIS | Although usually available, not a good measure of social care need |
| Number, and proportion, of older people in prison who are registered as “locate flat” | p-NOMIS | |
| ’Older person in prison’ survey to identify any form of self-reported social care need. | Local older person in prison survey | |

7.4 Examples of practice

It is likely that the best insight into social care need will be drawn from interview or survey data of older people in prison. Although this can be resource extensive, the richness of data gained from people in prison themselves can make it a worthwhile and cost-effective endeavour. Surveying people in prison to ascertain need can be combined with broader user engagement in an older prison population H&SCNA (see chapter 10).

Hamoodi and Christie (2013)⁶³ undertook a user survey by both electronic and paper means which targeted the 50+ population specifically and covered health and ADL questions. Further information on this can be requested from health-justice@phe.gov.uk

The SPS (2017)⁶⁴ asked officers and healthcare staff to identify anyone for whom they had concerns about their ability to self-manage in any area of day to day functioning. Those identified were assessed through interview by social workers with experience in assessing for potential social care needs in the community. A specially designed template form was used to standardise reporting. This is available in Appendix 1 of the report at <http://www.sps.gov.uk/Corporate/Publications/Publication-4941.aspx>

A number of assessment forms exist; for example, the CANFOR-S⁶⁵ assessment form can be freely copied and used. Although developed for a forensic environment, it is also useful for a prison context. Pathway to care for Older Offenders (DoH 2007)⁶⁶ contains a very useful list of questions and criteria to be measuring against in regard to the extent to which support is currently available within existing prison services. Available at:

http://webarchive.nationalarchives.gov.uk/20130123192716/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079928 (see pages 16-20).

The West Midlands cluster of prisons has a significant older population. One of the initiatives being piloted is a “social care need tracker”. This is completed on a weekly basis per establishment. It categorises level of social care need into 4 different levels, depending on the level of supported needed. In time, this will prospectively capture the level of need across the regional estate with services adapted accordingly. Further information can be sought from J or health-justice@phe.gov.uk

All prisons have some form of “buddy schemes”. Several have developed these so that the more able bodied peers help those in need of support for basic (non-intimate) day to day activities (such as collecting meals, cleaning the cell, or getting around the prison). This is beneficial to both the person in need and the one providing support, and with the correct training and safeguards can be a success for all involved.

RECOOP has been commissioned by the three Devon cluster prisons and the Local authority (Devon County Council) to deliver a Buddy Support Service providing people

⁶³ Ibid

⁶⁴ Scottish Prison Service (2017) An Estate wide social care needs assessment. SPS: Available at <http://www.sps.gov.uk/Corporate/Publications/Publication-4941.aspx>

⁶⁵ Thomas S, Harty MA, Parrott J, et al. 2003. CANFOR: Camberwell Assessment of Need – Forensic Version. Gaskell: London.

Department of Health (2007)⁶⁶ *Pathway to care for Older Offenders*. DoH. Available at; http://webarchive.nationalarchives.gov.uk/20130123192716/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079928

in prison with training (National Care Certificate equivalent) and mentoring to help those requiring assistance. RECOOP offer support and advice in implementing such a scheme for prisons where this is not yet in place.⁶⁷ Further examples of prisons with such schemes are described in the report available at <https://www.mentalhealth.org.uk/sites/default/files/losing-track-of-time-2013.pdf>⁶⁸

To ensure that local authority assessments for eligibility of social care need is as accessible as possible for people in prison, a leaflet that outlines what The Care Act is and how it applies in prison has been developed. This provides useful information to people on their expectations and rights (See “The Care Act and You” leaflet available in the members’ area resource library at <http://www.recoop.org.uk/pages/services/index.php>). A helpful summary of the key issues and a further example of good practice is also available here: <http://www.recoop.org.uk/pages/home/news.php?id=294>

⁶⁷ RECOOP (2017) Chapter 12 The buddy support worker. *In: Working with older prisoners good practice guide*. RECOOP. Available at; <http://www.recoop.org.uk/dbfiles/pages/54/FINAL-Older-Prisoners-Good-Practice-Guide-2017.pdf>

⁶⁸ Mental Health Foundation (2013) *Loosing track of time; Dementia and the ageing prison population*. London: MHF

8. Promoting health and wellbeing, including addressing wider determinates of health

8.1 Specific considerations for older people

To successfully promote health and wellbeing among older people in prison a variety of services are required. This will be a combination of services that seek to either: prevent ill health, detect latent disease at an early stage, improve health or avoid health declining. This includes services such as national screening programmes, immunisation programmes and the physical health checks in prison programme. As illustrated below, the vast majority of those eligible for such programmes will be drawn from the older prison population. However, it is also important to include other areas such as weight management and physical activity programmes, as well as services that promote broader determinates of wellbeing such as social inclusion and intellectual stimulation. Engagement in purposeful activity is crucial in promoting health and wellbeing in the older person in prison, an example of which is given in section 8.4 below.

Immunisation: The older prison population are eligible for: the annual flu vaccination from age 65 (or from any age if they have certain chronic conditions), pneumococcal vaccination at age 65 and shingles vaccination at age 70⁶⁹.

Screening: The older prison population are eligible for; bowel cancer screening every two years for those aged 60-74 (with an opt in programme from age 75+), abdominal aortic aneurysm screening for men only in their 65th year, annual diabetic retinopathy screening for those with diabetes of any age (note the diabetes prevalence is significantly higher in the 50+ population than with younger groups), 3 yearly breast cancer screening from aged 50-70 for women only (note that in some areas an extended age range of 47-73 years-olds is being piloted), and cervical cancer screening from women aged 50-64 every 5 years⁷⁰.

Physical health checks: All people in prison aged 35-74 years-old, who have been in prison for 2 years or more and who are not already on a disease register for one of the assessed conditions⁷¹.

⁶⁹ For the full NHS immunisation schedule see <https://www.gov.uk/government/publications/the-complete-routine-immunisation-schedule>

⁷⁰ For more information see the programme specific pages at <https://www.gov.uk/topic/population-screening-programmes>

⁷¹ For full guidance and eligibility criteria see http://www.healthcheck.nhs.uk/commissioners_and_providers/guidance/national_guidance1/

8.2 National level data

At present there is a limit to the availability of national level data on uptake of immunisation, screening or health checks services within the prison estate. However, during the 2016/17 flu season, approximately 57% of “at risk” people in prison received the flu vaccination⁷² (NB- this includes people in prison of all ages not just the 50+ population).

All programmes have an uptake target and, based on the principle of equivalence of care, target uptake levels for those in detained settings should be the same as for the population in the community. However, the proportion of older people in prison with risk factors for diseases being screened or checked for is likely to be higher than in the general community, and therefore the potential to benefit from such programmes is higher. In addition, screening programme positivity (the proportion of those tested that are diagnosed with the disease) is also likely to be higher than general community levels.

8.3 Data sources and indicators

The following sources of data mostly pertain to uptake of screening or immunisation services. This data is useful if such programmes are fully implemented within the prison. However, as noted in section 8.4, this is not yet consistent across the country. Where local screening programmes come into the prison to offer clinics (such as for Abdominal Aortic Aneurysm or retinal screening) they should be able to provide data on the number of clinics run in a specified time period and the number of people who tested positive at the initial screening test. Data from local screening and immunisation teams should be utilised alongside HJIP data.

Less quantitative data will be available for the availability of, or participation in broader health promoting activities or services that exist in the prison. As per below, the data that is available in regard to this should be obtained, however it is likely that there will be some cross-over between this data and that on service mapping, discussed in chapter 11.

| Indicator | Source | Comment |
|--|--|----------------|
| Abdominal Aortic Aneurysm (AAA) Screening Uptake | HJIP- A01K01/ local screening and imms team data | |

⁷² PHE (2017) PHE Health and Justice Annual review 2016/17. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/642924/PHE_Annual_Report_1617V2.pdf

| | | |
|---|---|---|
| Retinal Screening Uptake- | HJIP- A01K02/ local screening and imms team data | For Diabetics only. If possible, helpful to stratify uptake by older (50+) and younger (<50) age groups |
| NHS Health Check Screening Uptake | HJIP- A01K04/ local screening and imms team data | If possible, helpful to stratify uptake by older (50+) and younger (<50) age groups |
| Bowel Cancer Screening Uptake | HJIP- A02K03/ local screening and imms team data | |
| Seasonal Flu Vaccination Uptake | HJIP- A03K01/ local screening and imms team data | |
| Shingles Vaccination Uptake | HJIP- A03K03 / local screening and imms team data | |
| Breast Cancer Screening Uptake | HJIP- A02K01/ local screening and imms team data | Female prisons only |
| Cervical Cancer Screening Uptake | HJIP/ local screening and imms team data- A02K02 | Female prisons only |
| Numbers participating in age-appropriate physical activity services | Local data/ user survey | See below for example |
| Numbers participating in age-appropriate purposeful activity services | Local data/ user survey | See below for example |
| Participation in alcohol and smoking services | | Data already collected in section 4 |

8.4 Examples of practice

Nationally agreed pathways for the provision of screening programmes in prisons have been released (see <https://www.gov.uk/topic/population-screening-programmes>). To embed this locally, some prisons and local screening programmes have developed SOPs (Standard Operating Procedures) on how to run screening services in prisons. These have been created because of the potential complexity involved in taking screening equipment or screening staff into a prison, or those detained out of prison, in

order to be screened. It also supports local processes whilst IT systems are not available between community and prison services. For screening to offer the fullest benefits to those in prison it must be offered as part of the national screening programme i.e. in an ongoing way; at the correct screening intervals, with positive results handled correctly. For SOPs and further information on this please contact england.tvatpublichealth@nhs.net

HMP Whatton takes a broad view of health promoting activities and provides a number of services for its older population. These include: advice on healthcare, resettlement, debt, housing advice, finance planning and weight management issues, as well as activities promoting the constructive use of leisure time (quizzes, board games, community singing, veterans family support group, etc). This has been run in conjunction with Age UK. Also, modified exercise programmes and activities suitable for the over 50s (walking groups, bowls, gym sessions, badminton and modified cardiovascular sessions) have been developed by the gymnasium team. People in prison can have a piece of land to garden. These opportunities ensure there is purposeful activity outside of the cell for older people in prison. In addition, it allows the development of skills which will support the constructive use of leisure time once released from prison. For more information please contact health-justice@phe.gov.uk

Age UK North Tyneside have worked in partnership with Northumbria University and HMP Northumberland to successfully establish a model of support for older men in HMP Northumberland which has now been operating for 3 years. The service provides social and physical activities for the men and explores different therapeutic interventions to improve their physical and mental health and wellbeing. The service also offers one to one support and information session on a variety of issues, as well as support for older men pre-release to help them reintegrate into society. Through this work and the Older People's Strategic Group at HMP Northumberland overseeing it, they have successfully made a number of changes to the prison environment and regime to better support older men within the prison. The success of the work has been recognised regionally and is now being replicated within prisons across the North East. For more information please contact health-justice@phe.gov.uk

Understanding older people's views on access to purposeful activity is important and chapter 10 discusses user engagement generally. However, a user questionnaire specific to issues around purposeful activity is available in the members' area resource library at <http://www.recoop.org.uk/pages/services/index.php>.

Health information posters can also be a useful way of promoting health and wellbeing for those in prison. Examples are available in PDF format from the same link above that cover a variety of different common diseases. These provide some key facts as well as outlining what individuals can do to "self-manage" and improve their own control over the disease in question.

The age criteria for immunisation and screening programmes were outlined above. However, as discussed in section 1, a person in prison's physical age is estimated to exceed their chronological age by 10 years. Therefore, there is an argument to commence screening and immunisation services at an earlier age in prison than in the community. There is not yet a strong evidence base to do so, but this is being piloted in North West England, where the 2017/8 flu vaccination is being offered to people in prison from age 55 not 65.

9. Palliative care services

9.1 Specific considerations for older people

There has been a continual increase in the overall number of deaths in prison over the 10 years to 2015⁷³. The majority of these deaths are in the over 50's age group (55%⁷⁴). Such deaths are categorised as either homicide, self-inflicted or from natural courses. When considering deaths from natural courses only 84% occur in those aged 50 or over⁷⁵. In instances where a death from natural courses was expected, the need for palliative care and end-of-life services becomes paramount. The majority of those in prison in need of palliative care support will be from this older cohort.

9.2 National level data

There is no nationally collated data available on the number of people in prison per year who require access to palliative care services. However, it is known that in 2016 there were 164 deaths in England and Wales from natural courses in the older prison population⁷⁶ which equates to a rate of 13 per 1,000. However, as palliative care services should be made available to those in the last 12 months of life, not just in the final few days⁷⁷, this rate does not estimate well the level of need for palliative care services in prisons. Furthermore, in practice it is often not possible to be clear when the final 12 months of life starts. It is therefore difficult to ascertain exactly what the need for such services is at a national level.

9.3 Data sources and indicators

The number of people in prison in need of palliative care services at any one time is likely to be quite low, when compared to other services or areas of need highlighted elsewhere in this document. However, due to the complex nature of palliative care generally, which is increased when delivered within a prison context, it is important to try and draw data on the level of need within the prison in question.

⁷³ IAP on Deaths in Custody (2015) *Deaths in State Custody An examination of the cases 2000 to 2014*. Available at: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/12/IAP-Statistical-Analysis-of-recorded-deaths-in-state-custody-between-2000-and-2014.pdf>

⁷⁴ MoJ safety in Custody Statistics. Deaths in prison custody 1978 to 2016. Available at; <https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-march-2017>

⁷⁵ Ibid

⁷⁶ Ibid

⁷⁷ Leadership Alliance for the Care of Dying People (2014) *One Chance to get it Right Improving people's experience of care in the last few days and hours of life*. Available at: <https://www.england.nhs.uk/ourwork/qual-clin-lead/lac/>

| Indicator | Source | Comment |
|---|--|--|
| Number and proportion of patients on a palliative care register or care pathway out of whole 50 year-old and older cohort | SystemOne | If prison has such a register available. |
| Number of people with a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) | SystemOne | Does not necessarily indicate patient is in receipt of end of life care |
| Number of natural course deaths in prison in last year | MoJ | Available from the most recent "deaths in prison custody spreadsheet", per prison at https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-march-2017 |
| Review of findings from PPO investigation into deaths by natural course in the prison | PPO | PPO reports can be filtered by; age, gender, establishment, cause of death at https://www.ppo.gov.uk/document/fii-report/ |
| Users views on the adequacy of current palliative care services and preferred delivery models | Older person in prison survey or focus group | If being undertaken- see chapter 10 on user engagement. |

9.4 Examples of practice

In response to the increasing demand for palliative care services in prisons, NHS England and MacMillan have developed a Community of Practice in Health and Justice for Palliative and End of Life Care. This group aims to provide an opportunity for key stakeholders to build a broad network, to share learning, best practice and resources in this area. A dying well in custody charter will be developed to address some of the challenges faced when providing palliative care in prison. More information on this initiative is available at <http://learnzone.org.uk/blog/articles/article.php?post=128>

In HMP Whatton, a palliative care suite has been developed and is based on a community hospice model. The aim is for people in prison to remain in their residential wing as long as possible, in order to maintain the contact and support of peers, and then to be moved to the specialist suite for their final days. This enables families to stay with a loved one for longer as it is not dependent on prison regime visiting hours. Other people detained in the prison can also visit. The space and privacy the suite provides also allows for the more intensive support from health and care staff that can be required. In addition, compassionate release is initiated for any person needing hospice

care. Their experience since 2008 is that many people prefer to stay in prison to die because they feel better looked after there than in the community. This is because they might not have family support in the community and their friends and support are in prison. For more information please contact Susanne.Howes@phe.gov.uk or health-justice@phe.gov.uk

The Prison and Probation Ombudsman (PPO) report on lesson's learned from their investigations into naturally-caused deaths of people in prison over 50⁷⁸, makes recommendations for palliative care services. These include ensuring palliative care services are holistic in their scope, are commenced early in the terminal disease pathway, and include consultation with the individual over the most suitable environment for them to end their life. In addition, a recommendation not to continually shackle people in prison until death is also made.

Devon county council included the need for palliative care services in their local prisons in a county wide palliative care specific needs assessment⁷⁹. The integration of community and prison palliative care assessment is a good approach, especially as some people in prison may require palliative services at a community hospice and community palliative care nurses will provide support within a prison. There can therefore be considerable movement between prison and community settings. See pages 33 and 34 at <http://www.devonhealthandwellbeing.org.uk/library/needs-assessments/>

For more information on this approach please contact: health-justice@phe.gov.uk

⁷⁸ Prison and Probation Ombudsmen (2017) *Learning from PPO Investigations: older prisoners*. Available at <http://www.ppo.gov.uk/document/learning-lessons-reports/>

⁷⁹ End of Life Health Needs Assessment (2017), Devon County Council. Available at; <http://www.devonhealthandwellbeing.org.uk/library/needs-assessments/>

10. User engagement

10.1 Specific considerations for older people

As referenced previously there is a richness of data and insight that can only be obtained by successfully engaging service users with the H&SCNA. It is well documented that it is very easy for the voice of older people in prison not to be heard by those who commission or deliver services⁸⁰. Although the voice of users of any age can be failed to be heard, this is more of a risk for the older cohort. This can be because they invariably pose no control problems to prison staff and can often have an attitude of not wanting to “make a fuss”. It is therefore all the more important to be pro-active in engaging with this group to ensure they can raise their needs and concerns in an appropriate forum.

There is a limitation to the extent that the quantitative data sources listed in earlier chapters can provide a full picture of the needs of the older prison population. The qualitative data gained from service user consultation complements the data already referred to. To support this examples of practice and pre-designed questionnaires are available to be used and existing prison councils or forums can be used.

10.2 Examples of practice

HMP Lewes prison has used a focus group approach to engage with older people. In collaboration with NHS England and User Voice they have explored to date:

- issues with the regime- For example, whether they have enough time to shower or wash as they get frailer, whether they are confident to go out in free flow if they have reduced mobility
- issues with the environment- For example, are there enough grab rails or seats in showers for those that need them
- issues with their own health- For example, whether they feel isolated, what support they feel is more needed. Issues like replacement of hearing aid batteries and access to fitness sessions dedicated and geared to older people were raised

For more information on this please contact health-justice@phe.gov.uk

⁸⁰ HM Inspectorate of Prisons (2004) *'No problems – old and quiet': older prisoners in England and Wales: A thematic review by HMP Chief Inspector of Prisons*, London HM Inspectorate of Prisons

RECOOP advocate for engagement with service users, and from their experience of supporting this within a number of prisons, have developed an age-specific questionnaire that can be downloaded from the members area of the website and utilised in a local context. See <http://www.recoop.org.uk/pages/members/login.php>

If an older person in prison forum does not yet exist within the local prison then the process of engaging service users for the purpose of an H&SCNA can be used as a catalyst to start this. Examples of where this has been done and how to establish such a forum are detailed in:

- Chapter 2 of Prison Reform Trust (PRT) (2010) *Good practice with older people in prison - the views of prison staff*, available at <http://www.prisonreformtrust.org.uk/uploads/documents/doingtimegoodpractice.pdf>
- Chapter 3 of RECOOP (2017) *Good Practice Guide: working with older prisoners*, available at <http://www.recoop.org.uk/dbfiles/pages/54/FINAL-Older-Prisoners-Good-Practice-Guide-2017.pdf>
- CLINKS (2016) *Good practice in service user involvement*. CLINKS. Available at: https://www.clinks.org/sites/default/files/clinks_good-practice-sui_final.pdf

11. Mapping of services to meet need

11.1 Specific considerations for older people

This element of the H&SCNA is a crucial part of the process. The proceeding chapters will have built, step by step, a picture of the nature of health and social care need within the population of older people in the prison in question. This section serves two related purposes; firstly, to map out the provision of health services as they currently exist and how well they are currently utilised. Secondly, to identify gaps in services where provision is not currently sufficient, and areas where services in their current form are surplus to requirement.

This is particularly important for older people in prison because they are likely to be; in contact with the prison health services for longer (due to average sentence length) than younger people, have a higher burden of complex chronic diseases (as demonstrated earlier) and use health services more frequently than younger peers (see below).

An important principle that underpins this section is that of equivalence of care. This principle is that those who are detained in a custodial setting should have access to the same range and quality of services as someone in the community would expect to have.

In addition, this section needs to outline what training specific to the needs of older people in prison have been undertaken by prison and healthcare staff as the degree to which they are or are not trained to support them effectively will have a direct effect on the quality of services delivered.

11.2 National level data

Wangmo et al (2016)⁸¹ found that older people in prison visited GPs 1.43 times more often than younger people in prison over a 6-month study period, whilst Marquart et al (2000)⁸² recorded that the average number of visits to the prison infirmary for those aged 50 or over was 20-24 per year. A survey of prison staff throughout England identified that only those in a third of establishments had undergone any training specific to older people⁸³.

⁸¹ Wangmo et al (2016) Aging Prisoners in Switzerland: An analysis of Their Health Care Utilization. *Journal of Aging Health*. Apr; **28** (3): 481-502

⁸² Marquart (2000) The health-related concerns of older prisoners: implications for policy. *Ageing and Society* **20**; 79-96.

⁸³ Prison Reform Trust (2010) *Good practice with older people in prison - the views of prison staff*. PRT; London.

Available

at;<http://www.prisonreformtrust.org.uk/Portals/0/Documents/doing%20time%20good%20practice%20with%20older%20p eop,.pdf>

11.3 Data sources and indicators

To effectively map services to the health need identified in earlier sections, the following data sources can provide useful data. This then allows a gap analysis to be conducted. Where possible, focusing this section specifically on data from those aged over 50 is helpful. This is because they might face particular challenges over accessing clinics (remembering appointments if suffering with dementia or reliant on others if in a wheel chair).

| Indicator | Source | Comment |
|--|---------------------------------|--|
| Waiting times for key long term conditions clinics utilised by older people | HJIP- A09K02 | Can be sub-divided by main types of clinic |
| Clinic utilisations for older cohort- Number of older people seen in clinic as a proportion of number of older people “called up” | HJIP- A09K01 | |
| DNAs for older cohort- Number of older people not attending/ attending too late to be seen in clinic as a proportion of number of older people “called up” | HJIP- A09K03 | |
| Timeliness of MH secure transfers for older cohort | HJIP- A05K11-16 | |
| List of clinics and services | Provider and commissioner | |
| Number of clinic sessions per week/ month | Provider and commissioner | |
| The number of older people attending specific clinics | HJIP- A09K05 | Can be used to identify clinics most commonly used by older people |
| Healthcare staffing establishment | Provider and commissioner | |
| Older person specific training undertaken | Survey or discussion with staff | Can be undertaken formally or informally |

| | | |
|------------------------------|-------------------------------|--|
| Users perception of services | Older person in prison survey | Will identify barriers to access and perception of quality and suitability |
|------------------------------|-------------------------------|--|

11.4 Examples of practice

The existing PHE HNA toolkit (<https://www.gov.uk/government/publications/prescribed-places-of-detention-health-needs-assessment-toolkit>) has a table on page 41 that can be used as a template to summarise what healthcare services are in place already within an establishment. Page 45 then provides a list of 7 questions to consider to help determine what they key findings of a needs assessment are and where gaps in services exist.

In addition to the use of the table described above in the HNA toolkit, HMP Northumberland’s HNA (Hamoodi and Christie 2013⁸⁴) obtained a more detailed description of current services from the Head of Healthcare. These were for a specific, smaller group of diseases that the HNA had identified as being priority areas. For more information on this approach contact health-justice@phe.gov.uk

⁸⁴ Hamoodi and Christie (2013) HMP Northumberland; Health Needs Assessment. *Personal Correspondence*

12. Planning for release and continuity of care

12.1 Specific considerations for older people

The continuity of health and social care for people entering and leaving prison is of upmost importance, however the experience of people moving through the criminal justice system can often one of fragmented and disjointed care. Older people entering or leaving prison can be particularly vulnerable and more susceptible to the negative consequences of a lack of continuity of care. For example, on reception into prison, the older person is more likely to be on long-term medication for chronic diseases. Their need for prompt medicines reconciliation (as per NICE guidance⁸⁵) is significant because of the potential negative effects of un-planned changes to their medication regime.

Release from prison poses another significant challenge for the older person. Those who have served long sentences have the potential to be the most “institutionalised” of those being released⁸⁶ and for those convicted of sexual offences there may have been a breakdown of their community support network, resulting in less help from family and friends. Challenges can exist in obtaining GP registration in the community or for GP’s to access medical records of those recently released. This provides a disproportionately high challenge for the older person on release because of the high prevalence of long-term conditions and associated health-care utilisation to manage these. The outcome of this lack of continuity of care in this group is of mortality rates have been calculated as almost 3 times higher than those in the community⁸⁷.

The challenges around social care provision have been highlighted in chapter 7 of this document. Such challenges continue upon release into the community where it can be extremely difficult to arrange a social care package prior to release, even if a need has been formally identified in the custodial setting. This can be because upon release, an individual may not live in the same Local authority area that they have been detained within

Release support also needs to recognise wider rehabilitation needs appropriate to an older population for example appropriate housing

⁸⁵ NICE (2016) *NG57- Physical health of people in prison*. Available at; <https://www.nice.org.uk/guidance/ng57>

⁸⁶ PRT (2008) *Doing Time: the experiences and needs of older people in prison*. London: PRT. Available at: <http://www.prisonreformtrust.org.uk/Portals/0/Documents/Doing%20Time%20the%20experiences%20and%20needs%20of%20older%20people%20in%20prison.pdf>

⁸⁷ Revolving Doors Agency (2017) *Re balancing Act*. Available at: <http://www.revolving-doors.org.uk/blog/rebalancing-act>

12.2 National level developments

The prison reconfiguration programme provides an opportunity for the situation described above to be improved upon. It is anticipated that a significant part of the function of resettlement prisons will be around the successful planning of release from prison. This is of course a collaborative exercise and requires engagement of community rehabilitation companies, probation services, parole boards, health services, local authorities, 3rd sector groups and others. The implementation of the new Health and Justice Information Service will also allow for the “mainstreaming” of health records for those in prison and make transfers of care significantly easier for those being released. Furthermore, it is anticipated that reception prisons will developed the expertise around the support of individuals entering the prison system, especially those for the first time.

12.3 Data sources and indicators

Nationally there were 21,357 offenders were received into custody as first receptions in the latest quarter (Q4 of 2016/17), while 17,703 were released from custody in the same time period⁸⁸. For the purpose of the local needs assessment, it is important to obtain the same details for the local establishment. This should already have been undertaken as part of section 2.3.

In addition, the following data is important to collect:

| Indicator | Source | Comment |
|--|-----------|----------------------------|
| The number and proportion of all transfers received from within the older person cohort who have an initial health assessment on reception before transfer to their cell | SystemOne | As per NICE guidance NG 57 |
| The number and proportion of all transfers received from within the older person cohort who have a second-stage health assessment within 7 days | SystemOne | As above |

⁸⁸ MoJ (2017) *Offender Management statistics quarterly, England and Wales*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/633154/offender-managemen-statistics-bulletin_-q1-2017.pdf

| | | |
|---|---|--|
| The number and proportion of all transfers received from the older person cohort with a minimum of 7 days' supply of medicine | - HJIP A08K06 | Gives an indication of the degree to which medicines optimisation guidance is adhered to |
| The number and proportion of all discharges from the older person cohort with a minimum of 7 days' supply or FP10. | - HJIP A08K07 | As above |
| The number and proportion of all discharges from the older person population who had eligible care needs | - Local data from prison or from Local authority social care team | Assess the volume of need for planning of social care need upon release |
| The number and proportion of all discharges from the older person population who are released to "no fixed abode" | - Local data | |
| Perceived needs in planning and upon release from prison amongst the older prison cohort | | |

12.4 Examples of practice

RECOOP have identified the potential challenge for older people at reception and induction. For someone, with even low levels of cognitive or sensory impairment, the process of entering the prison establishment can be particularly challenging. They have therefore produced some "top tips" to help make reception and induction as age-friendly as possible⁸⁹ available at: <http://www.recoop.org.uk/dbfiles/pages/54/FINAL-Older-Prisoners-Good-Practice-Guide-2017.pdf>

Age UK Evergreen 50+ Advocacy Service in HMP Leicester have actively sought funding to ensure that older people are released from prison into suitable accommodation i.e. sheltered housing, hostels etc., with needs identified through their advocacy service that relate to resettlement noted in individuals' resettlement passport folders. For more information, see:

⁸⁹ RECOOP (2017) Chapter 2 Age-friendly reception and induction. In: Working with older prisoners good practice guide. RECOOP. Available at: <http://www.recoop.org.uk/dbfiles/pages/54/FINAL-Older-Prisoners-Good-Practice-Guide-2017.pdf>

<http://www.prisonreformtrust.org.uk/uploads/documents/doingtimegoodpractice.pdf>

Services highlighted in chapter 8 that provide purposeful activity for older people often include support on preparation for release. For example, the Age UK service in HMP Northumberland provides support for older men pre-release to help them reintegrate into society (see section 8.4).

The Restore Support Network have been trialling a user-friendly and personalised 'My Life My Care' approach to release planning. This involves production of guidance notes for all older people with care needs in prison prior to release and signposting them to services while serving their sentences and in preparation on their release. They are then issued with a personalised pathway document to fill in and take with them when they are released (or transferred to another prison). This approach has now been introduced in HMP Wymott, Guys Marsh and Portland. For more information contact info@restoresupportnetwork.org.uk

13. Prioritisation and implementation

The final section of the H&SCNA brings together the findings and translates the report into a plan for action. It is important that the key findings are summarised in this section. This should include any inequalities noted from the findings, how it compares to previous needs assessments and what the main priorities for action are as a result of the work.

Full engagement of the working group for the H&SCNA will ensure the recommendations are implemented successfully through collaborative working.. It is good practice to take the list of recommendations and transform these into an action plan. This can highlight timescales for implementing the recommendation, state who is responsible, outline how it can be achieved and also record progress against each point.

Depending on the governance structure that exists locally, the H&SCNA working group can continue on at this stage and keep ownership of the action plan (potentially turning into a task and finish group). Alternatively, a pre-existing group such as the Local Prison Partnership Board, or Local Delivery Quality Board may take on oversight of the implementation of the recommendations. Engaging with the local Health & Wellbeing Board may also be of value especially given the local authority's responsibility for identifying and responding to the social care needs of people in prison. Such an approach could also help mitigate the historic tendency for prisons to have little or no local accountability and to exist in isolation from the community in which they are sited.

A needs assessment is a key part of the commissioning cycle. The results from it should be used to inform documents used during the process of procuring services. For example, in the development of service specifications that will outline what specific services that commissioner expects to be provided. These expectations can then be established in the provider/ commissioner contracts, and monitored via the usual contract monitoring processes.

It is therefore expected that undertaking a needs assessment, as described in this document, should have a direct and tangible impact on the services provided for older people in prison. This should then impact positively on the health and wellbeing of this population group