Prison Health

Proposed Models of Care (Adult Male Prisoners)

Consultation Exercise

February 2009
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Introduction

South Staffordshire Primary Care Trust (PCT) area includes six prisons for which the PCT has responsibility for commissioning a range of primary and secondary care health services.

The PCT, along with the Prison Service, has formed a Prison Health Partnership whose objective is “the development and delivery of healthcare services that provide prisoners with access to the same range and quality of services as the general public receives from the NHS.”

The possibility of a new prison development within South Staffordshire has provided the PCT with an opportunity to consider, on a large scale, how prison healthcare services should be structured in the future. Provisionally named Featherstone 2, this proposed establishment will house upwards of 1,600 adult male prisoners.

The following document represents notes from the discussions and debates that occurred during a number of workshops (held between October and December 2008). Facilitated by West Midlands Care Services Improvement Partnership (CSIP) and attended by a wide range of clinical leads and commissioners, the workshops purpose was to identify best practice models for healthcare delivery within a prison setting. The underpinning principles upon which discussions were based are outlined below.

The context of the workshop discussions was around Featherstone 2, a large adult male remand prison; however the principles identified regarding care delivery are largely applicable to any adult male prison setting. The models of care are also applicable to female and young offender’s establishments, although further work will be undertaken at a future workshop to identify additional gender and age specific service requirements.

At the end of each section additional issues pertinent to the proposed new prison have been recorded.

A wide range of services are described in this document. The range and depth of services commissioned will be shaped by the resources available and the priorities set by the Prison Health Partnership.

Ultimately the models of care proposed in this document, once tested through the consultation process, will provide the Prison Health Partnership with a comprehensive description of the direction of travel for prison health development over the coming three to five years.
Aim of the Consultation

Although the Models of Care workshops sought to engage as wide an audience as possible (group membership is detailed in Appendix 1) the PCT is seeking to undertake a formal consultation exercise to enable the views and comments of a wider range of stakeholders to be obtained.

The purpose behind this consultation is to address the following questions:
1. Will the models proposed meet the health needs of prisoners? Yes/No
2. If no, what amendments are required?
3. Are the models comprehensive? Yes/No
4. If no, what is missing?
5. What barriers exist to the implementation and delivery of these models?
6. How can these barriers be overcome?
7. Can these models be applied to both the female and young offender populations? Yes/No
8. If no, why can they not be applied?
9. Will the models proposed provide equity with the community? Yes/No
10. If no, how could equity be achieved?
Who is involved in the consultation?

The following organisations have been invited to participate in this consultation exercise:

- South Staffordshire PCT (SSPCT) Commissioners.
- South Staffordshire PCT (SSPCT) Provider Arm.
- South Staffordshire Prison Health Partnership Board.
- West Midlands Strategic Health Authority.
- Prison Service Area Office.
- Serco Health.
- National Offender Management Service.
- Offender Health (Department of Health).
- South Staffordshire Council.
- Staffordshire County Council.
- South Staffordshire and Shropshire Healthcare NHS Foundation Trust.
- Birmingham and Solihull Mental Health Foundation Trust.
- Mid Staffordshire NHS Foundation Trust.
- The Royal Wolverhampton Hospitals NHS Trust.
- South Staffordshire Local Medical Committee (LMC).
- Staffordshire Drug and Alcohol Action Team (SDAAT).
- National Treatment Agency (West Midlands).
- West Midlands Deanery.
- Staffordshire University.
- Keele University.
- Wolverhampton University.
- Voluntary Sector Agencies.
- Staffordshire Health Scrutiny Committee.
- West Midlands Ambulance Service NHS Trust.
- Wolverhampton City Primary Care Trust.
Underpinning service principles

All models of care should provide:
- Best practice.
- Equivalence to the community.
- Innovation.
- Effective use of resources to reduce the need for external movement of prisoners.
- Cost effective care.
Summary of health needs (adult male prisoners)

National and local prevalence data for adult male prisoners is as follows:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Remand prisoners</th>
<th>Sentenced prisoners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>19%</td>
<td></td>
</tr>
<tr>
<td>Coronary Heart Disease (CHD) risk factors</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>0.8%</td>
<td></td>
</tr>
<tr>
<td>Neurotic Disorder</td>
<td>58%</td>
<td>40%</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>78%</td>
<td>64%</td>
</tr>
<tr>
<td>Functional Psychosis</td>
<td>10%</td>
<td>7%</td>
</tr>
<tr>
<td>Suicidal thoughts (past week)</td>
<td>12%</td>
<td>4%</td>
</tr>
<tr>
<td>Non suicidal self harm</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Severe alcohol misuse</td>
<td>7%</td>
<td>4%</td>
</tr>
<tr>
<td>Opiate dependence only</td>
<td>11%</td>
<td>8%</td>
</tr>
<tr>
<td>Opiate and stimulant dependence</td>
<td>15%</td>
<td>10%</td>
</tr>
<tr>
<td>Stimulant dependence only</td>
<td>175</td>
<td>16%</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>4.5%</td>
<td></td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td>1.5%</td>
<td></td>
</tr>
<tr>
<td>Herpes</td>
<td>2.5%</td>
<td></td>
</tr>
<tr>
<td>Genital Warts</td>
<td>3.5%</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>15%</td>
<td>7.2%</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>20%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Speech and language disability</td>
<td>11%</td>
<td></td>
</tr>
<tr>
<td>Learning Disability</td>
<td>6.7%</td>
<td></td>
</tr>
<tr>
<td>Borderline Learning Disability</td>
<td>25.4%</td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td>74%</td>
<td></td>
</tr>
<tr>
<td>Overweight</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Obese</td>
<td>30%</td>
<td></td>
</tr>
</tbody>
</table>

A detailed desk top health needs assessment (HNA) has been completed for Featherstone 2 which is available upon request.

References:
- SSPCT HNA (2007).
- Toolkit for HNA in Prisons (University of Birmingham 2000).
- No One Knows (Prison Reform Trust).
Primary Care Services (GP and Nursing)

- Clinics (GP, Nurse and Specialist).
- Screening.
- Triage.
- Secondary Health Assessments.
- In House Diagnostics.
- Tele-medicine.
- Care Closer to Home.
- Discharge.

Clinics

GP led clinics should include:
- Substance Misuse.
- Primary Mental Health.
- Minor Surgery (removal of lumps, bumps, aspirations and joint injections but not endoscopies or sigmoidoscopies).
- Epilepsy.

Nurse led clinics (physical health) to include:
- Diabetes.
- Dermatology with Tele-medicine link to secondary care to reduce the need for external escorts.
- Asthma/Chronic Obstructive Pulmonary Disease (COPD).
- Wound Care (related to substance misuse/self harmers) with Tele-medicine link to secondary care.
- Hypertension (related to substance misuse).

Obesity management should be built into health promotion activities.

Nurse led clinics do not work well when the nursing staff work in isolation. These need to be delivered in partnership with a GP (ideally with a specialist interest) with nurses working under the GPs direction. Using General Practitioners with a Specialist Interest (GPwSI) should reduce secondary care referrals. To maximise resources GPs could be employed on a sessional basis and may not necessarily have a formal GPwSI qualifications, but have proven experience.

Specialist clinics to include:
- Warfarin (Deep Vein Thrombosis (DVT)) aimed at drug users.
- There is a possibility of using Tele-medicine to reduce secondary care activity.

Reception Screening (remand prisons)

Initial screening in remand prisons would continue to be undertaken using the Grubin Tool which includes weight, height, Body Mass Index (BMI), Blood Pressure (BP) and a urine test (which could also be used to check sugars levels for diabetes.) If a positive result was achieved the prisoner would then require a blood test.
Reception Screening requires a very fast turnaround, concentrating on immediate health concerns. There would therefore, ideally, be an option to take those returning to the prison with bad news (i.e. long court sentence) through to healthcare for support in a quiet/sooth room. A member of staff would need to be available for this during intake.

Peak times in reception are between 4.00 pm - 8.30 pm.

**Secondary Health Screens**

Secondary health screens are more in depth than the initial reception screen. The assessments would be guided by the clinical I.T. system, with suitable algorithms to flag patients who need referrals and tests or who need to be added to the appropriate chronic disease registers.

Screening would be undertaken as part of the induction period and would be in addition to the current processes which include assessment of substance misuse and mental health history, height, weight, urine testing and BP. Additional screening would include:
- Coronary Heart Disease (CHD) / Cholesterol for those with the correct indicators (pulse, blood pressure, exercise, alcohol and smoking).
- COPD.
- Cardio Vascular Disease (CVD) – patients are screened at 40 years old in community, however because prisoners are a higher risk they should be screened in relation to the presence of risk factors.
- Chlamydia (under 25 years of age).
- Cancer screening programmes – also need to be linked to health promotion activities.
- Faecal Occult Blood test (FOBs) for colorectal cancer. Targeted at those over 59 years of age. Concerns were raised over the sensitivity of this test, the high positive results and the possible need for next stage investigations (endoscopies and biopsy).

**Screening Programmes**

These would be supported through the use of templates on the clinical I.T. system, like those used for the Quality and Outcomes Framework (QoF).

Registers need to be set up and maintained following screening.

Diabetic Retinopathy should be made available as part of the annual multidisciplinary diabetic review undertaken by a GP, optician and nurse. The nurse would provide referrals on to the podiatrist where required.

**Triage of Applications**

The aim is to ensure that all prisoner applications are directed to, and seen by, the correct health care professional as quickly as possible. An application system, either I.T. or paper based, will be required for this purpose.

A triage algorithm would support the initial triage and allocation of clear cut applications and could be managed by an administrator.

A clinician (nurse) would triage more complex applications with access to a GP for advice, if required. These nurses would also be responsible for running the minor injuries/illness clinics (to pick up patients making referrals for these reasons).
For patients on a health professional’s existing caseload there would be direct access back to see them, rather than the need to complete a further application.

**In house Diagnostics**

- Mobile Ultrasound.
- Standalone Electrocardiogram (ECG).
- 24 hour blood pressure testing.
- Spirometry.

**Tele-health /Tele-medicine**

Three High Security Prisons within the UK currently use Tele-medicine. A successful system is based on good operation, secondary care communications/links, a shift in culture and suitable training packages.

For Tele-medicine to work effectively it will require sign up from, and good working relationships with, secondary care services (to work as partners and to provide the necessary remote consultation and advice). Suitable training packages will also need to be delivered.

Clinical Uses of Tele-medicine:

- Tele-conferencing and remote secondary care consultations.
- Pictorial information for review and advice (e.g. wounds, dermatological issues).
- Urgent care assessments e.g. ECG for suspected heart attacks.
- Vital sign monitoring (e.g. remote / 24 hour monitoring of falls, diabetic alarms, blood pressure, ECG).

Suggested ideas for use:

- Wound Care.
- Out of Hours (OOH).
- Urgent Care.
- Dermatology (if a biopsy is required this could be undertaken by the prison GP to prevent an external escort).

**Quality and Outcomes Framework (QoF)**

It would be best practice to introduce the principles of the QoF into prisons, although not necessarily the payment mechanism or the exact same community QoF indicators, as the population has different health needs.

**Access to NHS Direct**

Pin phones are available on prison wings; with prisoners having access to certain free numbers e.g. Samaritans. Discussions took place as to whether NHS Direct should be included within these free numbers. It was felt that overall this was not required due to enhanced access to healthcare staff that prisoners would have. It would be important, however, to ensure prisoners were aware of NHS Direct on release.
Care Closer to Home

Secondary care demands tend to be primarily for:
- Mental Health.
- Trauma and Orthopaedics.
- Forensic Psychiatry.
- Ear, Nose and Throat (ENT) – an ENT triage service is run in the community with an experienced GpwSI. This model could be adapted for the prisons.
- Oral Surgery.
- Urology.

Tele-medicine would be unlikely to help in many of these areas.

There is a need to engage with secondary care staff to advise them of the healthcare facilities and skills available within the prison to prevent unnecessary inpatient stays.

The Seisdon Peninsula currently has an Intermediate Care Team going into New Cross Hospital to assess patients and move them back into the community. This could evolve to include prisoners.

Other activities that could be delivered within the prison include:
- Pre-operative tests.
- Post-operative patients could be returned to Inpatients Units (Brinsford and Dovegate). This would need to be assessed on a case by case basis.
- Follow-up. Could be supported by Tele-medicine or GPs working under the consultant’s direction, on an agreed management plan.

All areas of “care closer home” delivery require good working relationships between prison health and the acute provider to enable access back into the acute system if necessary.

Discharge Planning

Healthcare needs to be actively engaged in the resettlement process. Ideally all prisoners could be pre-registered prior to release, with the main priority on ensuring that prisoners with high and complex needs are registered. Healthcare could complete any necessary forms and health checks prior to the prisoner’s release.

Access to the Exeter System is not available within the prison, therefore the high turnover of the prison and the need to check registrations will place extra workload on the healthcare team’s administrators.

The Clinical I.T. system should have a function to enable a summary of healthcare interventions to be sent to the prisoner’s community G.P. on release.

Due to the short time in a particular prison remand prisoners require a more streamlined discharge planning process to ensure a timely response.

Issues pertinent to Featherstone 2 (F2) only

- There will be an estimated 26 new receptions per day over five days per week, excluding
returns from court.

- There is a need to ensure that channels of communication are kept open between the separate wings, as they are likely to be very regimented (not free flow).
- Rooms will be specified to be multifunctional wherever possible. All treatment rooms will be designed to minor surgery specification (infection control standard).
- It was agreed that an in house X-ray facility was not appropriate; instead arrangements should be made to use a mobile unit. This could be used for fracture follow up appointments for example. There would be an assessment of the demand and cost of bringing in a mobile unit versus taking prisoners out. Some concern was expressed over the quality of x-rays from mobiles facilities.
- Planned Tuberculosis (TB) screening could also be undertaken at F2 using a mobile screening unit.
- Due to the predicated activity levels it has been requested that the prison reception area has two interview rooms, both of which will need to be staffed by healthcare staff during intakes. It has also been requested that the reception area has a small treatment room to enable minor injuries to be addressed straight away. This will also require staffing during intakes.
- Based on current adult male prison activity it is estimated that there will be 40-50 healthcare applications a day. Some of these could go through the proposed Advice and Referral Centre model discussed in the mental health workshop.
- A team of 3/4 three/four (head count) skilled nurse prescribers could triage more complex applications on a rota basis.
- Advice is required regarding whether pre-registering patients with a GP is allowed.
- Access to the Exeter System is not available within prisons. The high turn over of the prison and the need to check GP registrations will place extra workload on the PCT Registration Team (an estimated 3,500 calls / year or 67 a week).
- It was felt that due to the population needs it is likely the numbers will be too small to make an Expert Patient Programme work. In addition groups need to be consistent and stable which a local prison could not support. This development was therefore considered a low priority.
- Activities that would be undertaken in the central healthcare facility were minor surgery, joint injection clinics, secondary care clinics and other low volume services.
- Activities that would be undertaken in the wing based healthcare facilities were all higher volume activities, GP clinics, nurse led clinics and primary mental health
- A minimum of three GPs are needed for the in hours service.

**Prison Health Performance and Quality Indicators**

This Primary Care Services (GP and Nursing) model supports delivery of the following Prison Health Performance and Quality Indicators:

- 1.4 Chronic Disease and Long Term Condition Care.
- 1.5 Continuity of Case Management.
- 1.6 Discharge Planning.
- 1.16 Comprehensive Range of Services.
- 1.17 Access and Waiting Times.
- 1.21 General Health Assessment.
- 1.22 Secondary Health Screen – Prison Transfers.
- 1.32 Sexual Health.
Primary Care Services (Dental)

Treatment

- For prisoners serving less than six months; reactive treatment for acute symptoms only will be provided.
- For those serving reasonably longer than six months; full treatment and annual check up will be available and a care plan agreed.
- A robust triage policy and process will need to be in place.

Treatment will be given at the discretion of the dentist working within PCT guidelines in order to provide reasonable care and to promote self care and oral health.

Oral Health Promotion

The dentist and hygienist will work with, inform and liaise with Health Trainers who will deliver oral health promotion and sign posting.

Emergency Dental Care

- Nurses will provide pain relief for severe dental pain when the dentist is not on site.
- OOH services will provide 48 hours (weekend) antibiotic cover for dental/facial abscesses.
- Access to the Dental Access Centre for severe dental pain or urgent dental need.
- Trauma cases will be sent to A&E.

Provider Requirements

There will continue to be agreed standardised policies across the prison cluster for the management of dental conditions and dental pain. Cross cover for annual leave and sickness will be provided. The dentist will also:

- Attend Clinical Governance meetings at the prison.
- Undertake audits.
- Take responsibility to make sure equipment and premises are in working order.
- Take a proactive approach to the management of waiting lists.
- Provide performance information back to the PCT.
- Participate in I.T. training and use the clinical I.T. system.
- Comply with security arrangements for I.T.
- Comply with the PCT directives regarding referral of patients.

Issues pertinent to Featherstone 2 (F2) only

- Facilities requested within F2 are: Two dental surgeries with a linked decontamination area (in line with HTM0105) and a separate secure waiting area. The decontamination unit must be situated next to an outside wall for venting purposes.
- Based on Home Office Statistics and local figures, there will be 3351 dental consultations per year. This will require 1 wte dentist, 1wte dental nurse and 0.2 wte hygienist.
- The local Dental Access Centres (DACs) should be made aware that by 2012 there will be potentially 2000 more patients on their list and this could have workload implications.
Prison Health Performance and Quality Indicators

This Primary Care Services (Dental) model supports delivery of the following Prison Health Performance and Quality Indicators:

- 1.18 Prison Dentistry.
Emergency Care, Minor Injuries and Out of Hours

- Out of Hours (OOH).
- Minor Injuries.
- Emergency Care.

Out of Hours (OOH)

Remand Prisons
There are peak times when extended GP support is required, therefore an in hours GP model of extended working is proposed with evening clinics taking place. This would enable evening receptions into the prison to be seen by a GP if required and any prescriptions to be completed. (4.30 pm - 8.30 pm is the main arrival time for evening receptions.)

Frequently required medication could be predicted to ensure that stock cupboards contained these, rather than have a costly extended hour's service from a pharmacy. The stock cupboards could be supported by a pharmacy OOH service for emergencies.

In addition one session (3.5 hrs) would be required on a weekend (probably a Sunday). This would also be available for any patients who had become ill, and the nursing staff felt required medical review. The weekend session would be provided as part of the extended hours model by the main in hours GP.

From an OOH service, a Remand Prison would benefit from:
- Good links with the extended in hours GP service.
- 24 hour healthcare cover. The nursing team would be the first line assessor who would then refer patient to the OOH GP, as required.

Summary
- Robust links with the extended in hours GP service (creating a more joined up approach).
- Not straight to OOH but to the primary care team.
- Realistic in specification.
- Sunday and Bank Holiday surgeries (for larger prisons) from the extended in hours GP service.
- Inpatient beds could be accessed for observation, if required.

OOH (all prisons)
- The importance of OOH visits to the prison was emphasised to prevent inappropriate escorts to A&E.
- Suturing is a requirement, although it was recognised that certain wounds (e.g. facial) would still require a visit to A&E.
- Arrangements would be required with local hospitals to ensure that blood tests could be completed where required e.g to confirm overdoses.
- OOH services will provide 48 hours (weekend) antibiotic cover for dental/facial abscesses.

Acute Psychosis occurring in OOH period.

Rapid tranquilization could be undertaken if required (but no more than twice). The OOH service would be called and the OOH GP would have access to the on call community psychiatrist for advice or a visit, if necessary.

See the Mental Health Model of Care for Crisis Resolution
**Minor Injuries**

Minor injuries could be caused by fights, trips, falls or sports injuries.

An Emergency Nurse Practitioner, qualified in both minor injuries and minor illness care, or an Emergency Care Practitioner should be on site daily and could operate an on call function to compliment the OOH service.

Emergency Nurse Practitioner/ Emergency Care Practitioner could treat:
- Eye injuries.
- Minor head injuries (including suturing and wound dressing).
- Asthma attacks.
- Chest/back/abdominal pain.
- Cold and flu symptoms.
- Cuts and lacerations (including suturing and dressing wounds).
- Minor burns and scalds.

Bony injuries which are potential fractures would still require A&E attendance.

Emergency Nurse Practitioner/ Emergency Care Practitioner would form part of the inpatient rota overnight and the core nursing team during the day.

Minor injuries can be managed in any of the wing based treatment rooms. These would need to hold the correct equipment and materials.

Any minor surgery rooms will not be used to treat minor injuries, but minor surgery could be performed in treatment rooms with the correct specification i.e. infection control etc.

It was suggested that named nurses should be assigned to each house block to support continuity of care, whilst their main base would remain the central healthcare facility.

Should a patient need to go to A&E this could be arranged on an appointment basis i.e. if there is a four hour wait in A&E then three hours of this wait could be completed within the prison, thereby reducing the cost of escort charges. This could only be arranged if the patient had been assessed and triaged in the prison by a clinician. There is a need to build relationships between prison and hospital staff for this to work. The Emergency Nurse Practitioner could be the liaison for this.

The Emergency Nurse Practitioner Handbook has been created by AM Curtis & A Rollason for use in both the SSPCT Minor Injury Units and the South Staffordshire Prisons (Awaiting final approval). These could possibly be put onto a TPP/SystmOne template for computer use.

**Urgent Dental Care**

Prisoners would have access to Dental Access Centres although opening times are restricted. NHS Direct also offers advice on dental queries 24 hours a day.

**Issues pertinent to Featherstone 2 (F2) only**

- It was initially considered that, due to the remand nature of the prison and its size, extended pharmacy hours for any prescribing requirements would be required; however the advice of
the Medicines Management Advisor was that it would be easy to predict frequently required drugs and therefore ensure that stock cupboards contained these, rather than have an expensive extended hours service. The stock cupboards could be supported by a pharmacy OOH service for emergencies.

- OOH provision would still be required, but demand would be low and it would only be required between 8.00 pm and 8.30 am (Monday-Friday) due to the extended in hours GP service. Weekend cover would be required as normal.
- Sunday and Bank Holiday surgeries would be required from the extended in hours GP service.
- The large gym may increase the incidence of sports injuries.
- An Emergency Nurse Practitioner/ Emergency Care Practitioner would be on site 24/7 as part of the healthcare staffing rota (on inpatient rota overnight and core nursing team during the day). They would act as the first line of contact and would refer to the OOH service where GP input was required.
- It is estimated that F2 will require 8 or 9 wte qualified Emergency Nurse Practitioners. This created challenges regarding whether the local health economy has sufficient capacity to enable the recruitment of the required number of staff with the right skills.

**Prison Health Performance and Quality Indicators**

This Emergency Care, Minor Injuries and OOH model supports delivery of the following Prison Health Performance and Quality Indicators:

- 1.16 Comprehensive Range of Services.
- 1.18 Prison Dentistry.
The Stepped Care Model is the best practice model for adoption within a prison setting.

The PCTs Strategic Objectives should be applied to prisons e.g.

- Ensure everyone with mild to moderate mental health problems has access to preventative and primary care based services.
- Ensure that people with severe and enduring mental health problems have access to safe, supported services and that physical health needs are supported.
- Address the mental health needs of all individuals in culturally appropriate ways, tailored to the individual circumstances.
- Develop services for people with dementia which minimise their reliance on hospital-based services or other institutional care, and ensure 100% of those on a dementia register have a care plan.
- Give people with a learning disability more independence, choice and control in their lives.
- Deliver more appropriate less socially-excluding services, particularly in respect of accommodation and care.

**Foundation Step (Self Help, Self Management, Advice, Guidance and Signposting)**

The foundation stage is holistic, representing a “Whole Prison Approach” as a variety of factors will affect a person’s mental wellbeing, not all of which are related to their health (e.g. housing, employment, family issues).

Good self help information is crucial at this stage and needs to be easily accessible across the whole prison (e.g. chapel, gym, at reception, throughout the induction process.) Could health promotion material be directed to TVs in prisoner’s cells?

Ultimately there is a need for good signposting at every stage of the Stepped Care Model.

The foundation stage provides opportunities to better involve voluntary agencies. These would need to be co-ordinated and integrated, with better communication regarding the range...
of services available.

A directory of services is needed to inform staff and patients; however these can become out of date too quickly. Instead it was recommended that a whole prison “Access and Resource Centre” should be developed. This would be made up of representatives from different prison departments (including healthcare) who would provide advice, signposting and make referrals. This could be located in the library.

All of the current community self help literature could be adapted for use within a prison (although it would need to be adapted to suit language and reading barriers). A key component of this would be advice on how to manage life in prison, which is in itself a stressful event.

Health Trainers and Insiders could be trained to signpost at the foundation stage.

Literature could be included in the resettlement packs that could then be delivered by any staff member.

There is a need to ensure that pre-release anxiety is also addressed. Healthcare should therefore form part of a multidisciplinary resettlement case review.

**How do Prisoners move up from the foundation to mild /moderate steps?**

- **Self referral.** A patient self referral system would need to be sophisticated (like an NHS direct approach). Based on the answers given, the referral would be triaged to the correct department and professional.
- **Referrals from prison staff, education etc.** This would need to be supported by mental health awareness training for all prison staff.

Visitors and relatives will also recognise signs of mental health problems and should be educated into how they can pass information on to prison staff where they have concerns.

The pathway needs a good filter mechanism as part of the referral process, with robust criteria to ensure that appropriate referrals are made to the primary mental health team.

A single point of access was suggested enabling referral to the correct departments /professionals. This linked back into the suggestion of a central prison wide Access and Resource Centre.

**Mild and Moderate Steps (1 to 3)**

A screening tool will be required to identify what level in the Stepped Care Model the patient needs (e.g. Hospital Anxiety and Depression Scale). This could be completed by a member of the generic healthcare team.

Alternatively all referrals could be assessed at a multi disciplinary team (MDT) meeting which would covers steps 1-5.

Patients should have the opportunity to participate in either one to one or group work

**One to one interventions at steps 1 to 3**

- **High Intensity (60%).** To deliver this will require a therapist (band 7) who is British
Association for Counselling and Psychotherapy (BACP) registered. They will undertake Cognitive Behaviour Therapy (CBT) at a higher level (e.g. pure therapy).
- Low Intensity (40%). This will constitute a brief CBT approach, self help and conversation.

A GPwSI would be required who would:
- Be the lead for prescribing.
- Run a dedicated mental health clinic.
- Work as part of the mental health team in order to ensure appropriate communication and integrated patient management.

Unless the patient is extremely disabled by mental health problems they will usually be tried on lower level treatments first.

Individualised treatment plans would be required and National Institute for Clinical Excellence (NICE) guidance would be adopted for management of anxiety, depression, panic etc.

One to one work lasts, on average, six to eight sessions.

**Group Work**

Would be available based on the needs of patients on steps 1-5 of the model. Group work would:
- Be restricted to twelve patients (maximum).
- Use a CBT model.
- Be outcome focused.
- Be delivered or supported by voluntary agencies.

There would be a need to ensure that only those with a mental health problem access these courses. These mental health focused groups would compliment, not replace, the offending behaviour programmes run by the prison which are not open to prisoners with a mental health diagnosis.

Proposed topics for group sessions are:
- Self Esteem.
- Coping Skills.
- Anger Management.
- Anxiety management.
- Life Skills.
- Relaxation.
- Hearing voices.

Each group would be run separately, rather than as a whole programme, enabling prisoners to take a “pick and mix” approach, dependent on their needs.

Drama therapy was proposed, but it was discussed as being hard to offer in a prison setting.

Also available at steps 1-3 of the Stepped Care Model would be:
- Exercise on referral.
- Referral to a counsellor.
- Understanding what is normal.
- Relaxation.
- Monitoring, if on antidepressants.
- Watchful waiting.
• Books on prescription.

Severe and Enduring Steps (4 to 5)

The current model for Mental Health In Reach services, based on a Community Mental Health Team (CMHT), was considered to be the most appropriate model of service. There is a need however to build integrated care pathways that run across the Stepped Care Model.

Remand prisoners

Remand prisoners require rapid access to the severe and enduring steps of the model and require a greater degree of psychiatry input to ensure serious offenders are identified, assessed and diagnosed before release or transfer. This is not related to court reports (which is a separate service requirement) but is about using the opportunity provided by a period in custody to identify prisoners with a significant mental health issue.

This could be achieved through both a dedicated liaison role for remand prisoners and a rapid assessment role within the Mental Health In Reach service, as remand prisoners are workload intensive. This would enable a more proactive approach.

Engaging family and relatives

There is a need to engage the patient's family more in the Care Programme Approach (CPA) process. The Prison Service would be required to support and facilitate this. This also requires access to a suitable room.

Structure of mental health services across the stepped care model

The generic role for healthcare nurses was not considered to be best practice.

A single provider should be responsible for delivery of mental health services (from mild to severe and enduring) within a prison setting. This would:

• Support integrated working.
• Support implementation of a seamless care pathway.
• Support continuity of care.
• Provide safeguards to ensure patients do not fall through gaps in service.
• Support supervision and career development for staff.

A skilled mix of mental health workers would be required including: occupational therapists, social workers and counsellors (for patients with a longer term interventional need)

The GP would be a member of this team, and MDT meetings would be critical to the team’s organisation and functioning.

Supporting Infrastructure

Good integrated clinical I.T systems will be crucial to support the functioning of mental health services. This needs to be used by all health care providers working within the prison.
**Safeguarding Adults**

Some services do not wish to treat abused prisoners as the environment is not conducive to effective interventions. If abuse is disclosed there needs to be a set of guidelines for all staff regarding their duties for reporting the abuse.

Access to specialist abuse counsellors (e.g. Emerge) is required.

**Inpatients**

The use of inpatient beds needs to be prioritised for:
- Prisoners waiting secure transfer under the Mental Health Act.
- Short term crisis admissions (one night only.) The patient would require discussion next day at an MDT meeting. An inpatient stay should only be adopted where the patient cannot be safely managed on the wings.

Inpatient beds cannot be used for poor copers. Physical health will access inpatient beds for step up/down care.

Inpatient beds should be staffed 24/7 with both Registered General Nurses (RGNs) and Registered Mental Health Nurses (RMNs) to manage the mixed health needs of patients who will utilise these beds. Access to nurse and pharmacist independent prescribers would be beneficial.

Ultimate responsibility for the inpatient lies with the psychiatrist, however on a daily basis this will be delivered through the care co-ordinator. Good relations are required between the GP and psychiatrist to enable effective joint treatment of these patients as GP will be the prescriber.

Where possible the daily prison regime should still be applied within the inpatient setting.

**Transfers Out**

- There is a requirement for a fast, straight forward transfer process.
- Patient should always have been under the care of the Mental Health In Reach service.
- Communication needs to be both open and ongoing.
- Need active case management for tracking prisoners.

**Planned Discharge / Through care**

Discharge planning is easier for prisoners who have served a long term sentence or are under the Offender Management Scheme, as there will be a resettlement meeting three months prior to the patient’s release.

The Mental Health In Reach team and healthcare must be linked into any plans for a prisoners release or transfer. Links with the Resettlement Department are crucial and could be achieved by having a nominated resettlement healthcare link nurse.

The healthcare team need to identify a home address and a current GP for prisoners being released. This is recognised as a significant administrative task, especially if a new registration is required, and would require dedicated administrative time to undertake this
For patients on CPA there is a requirement to link the patient with the relevant CMHT prior to release. Members of the prison Mental Health In Reach team are likely to be invited to attend reviews with the CMHT so this needs to be factored into any specifications to support seamless continuity of care and best practice.

**Issues pertinent to Featherstone 2 (F2) only**

- Self help information would be available through the on site pharmacy.
- The size of the prison and the opportunity for working with voluntary agencies could support the recruitment of a specific coordinator, by the prison provider, to manage and support integrated working across the various prison departments and agencies.
- A 20 bed inpatient unit is planned within F2, with its own exercise area. These beds will require careful management to ensure they do not become blocked. Admission criteria and proactive discharge planning will be crucial.
- There is concern regarding mixing mental and physical health patients within one inpatient unit.
- Constant watch beds must be available across the prison and not be dependent on the inpatient unit.
- Discipline presence would be required.

**Prison Health Performance and Quality Indicators**

This Mental Health model supports delivery of the following Prison Health Performance and Quality Indicators:

- 1.4 Chronic Disease and Long Term Condition Care.
- 1.5 Continuity of Case Management.
- 1.6 Discharge Planning.
- 1.16 Comprehensive Range of Services.
- 1.24 Section 117.
- 1.25 Care programme Approach.
- 1.26 Suicide Prevention.
- 1.28 Primary Care Mental Health.
- 2.0 Mental Health Quantitative targets.
Crisis Resolution

The principles used within community crisis resolution services should be adopted for the prison setting e.g. 24/7 intensive assessment and treatment for individuals experiencing acute mental health distress.

The aim of the service would be to maintain patients safely in their cell and would be open to patients:
- Suffering a severe / enduring mental illness.
- In mental health crisis.
- At imminent risk of suicide or self harm.

Community crisis resolution services have a range of exclusion criteria e.g.
- Alcohol and substance abuse as the primary diagnosis.
- Brain damage or dementia.
- Learning disability.
- Crisis related to relationship issues where mental illness is not feature.

It is not appropriate to apply these exclusions within a prison setting due to the client group and the pressures placed on individuals simply by being in prison.

Access to the crisis resolution service would be through:
- Healthcare.
- ACCT (Assessment, Care in Custody and Teamwork) Assessor.
- Prison Officer (during the OOH period).

The crisis service would provide:
- Assessment.
- Care Planning.
- Interventions including medicine management, basic CBT, Solution Focused Therapy, anxiety management, relaxation, and recovery focused interventions. Interventions would be short term and intensive (for no more than 4 weeks).
- Liaison with other services.
- Mainstreaming and recovery.
- Discharge planning.

The proposed crisis resolution model for prison adoption is:
- Access to an in house healthcare Registered Mental Health Nurse (RMN) 24/7. This would be a crisis resolution function and could be managed as a cluster resource.
- Response within four hours.
- Access to inpatients for 24 hours if required (where available).
- Access to the OOH GP if required.
- Access to OOH psychiatrist for advice if required. The gateway would be through the OOH
GP.
- Joint working with prison staff to support patients on the wings would be required.
- Referral to the Mental Health InReach team the next day (where required).
- Issues around 24 hour prescribing were discussed and the need for rapid tranquilization. It was agreed that most patients this severe would already be know to the healthcare team.

**Dual Diagnosis**

Definition used in this instance: mental health and substance misuse.

There is not a need for a distinct specialist service, but there is a requirement for different services (mental health, substance misuse, Counselling Assessment, Referrals, Advice and Throughcare Service (CARATS) and healthcare teams) to work together on a joint care plan and patient management. The service user must be at the centre of this.

A comprehensive screening tool is required at induction covering relevant areas which will highlight patients that require referral.

Referrals should be considered at a central MDT meeting (primary mental health, Mental Health InReach, substance misuse, social care). The MDT decides on how to manage the client and agree the care coordinator.

There is a need for a clear pathway and one point of referral into services. It would also be beneficial to have an induction link nurse.

For patients under the care of the Mental Health In Reach the Community Psychiatric Nurse (CPN) will always be the care coordinator.

**Learning Disabilities**

Why is it a priority?
- There is often confusion between different organisations leading to a multitude of potential services and referral pathways, but with lack of clarity how each organisation works or what clinical governance is in place within each set-up.
- People with learning disabilities often have a poor experience of primary care services which acts as the gateway to screening and treatment, leading to unequal access and treatment, exacerbated by the difficulties that some people have in advocating for themselves.
- Some of the health inequality experienced is due to poor recognition of the particular health needs of people with learning disabilities by the NHS.

**PCT Community Strategic Plan and Objectives**

The PCT Strategic Plan outlines objectives that Prison Health should also look to adopt in future models of care:
- Health Facilitators working across the localities to support people in primary care with learning disability.
- Health Action Plans developed for people with a learning disability in primary care.
- Primary care mental health services in some localities, including Primary Care Mental Health Workers and Practice-Based Counsellors.
- Services provided through the voluntary sector for mental health service users and carers including out of hours drop ins, counselling and carers' support workers.
- Severe mentally ill registers/learning disability registers in place for all GP practices.
• Most areas are already providing or commissioning primary prevention activities. These should be continued and enhanced by partnership working with local authorities and the voluntary sector.
• Mental health services that are based on person-centred recovery and which deliver value for money.
• Give people with a learning disability more independence, choice and control in their lives.

There is likely to be a higher level of demand in prison from borderline, rather than for severe, learning disabilities. This is because patients with a severe learning disability are now more likely to have been diverted from prison. There is a need, however, to cater for prisoners already within the prison system and any new prisoners who enter prison whilst awaiting transfer out under the Mental Health Act.

Prisoners need to be screened on entry into the prison for learning disability. This should be part of the secondary screening process and would lead to signposting and assessment.

Within prisons there should be:
• Health Facilitators (a member of the healthcare team).
• Annual primary health check for all learning disability clients.
• Learning disability registers (similar to chronic disease registers).
• Referrals into healthcare from education.
• Multidisciplinary health action plans for all learning disability clients, developed in collaboration with social care and education. Would use a single assessment framework to meet the whole needs of prisoners.
• Robust communication between services.
• Use of therapy tools e.g. PC based tools, books.
• Access to the community specialist team for anyone with a complex learning disability need.
• A learning disability “befriending” service for trained prisoners to look after learning disability clients.
• An understanding of learning disabilities amongst prison staff to support their understanding of behaviour and enable meaningful engagement.

There is a forensic learning disability service commissioned through the West Midlands Specialised Commissioning Agency for those with severe learning disability needs.

**Early Intervention**

• Would be a part of the joint primary and secondary mental health services responsibilities.
• Requires an integrated mental health service, not fragmented into different services or providers.
• Training for Prison Officers would be required in how to spot the early signs of psychosis.

**Personality Disorders**

• Lots of prisoners probably have a low level personality disorder.
• There is a requirement to recognise the full variety of needs that personality disorder patients have.
• Personality disorders cover a wide spectrum of disorders. Patients with a severe and dangerous personality disorder should be referred out.
• There is limited access to personality disorder services in the community; however the mental health Stepped Care Model would work well for personality disorder patients.
• Mental Health In-Reach teams will undertake an assessment but will refer to the Specialist Commissioning Teams patients who have a severe / dangerous personality disorder. For patients who remain in the prison, if their personality disorder is not amenable to treatment, they are passed back for prison management as a personality disorder is not a mental health diagnosis.

• The forensic psychologists currently working within prisons on the Offender Management Schemes may be useful and offer good indicators, however they are not clinical.

This is an area that requires further development due to its specialist nature and the lack of available evidence on effective personality disorder management in prisons.

**Prisoner Carers**

The model of using prisoners as carers is supported and should be developed. Currently prisoners are informally taking on a carer’s role but this is not formally recognised. Formal implementation will require the prisoner carer role to be classed as paid work within the prison, with appropriate training and qualifications being made available.

**Advocacy**

Access to advocacy services is required for all areas of healthcare.

**Prison Health Performance and Quality Indicators**

This Specialist Mental Health model supports delivery of the following Prison Health Performance and Quality Indicators:

• 1.5 Continuity of Case Management.
• 1.6 Discharge Planning.
• 1.16 Comprehensive Range of Services.
• 1.26 Suicide Prevention.
• 1.27 Access to Specialist Mental Health Services.
Substance Misuse

There is a requirement to deliver the Integrated Drug Treatment System (IDTS) including the 28 day psychosocial programme (provided by CARATS). In respects to healthcare services IDTS provides a clinical management model that delivers equivalence with community treatment programmes. (Clinical Management of Drug Dependence in an Adult Prison Setting DH 2006.)

The assumptions around IDTS are:

- Phase 1: Days 1 – 7 (clinical guidelines states a minimum of five days). Screening, assessment, care planning, induction and stabilisation. This should only take place at prisons where there are dedicated substance misuse beds.
- Phase 2: Days 8 – 28. Ongoing clinical management, case management and continuity of care
- Phase 3: Days 28 days +. Reviews, including full treatment review at 13 weeks. Release and transfer planning.

The clinical substance misuse service also needs to deliver re-induction.

Alcohol

IDTS does not provide for alcohol detoxification on it's own, but will enable the treatment of patients with a multiple substance addiction.

Provision of alcohol only services are required which should include:

- Screening and assessment.
- Care planning.
- Access to brief interventions.
- Access to structured alcohol treatment programmes.
- Access to alcohol awareness and personal development /social and life skills modules.
- Access to peer support groups (e.g. Alcoholics Anonymous).

It was noted that in the community more alcohol beds are commissioned that substance misuse beds.

Younger prisoners are likely to present with an alcohol and substance misuse problems. There are likely to be only a small number of chronic alcoholics/ or those with embedded drinking practices.

If a person presents with an alcohol and substance misuse dependency their alcohol addiction should be treated first, as alcohol withdrawal has a higher risk.

Patients undergoing acute alcohol withdrawal should be managed in an inpatient bed. This will be a minority, but these patients will require of access to a Consultant Psychiatrist (as well as the substance misuse team) and referral straight into acute care if their condition deteriorates.

Suggested model for alcohol detoxification.

- Level 1: Nurse led detoxification.
- Level 2: GP (RCGP Level 2 qualified) with specific interest and nursing support.
- Level 3+: Inpatient care. Consultant Psychiatrist led with nursing support and direct access into an acute bed if required.
Substance Misuse Beds

For remand prisons substance misuse beds will be used for the induction and stabilisation phase (Days 1-7). After this time patients will then be managed on the wings on ordinary location.

Opioid Prescribing

Has 2 stages:
1. Induction and stabilisation.
2. Maintenance (offered to all with a sentence/expected stay of 6 months or less) or detoxification.

Extra facilities required during withdrawal and provided by the Prison Service are; extra bedding, food packs/hot chocolate, in cell TV/radio.

The model of care should include targeting prisoners for re-induction rather than taking a reactive approach and waiting to be approached by patients directly.

Dispensing

Methadone
- Once daily dosing, but with the option to use 6 hourly dosing on induction where necessary.
- Day 3 is the most critical.
- 1.5 minutes dispensing time using a biometric dispenser / 3 minutes dispensing time without using a biometric dispenser.
- Symptomatic relief will be dispensed upon first arriving at prison until the clinical team are able to provide the first methadone dose.
- Approximately 60% of patients will be on methadone.

Subutex
- Dispensed once daily.
- Proximity issues for dispensing which requires access to a larger area/small room.
- 8 minutes dispensing time.
- Oral cavity checked prior to dispensing, crushed tablet dispensed (with drink) and oral cavity checked afterwards.
- Approximately 40% of patients will be on a subutex detoxification.

Benzodiazepine
- No prevalence data available.
- Avoid dispensing whilst on methadone induction as this creates a risk.
- If already on benzodiazepines do not withdraw treatment.
- Liquid dispensing required, but has cost implications.
- Withdrawal is far slower so will have a greater impact on the regime.
- 3 minutes dispensing time.
- Usually dispensed once daily, but need to be twice daily if the dose ≥ 30mg daily.

The time period over which dispensing can take place will be dictated by the prisons. Quicker or slower dispensing times will have an impact on the number of dispensing points.
The delivery of the IDTS model does not require a 24 hour staffing presence, but should cover weekdays 8am – 10pm and Saturday mornings in remand prisons where induction and stabilization is occurring.

**Wing Based Services**

Following induction and stablisation (days 1-7) patients should be located on ordinary location.

The IDTS team can provide outreach care onto the wings however this will impact on staff time as they lose clinical time moving about the prison.

Group work could be undertaken on the wings and should be jointly delivered by CARATs and IDTS clinical staff.

Integrated working between CARATS, healthcare, mental health services and IDTS staff is crucial and joint MDT meetings should be held on a regular basis.

**Through care**

Robust systems need to be in place for patients coming into the prison and returning to the community.

The Drug Interventions Records (DIR) should follow the prisoner through their treatment. CARATS have the lead for completing the DIR. If the patient is already receiving treatment on arrest their treatment should be picked up and continued in prison, with the same on release.

Prisons should utilise a Single Point of Contact.

Clinical Information for transfer / release should be completed by the IDTS team rather than CARATS. This information should then be sent by the CARATs team to the relevant Drug Interventions Programme (DIP) team who will arrange for the patient to be seen by a DIP doctor.

It is recommended that a DIP prison link worker should be based in the prison (although the issue of commissioning responsibility would need to be identified) who has a knowledge of the local areas services. This would improve continuity of care, support discharge, build relationships with community services, and help to mitigate incidents happening after release.

**Health Promotion / Prevention**

This should be available to all prisoners as part of the general health promotion programme. The health promotion package on the induction wing should be centred on harm reduction. Health Trainers would not be the most appropriate way to deliver harm reduction initiatives.

Blood Bourne Viruses (BBV) falls into the generic prison healthcare responsibility and should be offered to all prisoners at reception. Healthcare would provide a BBV in reach service into the substance misuse wing.
Issues pertinent to Featherstone 2 (F2) only

- It is planned to have a 90 bed substance misuse wing in F2 where induction and stabilisation will occur (phase 1). Currently in the community the PCT commissions 6 tier 4 inpatient beds.
- The 90 beds are however counted in the prison capacity, so if empty the prison may fill them with non substance misuse prisoners.
- After the initial induction and stabilization period patients will be managed on ordinary location (the wings).
- All 90 beds (cells) will require: large observation hatches, be ligature free and have personal storage lockers.
- Access will be required to a dispensary and to an adequate number of dispensing hatches to ensure that timely dispensing can occur. (See below for estimates)
- Substance misuse dispensing hatches must be able to accommodate three people (1 patient, 1 RGN/ Pharmacy Technician and 1 witness). Where subutex is being administered, a small room rather than a booth is required to enable close observation.
- Approximately 10% of substance misuse patients will require multiple doses per day during their induction period.
- The high levels of supervised consumption will bring with it security issues.

Substance Misuse Wing

Methadone
- Approximately 60% of patients will be on methadone.
- 10 patients x 2 minutes dispensing time x twice daily administration = 40 minutes or
- 1 dispensing booths x 20 minutes x twice daily.
- 50 patients x 2 minutes dispensing time x once daily = 100 minutes.
- 2 dispensing booths x 50 minutes x once daily if there are two biometric dispensers. otherwise the full 100 minutes will be necessary at 1 booth.

Subutex
- 30 patients x 8 minutes dispensing time x once daily = 240 minutes.
- 2 dispensing booths x 2 hours x once daily.
- The more dispensing booths, the more staff required to staff them. Approximately 5 staff could be dispensing at peak times, based over 2 hours of dispensing at the central pharmacy/ substance misuse dispensary purely for substance misuse needs.
- Estimated a minimum 4 booths would be required on the substance misuse wing. 3 booths will needed to manage peak times, plus the additional ability to manage supervised dispensing for patients leaving primary and secondary care appointment, within the central healthcare building with prescriptions.
- The time period over which dispensing can take place will be dictated by the prison. Quicker or slower dispensing times will have an impact on the number of booths.
- These figures take no account of: dispensing on the wings (which will be undertaken as part of the generic healthcare function not the substance misuse team) or dispensing for patients attending court.
- Extra booth required for emergencies, court appearances/releases etc. Plus the dispensing facilities on the wings need to be able to accommodate subutex (e.g. a small room)

Ordinary Location
- A higher proportion of patients will be accessing substance misuse services on ordinary location that on the substance misuse wing.
- At HMP Leeds, which has a comparable population, dispenses 6 litres of methadone a day to 2 wings of approximately 350 patients at an average of 50ml per patient which is 120
patients. That is 240 minutes a day at 2 minutes with subutex on top.

- It was their experience that to fit into the regime, they had to dispense twice daily to manage this capacity from one booth.
- F2 has double the capacity of patients per house block and therefore is likely to have a major impact on dispensing services from those treatment rooms.
- 10m² dispensing room will be insufficient space for the size of facility.
- F2 will require: 4 booths, probably 2 biometric dispensers, all the storage for in possession, supervised and controlled drugs plus filing cabinets, sink space etc.
- To manage all this dispensing without disruption to the prisons will require at least 3 Pharmacy Technicians/ Nurses plus 2 Healthcare Assistants to manage the dispensing.
- Dispensing on the wings will be undertaken by the generic healthcare team.
- The time period over which dispensing can take place will be dictated by the prisons. Quicker or slower dispensing times will have an impact on the number of booths.
- Dispensing will need to commence at the central pharmacy and substance misuse dispensing points at 6.00am prior to court appearances.
- Two consultation rooms requested on the substance misuse wing both large enough for 4 people (more will be required if CARATs are also based here).
- All testing areas must be able to facilitate oral swabs and urine testing. There are concerns at present regarding the effectiveness of oral swabs and the length of time they take to complete (20 minutes) however it was recognized this may improve before 2012.
- There will be mandatory drug testing.
- The AUDIT Tool score used in the F2 desktop health needs assessment (HNA) is likely to have underestimated the number of prisoners who are alcohol dependent as it uses a high threshold (>32). In the community a score of >15 triggers referral to a substance misuse service for assessment.

The Department of Health IDTS Clinical Lead has advised on a likely IDTS staffing model based on a churn of 7000.

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- IDTS will not provide a 24 hour staffing provision but is more likely to cover weekdays 8am – 10pm and Saturday mornings.
- The substance misuse staffing model should include at least 1 nurse prescriber, with the GP carrying out reviews as required.
- The model for the house block based services will be different. The IDTS team will provide outreach care onto the wings. This will have impacts on staff time as they lose clinical time moving about the prison.
- Group work can be undertaken on the wings and should be jointly delivered by CARATs and IDTS.
- Integrated working between CARATS, healthcare, mental health services and IDTS will be
crucial, regardless of who their employing organisation is.

- The IDTS Team would take a holistic approach to their patient’s care on the substance misuse unit and would not pass the patient off to the primary care team, unless necessary.

**Prison Health Performance and Quality Indicators**

This Substance Misuse model supports delivery of the following Prison Health Performance and Quality Indicators:

- 1.5 Continuity of Case Management.
- 1.6 Discharge Planning.
- 1.16 Comprehensive Range of Services.
- 1.19 Substance Misuse Activities.
- 1.20 Alcohol Screening, Intervention and Support.
- 1.27 Access to Specialist Mental Health Services.
Inpatients

HMP Dovegate and YOI Brinsford are the only 2 South Staffordshire prisons at present with an inpatient facility, although the proposed new prison would also have a small inpatient unit.

Access to inpatients should be through the Healthcare Manager only. Admission criteria should be developed, agreed and published so that it is clear to all healthcare teams what patients the inpatient unit is able to cater for.

Prisons should adopt the community model of “care closer to home”, with patients discharged from hospital into their “home” (cell) rather than into an inpatient bed. These patients would be managed on an outreach basis by the inpatient nursing team. Palliative care would also be wing based, where required.

Arrangements are required between acute providers and the prison to support the timely and successful discharge and ongoing management of patients.

Daily ward rounds with the GP, nursing staff and where possible a pharmacist would be good practice. For mental health inpatients, the ultimate responsibility of the patient lies with the psychiatrist, however on a daily basis this will be delivered through the care co-ordinator. The GP (as the prescriber) will need to liaise with the Mental Health In Reach team and consultant psychiatrist.

The name “Inpatients” can imply a long stay. A name change may have a more successful outcome e.g. Acute or High Dependency Unit.

Discharge planning should commence at the point of admission to the inpatient bed.

The inpatient unit is staffed 24 hours and should be through a mixture of RGNs and RMNs who can also respond to any emergencies across the prison at night. A generic healthcare assistant role (health and social care skills) should be adopted.

The nurses on duty will need to have the ability to manage beds (e.g. ensure appropriate admissions/ prevent bed blockers) and make assessments.

Who should access inpatients beds
- Patients in crisis (if they cannot be managed on the wings) = short term, awaiting stabilisation
- Patients requiring overnight observation (e.g. head injury)
- Patients with an unknown risk where an assessment is required = can still apply the admission criteria, usually short term with unknown history
- Awaiting transfer to secure unit = can be a major source of bed blocking.
- High risk patients – e.g. those who pose a risk of harm to themselves or other, or with an acute mental health need. These may require constant supervision.
- Patients undergoing alcohol withdrawal.
- Patients with a low risk would be managed on the wings.
- Inpatients should not be used as a “poor copers” unit.

Constant Supervision
Patients should be managed up and down a risk ladder rather than an automatic assumption that constant supervision is required. Constant supervision activities must have a therapeutic purpose and should only occur on inpatients if there is a clinical need. Other cases should be
handled throughout the prison.

**Issues pertinent to Featherstone 2 (F2) only**

- 20 beds are planned. This is a small number for the size of the prison but can be managed providing access and discharge activities are rigorously applied.
- It is unknown at this stage whether F2 will be a regional resource for inpatient beds.
- The 20 beds will not be included in the prisons capacity figures.

**Prison Health Performance and Quality Indicators**

This Inpatient model supports delivery of the following Prison Health Performance and Quality Indicators:
- 1.16 Comprehensive Range of Services.
Pharmacy

Within a community setting pharmacies are developing the following services:

- Medicine Use Reviews – to manage long term conditions.
- Chlamydia screening.
- Smoking cessation.
- Minor ailments (e.g. impetigo, urinary tract infections (UTIs)).
- Vascular screening.
- Pharmacists as non medical prescribers supporting the principle of “right person, right time, right place”.

I.T. – electronic prescribing and electronic healthcare records are a crucial future development.

The vision for pharmacy services is a service that:

- Provides equity in terms of community pharmacy service provision (e.g. medicine use reviews, compliance assessments, advice and sign posting, minor ailment clinics, repeat dispensing).
- Has successfully implemented “A Pharmacy Service for Prisoners”.
- Supports prisoners in managing and controlling their own conditions (in possession medication and self care through canteen purchase of certain medicines).
- Minimises the impact of medication on nursing and GP time and supports cost and clinically effective prescribing practices and alternative models for the administration/supply of medication (non-medical prescribing/patient group directions, electronic prescribing, repeat prescribing and dispensing).
- Represents best practice in procurement, dispensing, supply and stock management, and disposal.
- Supports changing working practice and continued professional development (use of the full range of pharmacy grades and implementation of the skills escalator).
- Improved access to pharmacy staff for healthcare staff and prisoners.
- Enables prescribing trends to be appropriately recorded and monitored through effective IT systems, and appropriate and timely feedback is given to prescribers to support cost and clinical effectiveness in prescribing.
- Is timely, cost effective and grounded in best practice.
- Is supported by Drug and Therapeutic Committees.
- Utilises the skills of all health professionals appropriately in prescribing.
- Complies with controls assurance medicines management standards.
- Has an appropriate infrastructure to support and encourage safe medicines practices, e.g. assessment and review of in-possession supply, traffic lights on drugs in formulary.

Prison Pharmacy Model of Care

Pharmacy services can be involved with greater involvement in primary care.

Pharmacist/pharmacy technician led medication use reviews will be adopted for patients on 4 or more medications and for those with a long term condition/severe and enduring illness (e.g. COPD, mental illness etc.)

Additional services that could be provided by pharmacy technicians and pharmacists include:

- Chlamydia screening.
- Nicotine Replacement Therapy (NRT).
- Minor ailments.
Pharmacy technicians would:
- Manage all in possession medication, which would be administered on the wings (requires only 1 person to administer).
- Undertake stock controls duties within each wing and the central pharmacy.
- Administer NRT, operate under Patient Group Directions (PGDs), deliver minor ailment clinics and provide homely remedies on each wing.
- Supervise consumption. This does not need to be undertaken by a nurse but can be done by anyone with the appropriate qualification e.g. pharmacy technician or Health Care Assistant (HCA) (1 person required).
- Support controlled drug dispensing (2 people are required and this could be undertaken by a nurse or a pharmacy technician with a HCA.)

Pharmacist:
More complex cases would be referred by the pharmacy technician to the pharmacist for review.

The application and triage system would be adopted to enable patients to be appropriately referred to the correct health professional (including a pharmacist or a pharmacy technician).

**OOH Services (remand prisons)**

For those arriving into prison with need for urgent medication the OOH GP will need an on-call pharmacy facility (including Saturdays) if the required medication is not held in stock. (See OOH Model of Care). The prison will have Standing Operating Procedures (SOPs) for managing prisoners arriving with medication.

**I.T. systems**

The long term goal will be to adopt electronic prescribing. Where the pharmacist and pharmacy technicians are engaging with patients they will need a facility to add notes into the patients medical record.

**Inpatients**

Ideally a pharmacist should participate in daily ward rounds. The pharmacy team would also provide counselling to patients, advise to staff and checking of scripts on inpatients. This would require about 1 hour per day.

**Substance Misuse**

For prisons that will be delivering a large number of inductions and stabilisations, there is a need to manage the handling of a large volume of controlled drugs appropriately. A pharmacy technician could manage this which would also involve:
- Inputting of prescriptions into the clinical I.T. system.
- Stock balancing.
- Stock ordering.
- Audit checks.
**Issues pertinent to Featherstone 2 (F2) only**

- Proposals have been included in the build specification for an on site pharmacy with a small consultation room for pharmacy led services. This would be run by the prison pharmacy provider.
- Core pharmacy hours would be weekdays 9.00 am - 5.00pm.
- Electronic prescribing would be adopted.
- This pharmacy would have the option of being used to supply the surrounding prisons.
- Each house block will have a dispensary.
- Inpatients should be located next to the central pharmacy.
- The large amount of controlled drugs that would be required for the substance misuse service will require 7 day pharmacy technician support.

**Prison Health Performance and Quality Indicators**

This Pharmacy model supports delivery of the following Prison Health Performance and Quality Indicators:
- 1.3 Medicines Management.
- 1.4 Chronic Disease and Long Term Condition Care.
- 1.16 Comprehensive Range of Services.
- 1.19 Substance Misuse Activities.
- 1.32 Sexual Health.
Therapy Services

All therapies (except podiatry) will require a small number of key questions to be included in the secondary health screen to identify patients who may require therapy input.

The direction of travel for therapy services is self referral (as well as from health care professionals) which should be the model adopted for prisons.

Following referral all patients would require a full therapy assessment to identify a care plan by a qualified therapist.

All patients need to sign up to the care plan so it is important that the patient is clear from the outset how the care plan will work.

Therapists will work with services across the prison (e.g. gym, education, Prison Officers) as part of the patient’s treatment.

Due to short lengths of stay within a prison care plans/ interventions will be developed to account for this. The focus for therapy services will be on education, training and through care planning as well as short term interventions. A small number will be able to have a full treatment plan completed.

The standard should be for access for urgent treatment within 5 days. In the community routine access is 4 weeks.

All therapies will be involved in health promotion and education.

All therapies will provide input into inpatient units as required.

Facilities:
- All therapies would want to use workshop activities and will need to use real life interventions activities to assess and treat patients.
- Rooms must be of an adequate size to enable the therapists and patient to move around.
- Require access to the clinical I.T. system.
- Storage for equipment and walking aids
- Access to sooth rooms (where available)

Physiotherapy

All prisoners require access to exercise.

A physiotherapist will assess and review the patient’s previous medical history. Outcomes could then be as below:
- Exercise programme and advice or
- Treatment of condition or
- Refer onwards to secondary care if required.

Complex cases (mechanical and neurological conditions) will remain under the care of a physiotherapist. Physiotherapists would also undertake joint injections and would operate under a range of Patient Group Directions (PGDs).
The community model is split into 2 main areas: Musculoskeletal and Rehabilitation.

If help is required with the prescribed exercise programme, the physiotherapist may refer the patient to a gym or accompany them to demonstrate technique. A physiotherapy technician may accompany the patient more regularly to ensure that the programme is being carried out correctly.

Supplementary prescribing is not required, but PGD’s are useful in a prison setting. Individual prescribing maybe in place by 2012, this also would be useful.

Specialist exercise programmes could be available from the Prison Physical Education Instructors (PEI) under the supervision of a physiotherapist for prisoners reporting any musculoskeletal pain (remedial gym). This would also involve the PEIs delivering to a care plan and education. This would entail PEIs working up to physiotherapy technician level.

The gym will require facilities to enable planned programme of remedial exercise to be undertaken.

The physiotherapist would do all the manipulation and ultrasound of patients, but a physiotherapy technician may carry out an ultrasound with guidance.

Rehabilitation is a specialist area. This would need to be an in-reach service on a case by case basis. Rehabilitation is useful for patients who are substance misusers or have been in road traffic accidents.

Facilities
- Major problems are caused by the length of the prison beds and the quality of the mattresses. The population in general is getting heavy and taller.
- A double width couch for manipulation of patients (bobath couch) as patients are no longer treated on the floor.
- A room within which they can work around this couch with the patient.
- Folding parallel bars.
- Minimum 15m2 treatment rooms.

Occupational Therapy (O.T) for physical health issues
Undertake treatment through purposeful activity based on occupation (work or hobbies)

OT or OT technician would deliver a care plan depending on complexity. There would need to be links with the gym and education for the delivery of care plans.

OTs will become engaged in the care of patients with:
- Learning disabilities.
- Dyspraxia.
- Clients with a disability.
- Hand injuries - likely to be high level of work within a prison.
- Assessment and provision of equipment e.g. toilet raisers, grab rails.
- Life skills for prisoners nearing release.

Facilities required
- MULE (computerised therapy package).
- Wheelchair adapted facilities.
- Access to Community Loans Store.
• OT and physiotherapy need access to a splint bath (a sink with a trap).

Would like access to:
• Workshop activities.
• Kitchen in the Health Living Centre (n/b must be Disability Discrimination Act (DDA) compliant).

**Speech and Language Therapy (SALT)**

Would adopt the community model e.g. open referral or referral from health professional for patients with a range of conditions.

SALTs see a wide range of patients including: head injuries, strokes, degenerative conditions, autistic spectrum, learning disability, feeding and swallowing difficulties. There is therefore likely to be high level of need for SALT services within a prison.

SALT will:
• Complete a full assessment.
• Identify a diagnosis.
• Set a programmes of care.
• Provide education and training e.g. training others to identify behavioural problems and how to help change behaviours.
• Suggest alterations to the environment to improve behaviour.

SALT could use a PEI for support and SALT technicians.

Within larger prisons, with a higher level of service demand, there is an opportunity to develop a generic Rehabilitation Therapy Technician role across physiotherapy, OT and SALT. This role would support continuity of care and would provide greater efficiencies e.g. all required therapy could then be incorporated into 1 session. The generic worker role would be responsible to the individual therapy technicians.

**Facilities required:**
• All therapies would want to use workshop activities and will need to use real life interventions activities to assess and treat patients.
• Would look to work both on the wings and in the central healthcare facility.
• Will require access to the sooth rooms (where available).
• Rooms must be of an adequate size to enable the therapists and patient to move around.

Both SALT and OT would use group work, and role play. Life skill works well in this area.

**Podiatry**

The prison community has a higher level of demand than the outside community due to the higher prevalence of self neglect and substance misuse issues.

A screening tool will not pick up foot issues; instead there is the need for self referral or referral though health care.

A podiatry service will be required for
• Those who have self neglect.
• Substance misuser.
• Learning disabilities.
• Diabetics especially those with poor control, especially combined with misuse where the risk of foot ulcerations is substantially higher.
• Obese prisoners.

Podiatry must be part of the annual diabetic screen. The general diabetic review will be carried out by a nurse, who could be trained to check the feet, and would refer any patients with issues.

A podiatrist / podiatry assistant would need to be involved in running diabetes education programmes where a Nurse would advises on diabetes and the Podiatrist on foot issues.

There is a large role for podiatry in prevention and education.

Links would be required with the substance misuse team so they could pick up and offer foot screening (sensory loss would be the as the main indicator.)

A drop in session could be run in the gym, using a podiatry assistant.

Independent prescribing would be beneficial.

Nail surgery could be undertaken but will require access to the minor surgery room. Podiatric surgery is specialist and would need to be separately purchased on an in reach basis.

Facilities:
Required access to:
• A treadmill.
• Hydraulic Couch.
• Equipment trolley.
• Access to the consulting rooms.
• Also a requirement to use sharps.
• Storage for disposable instruments.

Families / carers

The possible use of school nurse input was raised, to support liaison and access to prisoner’s children and families. This helps to reinforce the bonds between fathers and children, provide parenting skills and School Nurses could be involved in organised family days. (Part of reducing re-offending action plan “Children and Families” section).

Prison Health Performance and Quality Indicators

This Therapy model supports delivery of the following Prison Health Performance and Quality Indicators:
• 1.4 Chronic Disease and Long Term Condition Care.
• 1.16 Comprehensive Range of Services.
• 1.34 Exercise.
Communicable Diseases and Infection Control

Reception is a good time to check vaccination history and requirements but can be a high pressured and time limited event. The alternative model is to catch patients whilst they are on the induction wing and undergoing their secondary health screen.

**Infection Control Issues**

Cleaning across all healthcare areas is required to be at Patient Environment Action Team (PEAT) standard.

Inpatient units
Activities undertaken here may include: observations, intravenous (IV) drips, short term antibiotics, step down prior to moving back to the wings, post surgery etc.

All clinical staff will need to receive full mandatory infection control training. The inpatient team will also need specific training on IV drips/catheters insertion and maintenance (re: saving lives document)

The unit will require either a macerator or a washer disinfecter.

Multi-drug resistant patients with Tuberculosis (TB) would require treatment in an acute hospital. Other infectious patients could use the isolation rooms, if they are available. If not, these patients would also need to be sent to hospital. Please note the implications of having infectious patients handcuffed to an escort.

Infectious patients can be managed by the inpatient nursing team with links to the thoracic team at the local acute hospital

**Dentistry**
New guidelines have been released regarding decontamination. A separate dental surgery and a linked decontamination facility is recommended best practise. There is a need to ensure that the flow of contaminated goods is set up, with an audit trail. It is unlikely that dental services will be using all disposable equipment by 2012.

All other services would have to use disposable instruments or Sterile Services Department (CSSD).

**Minor Surgery**
Minor surgery provides an opportunity to remove lumps and bumps, complete aspirations and joint injections, but not endoscopies or sigmoidoscopies. A minor surgery room could also be adopted to be used for Telemedicine consultations. Minor surgery facilities need to be kept for clean treatments and should not be used for dirty procedures or storage.

**Activities of Daily Living (ADL) Kitchens**
Anyone working in these environments will need basic food hygiene training and need to be linked in with environmental health. ADL kitchens should be used for therapeutic interventions only.
Hepatitis B

Vaccination programme.
A vaccination check should be included in the second healthcare screening undertaken within 48 hours of arrival at the prison. In relation to the quick turnover of prisoners evidence suggests that even receiving 1 jab is effective.

The accelerated programme will continue to be used (3 separate jabs on day 0, day 7 and day 21.) This should capture most prisoners.

Within larger prisons or across the cluster there is scope for a team of immunisation nurses, supported by PGDs, running a full immunisation programme including:
- Pneumococcal for the over 65’s or those at high risk (e.g chronic illness sufferers).
- Completion of childhood vaccines.
- Seasonal flu jabs.
- Hepatitis A.
- Hepatitis B.
- Meningitis.
- Tetanus.
- Measles, mumps and rubella.

In some cases there may be a lack of medical history which could lead to some patients being vaccinated twice. Good guidance is available for prisoners with no vaccinations (what they require, in what order and where they need to receive them).

Screening Programme for Blood Bourne Viruses (BBV)

Need to offer screening as standard.

There is a requirement for staff to provide pre and post test counselling, contact tracing and treatment.

In larger prisons there may be scope for a specialist BBV nurse to complete this function and oversee the immunisation team. Alternatively this could be a function that covers the prison cluster. This role would be the link between primary and secondary care and provide the counselling and contact tracing.

In relation to contact tracing the BBV nurse would link in with community BBV specialist to pass on information to possible contacts.

Best practise would be for needle exchange, as this is an inequality with the community, although it is recognised that this is not possible within the prison system at the moment and disinfecting tablets will continue to be used.

Healthcare and Prison Service staff all require appropriate vaccinations.

Outbreaks
Other viruses will be managed according to the PCT outbreak plan e.g. chickenpox, impetigo, norvo etc.

Infection control link nurses will be required for prison (or each house block in larger prisons) inpatients, substance misuse units, central healthcare and dentistry, with regular dedicated meetings. There will continue to be cluster wide link nurse meetings.
Issues pertinent to Featherstone 2 (F2) only

- The dental surgery/linked decontamination room proposal represents best practice.
- There are conflicting views nationally regarding the use of negative pressure rooms.
- Urgent X-rays to confirm a diagnosis of TB will need to be done externally.
- The new prison will have a significant impact on the local acute hospitals, especially departments such as Hepatology.
- Additional infection control /communicable disease capacity will be required. The prison will have sufficient capacity and need to justify a specialist BBV nurse and supporting immunisation team with infection control link nurses on each house block, substance misuse wing, central healthcare and dentistry.
- The prison will require its own link nurse meetings.
- Gym equipment will need to be cleanable.

Prison Health Performance and Quality Indicators

This Communicable Diseases and Infection Control model supports delivery of the following Prison Health Performance and Quality Indicators:

- 1.2 Healthcare Environment.
- 1.4 Chronic Disease and Long Term Condition Care.
- 1.16 Comprehensive Range of Services.
- 1.29 Vaccination / Immunisation Policy.
- 1.30 Hepatitis B Vaccination of Prisoners.
- 1.33 Communicable Disease Control.
The following model has been based upon service delivery within the community and a review of current methods for delivering in house prison G.U.M services.

<table>
<thead>
<tr>
<th>Foundation level</th>
<th>Activities Involved</th>
<th>Delivered by</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Health promotion</td>
<td>Health Trainers / Healthcare Nurse</td>
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<tr>
<td></td>
<td>Sign posting</td>
<td></td>
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<tr>
<td>Step 1</td>
<td>Reception Screening</td>
<td>Healthcare Nurses (weekly)</td>
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<td></td>
<td>Triage</td>
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<td></td>
<td>Advice and basic counselling</td>
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<td></td>
<td>Chlamydia screening</td>
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<tr>
<td>Step 2</td>
<td>Take referrals</td>
<td>Health Advisor</td>
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<tr>
<td></td>
<td>Screening (bloods and swabs)</td>
<td></td>
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<tr>
<td></td>
<td>Pre and post test counselling and advice</td>
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<td></td>
<td>Treatment (within agreed thresholds)</td>
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<td></td>
<td>Data collection</td>
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<td></td>
<td>Training for HCNs</td>
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<tr>
<td></td>
<td>Handover meetings with HCN Link Nurse</td>
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<td></td>
<td>Training for patients</td>
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<tr>
<td>Step 3</td>
<td>Diagnosis and treatment of symptomatic patients</td>
<td>GUM Consultant</td>
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<tr>
<td></td>
<td>Management of complex cases</td>
<td></td>
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<tr>
<td>Step 4</td>
<td>Interventions/ investigations that cannot be</td>
<td>Secondary care</td>
</tr>
<tr>
<td></td>
<td>Completed outside of prison due to equipment requirements</td>
<td></td>
</tr>
</tbody>
</table>

Healthcare would nominate a link nurse to work with the health advisor and take a lead for any sexual health/ GUM queries in the services absence.

**Reception Screening**

Initial Reception Screen for all prisoners using the Grubin Tool which will ask key questions regarding orientation and general questions around safe practice. This would flag up high risk prisoners who would be screened further, but due to constraints would not involve any screening at this stage. The outcome from the initial reception screen would either direct patients through the model of care (as above) or decide if no further treatment is necessary.

**Sexual Health Clinic**

Chlamydia Screening will be offered for all new receptions under the age of 25 and those who were flagged as high risk. In larger prisons there may be the requirement for a weekly Chlamydia screening clinic. This clinic could also carry out other screening programmes.

**Referral**

Referral pathways have to cross back and forth with primary care providers. Self referral is best practice.
**Contact Tracing**

Health advisors will only have capacity to carry out internal contract tracing only.

**Health Promotion and Sign Posting**

Prisoners working as Health Trainers could carry out health promotion and sign posting.

**Prison Health Performance and Quality Indicators**

This GUM model supports delivery of the following Prison Health Performance and Quality Indicators:

- 1.32 Sexual Health.
Health Promotion and Prevention

Prison health promotion priorities

To address:
- Mental health promotion and well-being.
- Smoking Cessation and Tobacco Control.
- Health eating and nutrition
- Physical Activity
- Sexual Health.
- Drug and other substance misuse (including BBV).
- Cancer prevention (including self examination and screening information).
- Oral health promotion.

These areas of health and well-being will involve a whole prison approach.

Aims and objectives

To help those working with prisoners to:
- Build the physical, mental and social health of prisoners (and where appropriate staff) as part of a “Whole Prison Approach”.
- Help prevent the deterioration of prisoners’ health during or because of custody, especially by building on the concept of decency in prisons.
- Help prisoners adopt healthy behaviours that can be taken back into the community.

Specific objectives to be achieved are:
- A “Whole Prison Approach” to health promotion in prisons.
- Extended use of evidence based health promotion in prisons.
- Monitor and evaluate progress made through whole prison /multidisciplinary health promotion action groups.

All prisons should be a Health Promoting Prison

Developing a “Whole Prison Approach” (see figure 1) to promoting health is fundamental, and has three main components:
1. Policies in prisons, which promote health (e.g. a No Smoking Policy for staff and prisoners).
2. An environment in prisons, which is actively supportive of health.
3. Prevention, health education and other health promotion initiatives.

In Health Promoting Prisons the vision is based upon an enhanced approach, recognising that prisons should be:
- Safe.
- Secure.
- Reforming and Health Promoting.
- Grounded in the Concept of Decency.

Core principles of a Health Promoting Prison

- Promoting health in prisons is core work for both the NHS and the Prison Service.
• Responsibility for health promotion must ultimately rest with prison management.
• Prisoners should be provided with a broadly equivalent range of quality services (based on assessed needs), which the general public receives from the NHS.
• Improving the health and well-being of prisoners is recognised as a vital element in their rehabilitation and resettlement.
• The needs and preferences of the target group in prisons will shape health promotion policy and practice. The target group is prisoners and where appropriate staff.
• It is fundamental to promoting health in prison that health inequalities should be tackled by addressing some of the wider determinants of health.
• The prison regime and environment should be assessed with regard to the concept of decency, and there should be an intention to avoid exacerbating inequalities or creating new ones. For example, there must be no discrimination against any target group on the grounds of age, gender, ethnicity, religion, disability or sexuality.

Figure 1

Addressing prisoners’ health promotion needs as defined through Health Needs Assessment and written into the Health Improvement Programme. Also addressing staff health promotion where appropriate through health at work initiatives.

From “Health Promoting Prisons: a shared approach (2002)”

Health Trainers
• Will be core to delivery of health promotion in prisons.
• Are grounded in the concept of peer educators.
• Provide opportunities to develop a health promotion workforce within the prisons.
• Provides education, skills development and employment opportunities for prisoners

Health Trainers will provide advice, guidance and signposting to health promotion activities as well as interventions in the following areas:
• Smoking cessation – some Health Trainers could also be skilled up to deliver weekly support and motivation before referring to healthcare for NRT products.
• Identify physical activity opportunities.
• Weight loss.
• Healthy eating.
• Substance misuse.
• Mental health awareness.
• Sexual health.
• Oral health.

Health Trainers will establish an action plan for each individual they see.

The whole prison will require access to a range of health promotion materials and aids. All materials must be able to address language and educational differences amongst prisoners. Health promotion material must be accessible across the prison estate (gym, wings, health living centre, healthcare, induction, education, reception etc)

**Lifestyle Checks**

Key questions will be built into the reception screening process to enable lifestyle choices, which affect a patient’s health, to be identified. Patients will then be provided with information about the Health Trainer scheme and referred to see a Health Trainer. This will compliment the process of self referral to the Health Trainer programme and enable a proactive approach that targets new entrants into the prison.

**Health Promotion Interventions**

Smoking cessation – can be provided by Healthcare, Gym Staff, Prison Officers and some Health Trainers.

Gym - could provide
• Weight management - Physical activity and healthy eating advice and support.
• Exercise on referral from GP or Healthcare for those identified, at reception or a later date, with a high BMI or undertaking no exercise. Prison staff and Health Trainers can refer to GP/Healthcare for onward exercise of referral.
• Could undertake walking for health initiatives

Substance Misuse – in addition to health promotion and awareness messages availability of CARATS (psychosocial interventions) would be required through the prison service.

Mental Health (see Foundation Step of the mental health workshop)
• Availability of self help information and awareness information.
• “Wish u well” approached (established at HMP Drake Hall) could be adopted to support signposting to appropriate services.
• Availability of advice and referral centre (as per mental health workshop model).

From the mental health workshop health promotion:
• Should be holistic – a “Whole Prison Approach” as a variety of factors will affect a persons mental health, not all of which are related to their health.
• Requires good self help information to be easily accessible across the whole prison e.g. chapel, gym, at reception, in the pharmacy and through the induction process.
• Requires good signposting at every stage.
• Could health promotion material be directed to TVs in prisoner’s cells?
• The Foundation Step provides opportunities to better involve voluntary agencies. These would need to be co-ordinated and integrated, with better communication regarding the range of services available. This would benefit from the recruitment of a holistic co-ordinator by the prison service.
• Recommend the development of a whole prison Access and Resource Centre that would be made up of a team from different prison departments (including healthcare) to do provide advice, signposting and make referrals. This could be located in the library.
• All of the current community health self help literature could be adapted for use within a prison (would need to be adapted to suit language and reading barriers) to then be available across the whole of the prison. Would need to include advice on how to manage life in prison which is in itself a stressful event which causes anxiety.
• Health Trainers and Insiders could be trained to signpost at Foundation Steps.
• Literature could also be included in the resettlement packs that could then be delivered by any staff member. There would be a need to ensure pre-release anxiety was also addressed at this stage.
• Healthcare could form part of a multidisciplinary resettlement case review.

Sexual Health – access to healthcare / GUM services would be required.

Well man/women clinics – provided by healthcare.

Oral health promotion – Health Trainers would advise on basic oral health promotion. For more complex cases referral to a hygienist for more intensive education and treatment would be required.

**Health Prevention**

The above represent reactive services. Key to the success of health prevention is a “Whole Prison Approach” recognising that this is the responsibility of all departments, not just healthcare.

The following will be required across the prison to support a preventative approach.
• Ready access to physical exercise.
• Good meal planning and availability of health options – including on the canteen.
• Availability of sugar free medication and good toothbrushes and paste on the canteen.
• Smoke free cells.
• Zero tolerance to alcohol and substance misuse.
• Promotion of safe sex, including the availability of condoms and lubricants.
• Access to the same screening programmes that are available within the community.
• Anti-bullying culture.
• Supportive environment which promotes mental health and wellbeing.
• Availability of purposeful activity.
• Contact with family and carers.

**Induction**

• Opportunity to target new entrants with health promotion messages and support.
• Need to strongly reinforce the message that this is healthy prison on the induction wing.
• Allocated a Health Trainer dedicated to the induction wing.
• Requires a range of health promotion information available in a variety of easy access media.

• Health promotion session should be included in the induction process. These could be co facilitated by the induction wing Health Trainer. These would:
  o Tackle all the key health promotion areas
  o Provide the option for one to one sessions with a Health Trainer, as required
  o Enable onward referral to wing based Health Trainers and other services, as required.

Health Promotion Action Groups

• Are crucial in directing health promotion activities across the prison.
• Must be Governor led and represent the whole prison.
• Health Trainers should be included in the membership.
• Would coordinate, and ensure there is, an annual health fare.

Issues pertinent to Featherstone 2 (F2) only

• Each house block will have 12 Health Trainers trained, enabling 4 to be active at any one time.
• Increased support will be required to run the Health Trainer programme.
• There should be capacity to run 1 well man clinic per week, per house block.

Prison Health Performance and Quality Indicators

This Health Promotion and Prevention model supports delivery of the following Prison Health Performance and Quality Indicators:
• 1.31 Health Promotion Action Groups.
• 1.34 Exercise.
## Appendix 1 - Workshop Participants

### Primary Care (GP and Nursing)
- **David Williams** - Programme Director Offender Health and Social Care (CSIP) – Workshop Facilitator
- **Sarah Forrest** - Priority Services Commissioner (Prison Health)
- **Jacky Punch** - Professional Lead for Prison Health
- **Murray Campbell** - Prison Health Medical Lead
- Betty Alford – representing the Professional Lead for District Nursing
- Malcolm Thomson - Programme Manager (Care Closer to Home)
- Lynne Deavin- Primary Care Manager, West Locality

### Primary Care (Dental)
- **John Morris** – Consultant in Dental Public Health
- **Lynne Deavin** - Primary Care Manager
- **Sarah Forrest** - Priority Services Commissioner (Prison Health)

### Emergency Care/Minor Injuries and Out of Hours
- **David Williams** - Programme Director Offender Health and Social Care (CSIP) – Workshop Facilitator
- **Sarah Forrest** - Priority Services Commissioner (Prison Health)
- **Jacky Punch** - Professional Lead for Prison Health
- **Murray Campbell** - Prison Health Medical Lead
- Malcolm Thomson, Programme Manager (Care Closer to Home)
- **Ann Marie Curtis** - Professional Lead Urgent Care

### Mental Health
- **David Williams** - Programme Director Offender Health and Social Care (CSIP) – Workshop Facilitator
- **Sarah Forrest** - Priority Services Commissioner (Prison Health)
- **Jacky Punch** - Professional Lead for Prison Health
- **Linda Ventress** - Mental Health In Reach Team Manager (S&SFT)
- **Murray Campbell** - Prison Health Medical Lead
- **Sharon Scottorn** - Safer Custody (HMPS)
- Steve Ingles, Professional Lead for Mental Health and LD
- **David Palmer** - Clinical Champion (Mental Health)

### Specialist Mental Health
- **David Williams** - Programme Director Offender Health and Social Care (CSIP) – Workshop Facilitator
- **Sarah Forrest** - Priority Services Commissioner (Prison Health)
- **Jacky Punch** - Professional Lead for Prison Health
- **Linda Ventress** - Mental Health In Reach Team Manager (S&SFT)
- **Linda Holt** - Mental Health and Criminal Justice Manager (JCU)
- Christine Adams - Commissioning Manager for Learning Disabilities (JCU)
- **Ron Daley** - Commissioning Manager for Mental Health (JCU)
- **Gary Holland** - Programme Lead (CSIP)

### Substance Misuse
- **David Williams** - Programme Director Offender Health and Social Care (CSIP) – Workshop Facilitator
- **Sarah Forrest** - Priority Services Commissioner (Prison Health)
- **Jacky Punch** - Professional Lead for Prison Health
- **Murray Campbell** – Prison Health Medical Lead
- **Jonathan Fletcher** - Head of District Partnerships
- **Debbie Roberts** - DIP Manager
- Peter Cope - Medicines Management Advisor (Prison Health)
Inpatients
David Williams - Programme Director Offender Health and Social Care (CSIP) – Workshop Facilitator
Sarah Forrest - Priority Services Commissioner (Prison Health)
Jacky Punch - Professional Lead for Prison Health
Malcolm Thomson - Programme Manager (Care Closer to Home)
Lynne Deavin - Primary Care Manager (West Locality)
Claire Clemson - Inpatient Manager (YOI Brinsford)
Steve Ingles - Professional Lead for Mental Health and LD
Dawn Llewlyn, Professional Lead – Acute Nursing
Gary Holland - Programme Lead, CSIP

Pharmacy
David Williams - Programme Director Offender Health and Social Care (CSIP) – Workshop Facilitator
Sarah Forrest - Priority Services Commissioner (Prison Health)
Jacky Punch - Professional Lead for Prison Health
Mark Seaton- Head of Medicines Management
Peter Cope - Medicines Management Advisor (Prison Health)

Therapy Services
David Williams - Programme Director Offender Health and Social Care (CSIP) – Workshop Facilitator
Sarah Forrest - Priority Services Commissioner (Prison Health)
Jacky Punch - Professional Lead for Prison Health
Claire Ward - Professional Lead for Physiotherapy
Julie Taylor - Professional Lead for Podiatry
Beth Hancox - PCT Professional Lead for Occupational Therapists
Karen Urbicki - PCT Professional Lead for SALT

Communicable Diseases and Infection Control
David Williams - Programme Director Offender Health and Social Care (CSIP) – Workshop Facilitator
Sarah Forrest - Priority Services Commissioner (Prison Health)
Jacky Punch - Professional Lead for Prison Health
Murray Campbell - Prison Health Medical Lead
Mandy Beaumont - Prison Communicable Disease and Infection Control Lead (HPA)
Aliko Ahmed - Public Health Consultant

GUM
Lesley Gerhardt - Priority Services Commissioner (Sexual Health)
Sarah Forrest - Priority Services Commissioner (Prison Health)

Health Promotion and Prevention
Mike Calverley – Head of District Partnerships/ Prison Public Health Lead
Sarah Forrest - Priority Services Commissioner (Prison Health)