NHS ENGLAND (SOUTH EAST)

HMP BULLINGDON

HEALTH NEEDS ASSESSMENT

July 2019

Ottaway Strategic Management

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NHS England (South East – Thames Valley)

HMP Bullingdon

Health Needs Assessment

Independently Reported by Ottaway Strategic Management ltd

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1 Executive summary and recommendations

Context

1.1 This health needs assessment was commissioned by NHS England and has been jointly supported by a steering group of representatives from the prisons in the region, healthcare and specialist health service providers in the Thames Valley.

Methodologies

1.2 The needs assessment incorporates a range of methodologies that are set out in detail in the main report. These include site visits, interviews with key practitioners and stakeholders, a review of service user focus groups and feedback surveys and a stakeholder survey. In addition, there has been a comprehensive review of the available data held that describes the epidemiological context and prevalence of health needs. Furthermore, this is supported with a review of the demands being placed and the take up of services. Priority issues have been exemplified through discussions with the prison establishment, healthcare providers and commissioners.

The prison

1.3 HMP Bullingdon is a category B local prison and serves remand, recall and sentenced offenders. Being a local prison, with 30% of the population on remand, there is a high throughput, currently measured at 3.54 to 1. At the time of this health needs assessment the population of HMP Bullingdon is 1,058 against an operation capacity of 1,114. The prison population is younger in comparison to the age profile of the male prison population of England & Wales. The diversity of the prison is reflective of the local catchment area and broadly reflects the national male prison population.

1.4 The prison is due to be included in the second phase of the reconfiguration of the prison estate. This means that HMP Bullingdon will increase its reception function to 55% of its population and will retain 45% sentenced prisoners for resettlement. One wing of 191 prisoners will be included in this resettlement number, as HMP Bullingdon will retain its sex offender wing. This is a critical change for the prison and a factor that has influenced this HNA, principally to assess and predict the likely impacts of this reconfiguration on the provision of health and social care in the prison.

Commissioning and organisation and delivery of health care and subsequent contracts

1.5 Health services are delivered by Care UK who hold the integrated healthcare contract; they are commissioned by NHS England. Non-clinical substance misuse

and secondary mental health services are sub-contracted by Care UK and provided through Midlands Partnership Foundation Trust NHS Foundation Trust (MPFT) operating under the title of Inclusion. This service model has been in operation since April 2016.

Current health profile

1.6 The healthcare provision seems robust in HMP Bullingdon. The volume of throughput in the prison significantly focuses the operation to cater to the changing client base in the prison.

1.7 The volume of receptions is high at 14.6 per day and this is likely to increase. Resources need to be put in place to assure the manageability of increasing volumes of receptions and transfers, post reconfiguration in the autumn.

1.8 The resources available to healthcare and its subcontracts seem to be relevant and proportional to the needs currently being presented. The stakeholder survey did however indicate strong views that staffing levels were low. However, resources will need to be reassessed post reconfiguration.

1.9 The take up of GP and nurse led clinics is high at 84% and 88% respectively. However, the take up of dental clinic appointments seems low, at 57% and work is needed to support the improvement of this utilisation rate.

1.10 DNA averages across the year were for GP clinics: 14%, nurse led clinics: 9% and dental clinics: 19%.

1.11 Dental healthcare is under much pressure in HMP Bullingdon, with the high flow of new patients many of whom have both urgent and routine care needs. The service operates on 5.5 sessions per week but arguably could increase to 6.

1.12 There seems to be a great need to maximise the number of external appointments that are being completed. The rate of only 7% of escorted appointments completed in 2018-2019 seems very low. The level of cancellations, for whatever reason, was 47%. This means that some 46% of planned escorts were not completed and no reasons were given.

1.13 The proportion of the prison with an in-possession status is 51% and those on a supervised consumption regime represent 49% of the population.

1.14 The vast proportion of medications prescribed relate to the central nervous system, accounting for 41% of all prescribed medications (pain relief), followed by 20% musculoskeletal and joint and 9% gastrointestinal.

1.15 Service users felt that there is a need for:

- Improved access to all services through efficient and effective application processes
- Improved triage processes that works with regime and not against it
- Additional services to reduce clear waiting lists

- Early intervention for simple conditions

1.16 Care UK need to sustain their efforts to maximise the filled positions in their healthcare workforce but will need to continue to supplement vacancies with agency staff until vacancies are met.

Physical Health needs and demand

1.17 HMP Bullingdon has a high volume of prisoners coming into and out of the prison. This is likely to increase substantially following the prison's reconfiguration in October 2019. The current physical health needs are relatively stable and demonstrate an increasing prevalence of some chronic conditions. In several cases there is prevalence of chronic conditions that are both above and below national and regional prevalence levels.

1.18 To summarise, the six most prevalent chronic conditions are set out in the table below and describe the prevalence trends on the register of the last 12 months. These are compared with national and regional QoF prevalence to highlight potential levels of met or unmet need by assessing those prevalence levels that are above and below national and regional expected levels.

Table 1: Major Conditions summary table HMP Bullingdon

Condition	HMP Bullingdon Trends[1]	HMP Bullingdon register[2]	HMP Bullingdon prevalence[3]	National prevalence[4]	SE Regional prevalence[5]	Above or below estimate
Asthma	Constant	116	10.3%	5.9%	6.0%	Above
Depression	Rising	182	16.13%	9.88%	9.93%	Above
Obesity	Rising	164	14.54%	9.76%	8.54%	Above
Diabetes	Declining	44	3.9%	6.8%	5.9%	Below
Epilepsy	Declining	18	1.6%	0.8%	0.7%	Below
Hypertension	Constant	84	7.4%	13.9%	13.4%	Below

1.19 There are indications that some conditions have a level of under representation particularly from an ethnicity perspective, this includes: hypertension, epilepsy and depression, where there are a disproportionately higher presence of prisoners from white ethnic groups on the register and hence disproportionately lower levels of BAME prisoners. Age profiles of major conditions were consistent with nationally derived age-related prevalence.

1.20 The summary of comparisons with similar prisons has shown that HMP Bullingdon has a higher prevalence of asthma, epilepsy (more than HMP Elmley, lower than

[1] HMP Bullingdon SystmOne 5 quarter trend review
[2] HMP Bullingdon SystmOne Register March 2019
[3] HMP Bullingdon SystmOne Register March 2019
[4] PHE Profiles QoF 2017-2018
[5] PHE Profiles QoF 2017-2018

HMP Hewell) and diabetes, but a lower prevalence of depression, obesity and hypertension.

1.21 Deaths in custody from natural causes have been relatively constant in the last 5 years. This being the case, there may be a case for the prison to provide a dedicated cell in the inpatients unit to support palliative and or end of life care.

1.22 The management of long-term conditions and national screening programmes are in place, however the volume of turnover in the prison often prevents these services to be fully maximised. This is likely to continue and potentially be exacerbated when the prison undergoes its reconfiguration in October.

Mental Health needs and demands

1.23 Based on national estimates of mental health need among prisoners, the table below summaries the expected and actual demand.

Table 2: Summary prevalence, expected and actual demand

Mental Health	Prevalence	Expected (rounded)	Actual
Male prisoners reported emotional or mental health	42%	445	518
Adult prisoner reported at risk of anxiety and depression	49%	245	183
Male prisoners reported symptoms of indicative psychosis	15%	160	16
Male prisoners have a personality disorder	64%	680	12
Male prisoners reported feeling suicidal on arrive to prisons	21%	220	286

1.24 On average, mental health services carry a caseload of 95 prisoners per month, representing 12% of the prison population. Service utilisation for mental health clinics is high at 91% with low DNA rates of 6%.

1.25 In the 12-months leading to March 2019 there were 52 prisoners diagnosed with a depression condition, representing 9% of the prison population. In the period between June 2018 and March 2019, there were 44 prisoners with severe and enduring mental illness, 4% of the prison population. In the past 12-months there have been 11 admissions to secure psychiatric hospitals.

1.26 Overall, it was felt the need for primary and secondary mental health services far outweighed the capacity either team had to deliver interventions. This was found to be especially true for short interventions for those prisoners remanded to the prison. This perception was supported by both the stakeholder survey and the mental health service users focus group.

1.27 There are no pathways for learning disabilities (LD), dementia or personality disorder (PD). This will need to be addressed particularly in the case of learning disabilities with the introduction of new national specifications.

1.28 Over the past three years there has been a significant increase in the number of self-harm incidents reported, with a total of 556 incidents of self-harm reported in 2018.

1.29 Data provided by the prison shows that 950 ACCTs were opened in the period between May 2018 and May 2019, on average 73 ACCTs per month.

1.30 Mental health services are integrated within the ACCT process and will assess all prisoners irrespective of whether they require mental health services.

1.31 Service users through their focus groups felt it was important to introduce:

- Increased service provision including counselling, groups and/or courses for stress, depression, anxiety and coping mechanisms
- Structured mental health and emotional wellbeing mentor/rep programme
- Increased health promotion, including mental health days and officer training.

Substance Misuse needs and demands

1.32 The table below summarises the application of national estimates of drug and alcohol need among prisoners in HMP Bullingdon:

Table 3: Summary of estimates of drug and alcohol use

Drug and alcohol use	Estimates	Expected (rounded)
Prisoners that would have used drugs in the month prior to entering prison	64%	680
Prisoners that develop a problem with illegal drugs in prisons	11%	115
Prisoners that would have reporting drinking in the month prior to entering the prison, of this population:	87%	920
Prisoners that would have reported having some problems with their drinking	46%	420
Prisoner that felt their drinking was out of control	39%	360

1.33 In May 2019, 16% of the prison population of HMP Bullingdon were undergoing clinical substance misuse treatment and 18% were in psychosocial substance misuse treatment (including some that are also receiving clinical treatment).

1.34 HMP Bullingdon is a prison with a high turnover rate, and as such it has a high throughput of prisoners accessing treatment, albeit in some cases for a short period of time. Much of the work of the DART is focused around assessment, harm minimisation and group work.

1.35 NDTMS data shows there are effective processes in place for early identification and engagement with treatment. In the 12-month period ending March 2019 there has

been a 9% increase in the number of prisoners in treatment compared to the previous year.

1.36 The service utilisation rate for substance misuse clinics is 89%. Clinic DNAs are low at 3%, though DNA rates for groups fluctuate and can sometimes be attended by half the expected number.

1.37 Prisoners on the substance misuse caseload are less diverse than the prison population, with prisoners from BME groups accounting for 13%, whilst representing 30% of the prison population.

1.38 Most of the prisoners in substance misuse treatment are in their thirties (46%) and twenties (41%) and are overrepresented when comparing to the age profile of the overall prison population.

1.39 Those on the substance misuse treatment caseload are reporting recent or historic drug and alcohol use.

1.40 30% of prisoners leaving HMP Bullingdon that had an ongoing need for treatment started treatment in the community within 3 weeks; this is lower than comparable prisons.

1.41 Of the prisoners who were transferred from HMP Bullingdon to another prison that had an ongoing treatment need, 36% started treatment in their new prison within 3 weeks. This is also lower than comparable prisons.

1.42 A higher proportion of prisoners felt it was easy to get drugs or alcohol in the prison (50% and 33% respectively) compared to the average across all prisons (47% and 23% respectively). The DART reported the prevalence of illicit drug use was high and varied in the types of drugs being used. Moreover 44% of respondents to the stakeholder survey felt that more than 60% of the prison's population was using illicit substances whilst in prison.

1.43 Outcomes of the random MDT at the end of 2018 show the positive test results stood at 24% for HMP Bullingdon. This is higher compared to the average across all prisons (20%). However, 87% of all tests were positive for PS whereas across all prisons this was 54%.

1.44 In the 12-months leading to March 2019, there were fewer prisoners in treatment reporting the use of PS compared to the previous year.

1.45 Service users through their focus groups felt it was important to introduce:

- Supportive responses to positive MDTs in preference to punitive ones
- Structured mentor/rep programme
- Introduction of AA/NA
- Wider course content
- Group interventions or wing-based drop ins
- Recovery awareness days
- Additional Gym – more meaningful and purposeful activities.

Social care needs and demands

1.46 Since April 2019, a MOU is in place for the management of the social care needs in the Oxford prison cluster, and Care UK have been commissioned to provide for those prisoners eligible for care packages.

1.47 In the survey results of the most recent inspection of HMP Bullingdon 31% of the prisoners surveyed considered themselves to have a disability. The disabilities described included a range of physical, mental and learning disabilities.

1.48 There have been 34 referrals to social care in the 12-months to May 2019 and 40% were eligible for either equipment or care or both.

1.49 Findings from the stakeholder survey suggest that from a social care perspective there were a number of concerns. These were in respect to the adequacy of staffing and of social care provision generally, and also the continuity of care arrangements for those on release back into the community. Findings from the primary care focus groups of service users indicated that residents feel there is an increased need of social care for older adults with more adaptations required for their environment.

Screening immunisation and health promotion needs and demand

1.50 Healthcare has many pressing throughput priorities, which often draw it away from many of the core activities that are critical to supporting disease prevention and escalation.

1.51 Being a busy local prison, the most significant points at which national screening and disease screening are most likely to be addressed is at the second reception session for new patients.

1.52 Currently there is a low take up of AAA screening (3%), Retinal Screening (6%), NHS Health checks (1%) and TB Screening (10%).

1.53 From a communicable disease perspective there has previously been a relatively strong take up of Hepatitis B and Hepatitis C testing and this is likely to improve significantly with the introduction of dry spot testing, which was introduced in April.

1.54 HIV screening is also relatively efficient, with 58% of reception prisoners being tested. However only 36% of those that test positive are being seen in hospital within 2 weeks of diagnosis, which is a potential concern; although this may clearly

be because prisoner is either released or transferred to other establishments post sentencing.

1.55 At 16%, the level of chlamydia screening does seem relatively low but this relatively typical for a reception focused prison. The national average for prisons is 16% which is the same as HMP Bullingdon.

1.56 Bullingdon's Infection control audit is strong and is showing improvement with the introduction of a rolling programme of audits enabling healthcare to focus on embedding improvements.

1.57 The volume of smokers entering the prison is high, at 63% of new receptions. This is likely to remain constant as a percentage, however with the increasing numbers coming into the prison the need and support for smoking cessation will increase.

1.58 From a health and well being improvement perspective there are a range of campaigns and health promotion activities that are being run by healthcare and jointly with the prison.

1.59 Programmes for dietary wellbeing are supported by the healthcare team dietitian.

1.60 The development peer mentors will be important going forward, particularly in light of the prison's reconfiguration, specifically the need to retain prisoners with these skills to support men living on each wing.

The reconfiguration of HMP Bullingdon impact on health care

1.61 A key component of this HNA has been the need to support commissioners and service providers to address the likely increases in service demand and hence need as a result of the reconfiguration of HMP Bullingdon from a Cat B local to a Reception and Resettlement prison.

1.62 A modelling exercise has been completed that assumes the reconfigured prison to be based on a 55% reception and 45% resettlement establishment.

1.63 The health needs of the prisoners coming into the prison are assumed to be the same as currently recorded, although there is an established argument that prisoners in reception will present with higher demands for substance misuse and mental health services. The critical difference will be the increased volume of prisoners that will pass through the prison as part of the reconfiguration process.

1.64 The current rate of receptions completed per day is on average 14.6. This is based on a throughput figure of 3.54 to 1. With the increase of receptions coming in from Woodhill courts this number will shift to 17.8 receptions per day and a throughput of 4.21 to 1. This is a static calculation and does not take account of any increase in the way courts are processing prisoners into the prison. In the first phase of its national reconfiguration programme HMP Durham experienced a 65% increase

against its projected figures for reception. This potential growth has been factored in by adding in a further set of assumption of 20%, 40% and 60% growth.

1.65 These increased assumptions identify a potential average of first night receptions of 21, 25 and 28 per day respectively. This will result in increased throughputs of 5.0 to 1, 5.9 to 1 and 6.7 to 1 respectively.

1.66 These growth rates have been applied to the required additional staff hours needed to fulfill this reception process. These staff hours are based on the roles of GPs, RGNs B5, RGN ISMS, and HCAs. Therefore, for the baseline reconfigured growth in first night and second day receptions this would require 61 additional staff hours per week. However, based on a 20% growth in flow this would require a further 130 hours per week, with a 40% growth in flow this would require a further 198 hour per week and with a 60% increase in flow this would require a further 267 hours per week.

1.67 NHS England and Care UK will need to compute how this converts to staff hours. They will also need to address the impact of discharges or transfers onto other prisons and the overall administration and management of resources to secure a safe and secure reception process, meeting the specification requirements for this critical process in a prisoner's healthcare experience.

1.68 Care UK have identified the need for 15.7 staff plus a further £182,431 for additional dentistry sessions, escorts and bedwatches and medical consumables in order to support the reconfiguration process for HMP Bullingdon.

1.69 In addition, Care UK have proposed a growth of mental health and substance resources of 9.2 FTE to secure the compliance with the new NHS England national specifications.

1.70 Collectively, the additional resources for the reconfiguration and the new mental health and substance misuse specifications come to an equivalent of 24.9 FTEs. This will need to be reviewed by NHS England against their budgetary capability and their perceptions of the way these services will be delivered within the prison. Additionally, the modelling exercise has identified likely growth to 267 hours per week. This needs to be translated into staff costs and compared to the proposal set out by Care UK.

Key Recommendations

1.71 The key recommendations for the improved primary healthcare of prisoners in HMP Bullingdon are:

- Healthcare to continue to review the levels of DNA in all clinics and to maintain the relatively high utilisation rates in its GP, and nurse led clinics.
- Healthcare with dentistry to maintain progress in reducing DNA and to continue to work with the prison staff to support the enablement of prisoners to attend their appointments.
- Healthcare to continue to work with the prison to ensure ready access to prison custody officers (PCO) during clinic times and enable clinicians to see all appointments allocated per session.
- Healthcare to review the increasing prevalence of depression and obesity, and to monitor the profile of asthma and hypertension.
- Healthcare to review the management of long-term conditions and national screening programmes in the light of the reconfiguration plans for the prison.
- Care UK as the prime provider to work with all healthcare staff to maximise clinic utilisation and to sustain the current strong profile of utilisation in the prison.
- Review dental healthcare provision to assess the adequacy of current arrangements and further review services to assess the true impact of reconfiguration.
- Care UK to sustain their efforts to maximise the filled positions in their healthcare workforce.
- Continue to improve areas identified by the infection control audit to raise the standards.
- Continue to develop a wellbeing approach across the prison to promote self-awareness and responsibility towards better health.
- Continue the development of support through health champions, focusing on healthy eating and weight loss.
- Develop a local health promotion group working alongside Care UK's health champions.
- As the age profile of the prison population is changing, monitor healthcare provision to ensure the needs of older prisoners are being met.

1.72 The key recommendations for the improved mental health and wellbeing of prisoners in HMP Bullingdon are:

- Increase mental health awareness and training amongst prison staff and healthcare providers
- Review resources to meet the demand for services in line with the new national service specifications this should be aligned to the recommendations from section 10 of this HNA

- Develop a pathway for the identification and assessment of learning disabilities
- Develop short-term interventions that will benefit those prisoners that are remanded and do not stay in the prison for long, such as managing emotions/emotional regulation
- Develop a dementia pathway to support older people coming into and or going through the prison
- Develop a review of counselling and talking therapies in the prison.
- Maximise joint working between primary and secondary care mental health services
- Health care, Inclusion and commissioners to agree the additional resources needed to meet the new specification for mental health and substance misuse services in the prison. This figure currently comes to 9.2 FTEs.

1.73 The key recommendations for the improved provision of substance misuse services for prisoners at HMP Bullingdon include:

- Incorporation of the DART activity data onto SystmOne to ensure data compatibility. This will require some supportive infrastructure
- Continue to support the joint working between clinical and psychosocial substance misuse teams
- Continue to raise awareness of substance misuse services among prison staff
- Develop evidence-based interventions including psychological interventions as recommended by NICE and other relevant bodies. This should include a group programme and provide a dual diagnosis group.

1.74 The key recommendations for the improved social care of prisoners in HMP Bullingdon are:

- Implement training for all prison staff to better understand the social care needs arrangements and referral pathway for prisoners
- Establish formal training for 'buddy'/'enabler' scheme.

1.75 Reconfiguration Planning

- Healthcare and commissioners will need to adapt provision to meet the needs of a reconfigured HMP Bullingdon to a reception and resettlement population.
- Healthcare and commissioners to address the likely increasing staff load that will be a requirement post reconfiguration. This is currently modelled at 15.7 FTEs.

- Healthcare and commissioners to agree, develop and recruit to a new staffing model to ensure the best skill mix is in place for the services provided.

2 Introduction and context

Commissioning context

2.1 This health needs assessment (HNA) was commissioned by NHS England Health and Justice (South East) in April 2019. HMP Bullingdon's HNA mirrors the Health and Justice HNA Toolkit for Prescribed Places of Detention.[6] This HNA is based on the available data to complete the requirements set out in this toolkit and guidance.

2.2 Within each prison establishment there are several key stakeholders with clearly defined roles and responsibilities in the provision of healthcare services. These include prison governors and their staff, NHS England as the commissioners of health services, prison healthcare leads and their contractors, and the prisoners themselves. Where feasible all these stakeholders have been engaged, either directly or indirectly in this HNA.

2.3 In relation to the health needs of the prison population there are key periods in the custodial experience of the prisoner that must be considered. These would include arrival at the prison, health screenings, diagnosis, transfer of notes etc., addressing health needs throughout the duration of their stay and planning the continuity of care on their release or transfer. Where possible, components of this cycle of the prison experience will be addressed in this HNA.

2.4 There are also factors about the prison itself that can impact on the health of its prison population. To this end the HNA has sought to appropriately describe the prison and draw from this any relevant impact and context there may be on the health needs of the prison population.

Aims and objectives of this Health Needs Assessment

2.5 The specific aims and objectives of this HNA are set out below:

1. To describe the prison population of HMP Bullingdon.
2. To describe the current healthcare service provision utilised by HMP Bullingdon in terms of their internal and external and wider health promotion activity e.g. smoking cessation services, healthy eating and physical activity.
3. To understand the complex needs of the older population and the care required for them.
4. Recognise and demonstrate the provisions of Social Care in the Prisons (commissioned by the Local Authority) and recommend opportunities for improved health and social care integration and provisions to enable prisoners to live an independent and quality life.
5. To investigate the full range of health needs and report on the epidemiology of health problems experienced by the men compared to the general population and compared to offenders in similar establishments,

[6] https://www.gov.uk/government/publications/prescribed-places-of-detention-health-needs-assessment-toolkit

with a specific focus on key health conditions within each prison. This will be determined from the data but is likely to include communicable disease (Sexually transmitted illnesses, TB, hepatitis, and HIV), coronary heart disease and mental health (cross referencing with sections below).

6. Conduct a gap analysis between current service provisions, needs of the population, best practice, effective interventions and national care standards.
7. Service user feedback reviewed to hear the views of patients who use healthcare – this includes patients that have relatively minimal use and try and understand any barriers of unmet need.
8. Identify and report on organisational barriers to the delivery of the current/proposed models of care.
9. Review escort and bed watch levels. Formulate recommendations for existing pathway improvements and opportunities for onsite care to reduce the need for external appointments.
10. To obtain user and staff perceptions on current service provision and how services can be improved as well as to explore and report on the attitudes towards the delivery and effectiveness of healthcare in each setting through interviews with prison staff, service users, internal/external service providers and where possible carers, families and advocates.
11. To use robust research methodology, including statistical modelling and analysis to compare the health of those in prison with sensible comparator groups in the community and in other establishments.
12. Consider equality of healthcare services in terms of access and provision and in relation to core equality strands (e.g. race, disability, age, religion, and sexual orientation) and complete an Equality Impact Assessment.
13. To make recommendations on future service developments.
14. Review the staffing profile against need, business continuity, recruitment and retention and resources.

Specific Focus to review

- Primary and Secondary Mental Health including provision of psychiatric and psychological services
- The health needs of Foreign Nationals
- Medicines Management
- Dental Services
- BBV Process
- Community Pathways and Links
- Health Promotion
- Sexual Health
- Discharge Planning
- Drug and alcohol service (NPS &Spice Use)
- Secondary care needs of inpatient unit
- Older men and Social care provision

- Provision for escorts and bedwatches, including details of need compared to resource and recommendations on what could be done to reduce external appointments. This will include an investigation of the volume and duration of escorts and bedwatches, the underlying patterns of reasons for treating a patient off-site and barriers preventing early return from secondary care or to treatment on-site.
- Vaccination coverage of measles, mumps and rubella (German measles) MMR
- Smoking cessation and stop smoking services for sentenced/un-sentenced prisoners
- Necessity for bespoke services, for example tissue viability and GUM
- Prevalence of personality disorder
- NHSE would like the report to outline the changing role(s) of the prison.
- To outline how the health needs of the men should be met according to length of stay based on the prison function. At 6 weeks/2 years and longer term.
- To review the healthcare needs now and how that might change via the reconfiguration or length of stay.

2.6 The most significant feature of this HNA is to support commissioners to address the reconfiguration of HMP Bullingdon to a reception and resettlement prison. To this end there has been a focus on assessing the future of the prison population's health needs in this context as well as how to better understand the impact that this reconfiguration will have on key healthcare operational practices and processes.

3 HMP Bullingdon

3.1 This section provides a description of HMP Bullingdon, the throughput of offenders entering, transferring or being discharged from the prison and a snapshot of its current population.

Description

3.2 Built 25 years ago, Bullingdon is a relatively modern local and resettlement prison near Bicester in Oxfordshire, serving the Thames Valley. It holds currently just over 1,100 adult and young adult prisoners of differing status. About a fifth of those held are unsentenced or unconvicted, while others comprise the full range of sentences, including nearly 200 men who are serving over 10 years and up to life. In this respect, Bullingdon is a complex prison that contends with disparate operational challenges.

3.3 HMP Bullingdon is a Category B local prison covering a catchment area from the courts of Oxford, Reading and the Thames Valley area. The prison has a capacity of 1,114 men in 6 house blocks. Many of the men are experiencing their first time in prison.

3.4 The prison consists of six residential units; A wing Substance Misuse Unit spur (199), B wing (199), C wing (199), D wing (199), E wing (Sex Offenders unit (191)), F wing (First night and enhanced (127)), Separation, support and challenge unit SSCU (27) and Health Care In Patients Unit (23).

Throughput

3.5 HMP Bullingdon is a prison with a high level of throughput. The turnover rate for the 12 months leading to March 2019 was 3.41 to 1 (this is a measure of the number of times the prison was used in a year[7]). During this period, the prison received 1314[8] transfers in (on average 110 per month) and discharged or released 2,489 (on average 207 transfers or releases per month).

Prison population

3.6 On 23 May 2019, the population of HMP Bullingdon stood at 1,058. The operational capacity of the prison is 1,114.

Prisoner status and sentencing

3.7 Most prisoners are sentenced (64%) or remanded (22%), with some prisoners on recall (11%). In total 27% of prisoners are currently unsentenced. The majority of

[7] This is measured as the ratio of first receptions to operational capacity
[8] P-Nomis May 2019

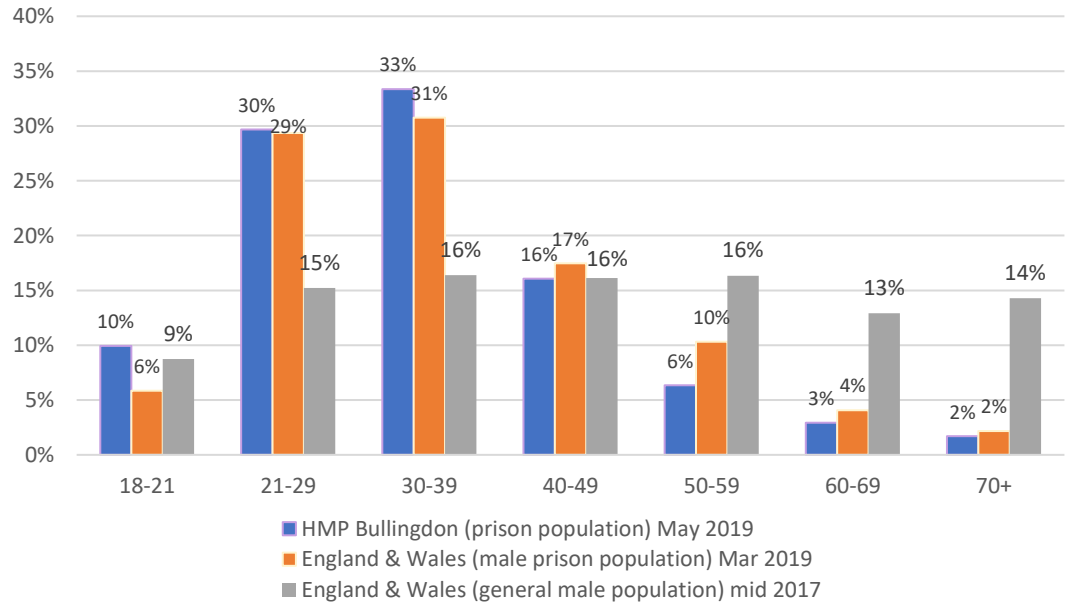
those prisoners that have been sentenced (73%) are serving sentences of between 2 and less than 10 years (56%).

3.8 The length of stay for the vast majority of sentenced (96%) and unsentenced (99%) prisoners in HMP Bullingdon is less than 2 years. Indeed 68% of sentenced prisoners stay no more than 6 months and 86% of unsentenced prisoners stay no more than 6 months. This adds to the constant flow of the prison as a cat B local and as a reception prison currently.

Age profile of prisoners

3.9 The age distribution of the current prison population ranges between 18 and 70+ years, which illustrates there is a broad representation across all ages. Overall, this prison population is younger in comparison to the age profile of the male prison population and the general male population of England and Wales. Most of the prison population of HMP Bullingdon are in their thirties (33%) and twenties (30%). Nationally, 16% of the prison population are aged 50 and over and this age has risen faster than any other age group over the last decade.[9] In HMP Bullingdon, a lower proportion of the prison population are aged 50 and over (11%).

Chart 4: Age profile of HMP Bullingdon on 23 May 2019, male prison population (England & Wales) and general male population (England and Wales) (source: HMP Bullingdon, Offender Management Statistics, Table 1.3, March 2019[10] and ONS mid-2017 population estimates[11])



[9] UK Prison Population Statistics, House of Commons Library Briefing Paper, 23 July 2018

[10] Offender Management Statistics, Table 1.3, March 2019

[11] ONS Annual Population Estimates (mid-2017)

Religion

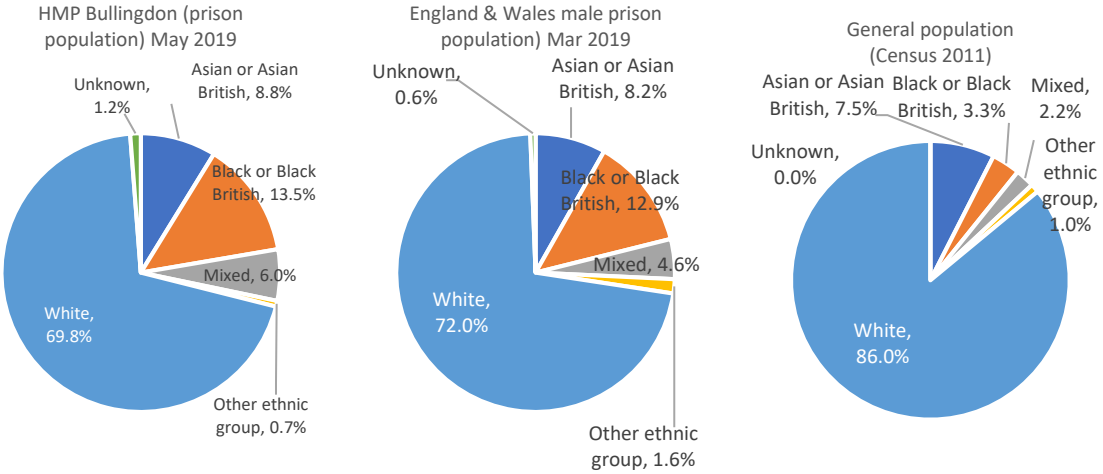
3.10 The profile of religious affiliation of the prison population shows that around half are affiliated with Christianity and 18% with Islam. There is a slightly higher proportion of Muslim prisoners compared to the proportion of Muslims in the male prison population of England and Wales (16%), and a similar proportion of prisoners from a Christian faith (48% compared to 47% across male prisoners in England and Wales). Fewer prisoners in HMP Bullingdon stated they had no religion (28%) compared to 30% across the male prison population of England and Wales.

Religion	HMP Bullingdon (prison population)	England & Wales (male prison population) [12]	England & Wales (general male population)
All Christian	48.2%	47.4%	59.3%
Muslim	17.8%	16.2%	4.8%
No religion	27.9%	30.3%	25.1%

Ethnicity and nationality

3.11 Most male prisoners in England and Wales identify as white, although prisoners from Black and Ethnic Minority (BME) groups are overrepresented, especially those identifying as black or black British or Asian and Asian British. The ethnic profile of the population at HMP Bullingdon is illustrated in the chart below, compared to the ethnic profile of all male prisoners and the general population of England and Wales. There is more ethnic diversity in the population of HMP Bullingdon with prisoners from BME groups representing 30%, compared to 28% across male prisons in England Wales.

Chart 5: Ethnic Profile of HMP Bullingdon 23 May 2019, male prison population (England & Wales) and general male population (England and Wales) (source: HMP Bullingdon, Offender Management Statistics, Table 1.4, March 2019[13] and NOMIS Census 2011, ethnicity[14])



[12] Offender Management Statistics, Table 1.5, March 2019
[13] Offender Management Statistics, Table 1.4, March 2019
[14] NOMIS Census 2011, Ethnicity

3.12 At the time of this report, 11% of the prison population was made up of foreign national prisoners. This is consistent with the proportion of foreign nationals that make up the male prison population of England and Wales (11%).[15]

Gender and sexuality

3.13 According to MOJ, in 2016, there were 70 transgender prisoners in 33 of the 123 prisons in England and Wales that can accommodate transgender prisoners. [16] Since then, this figure has been estimated to have risen to 125. At the time of the HNA there were 0.3% (>5) prisoners that had declared they were trans gender.

3.14 In the survey findings in the HMCIP annual report 2018, 4% of male prisoners in England and Wales indicated they were gay, bisexual or other sexuality.[17] In HMP Bullingdon, 83% reported they were heterosexual, 0.6% reported they were gay, 0.3% bisexual and for the remaining 16% sexuality was unknown.

Armed forces veterans

3.15 Armed forces veterans are more prone to mental health issues and some go on to develop post-traumatic stress disorders (PTSD) and therefore are especially vulnerable. In the prison population of HMP Bullingdon 25 prisoners declared that they were veterans, which represents 2.3% of the population at the time of this HNA.

Disability

3.16 In the survey results of the most recent inspection of HMP Bullingdon 31% of the prisoners surveyed considered themselves to have a disability. The disabilities described included a range of physical, mental and learning disabilities.

[15] Offender Management Statistics, Table 1.7, Jun 2017
[16] Prisoner Transgender Statistics: March 2016
[17] Findings from the Prisoner Survey (of 6,649 male prisoner responses), HM Chief Inspector of Prisons for England and Wales Annual Report 2017–18

Section summary

3.17 HMP Bullingdon is a resettlement prison with a remand function.

3.18 The prison experiences high throughput with a turnover rate of 3.4.

3.19 In May 2019 the prison held 1,058 prisoners against a capacity of 1114.

3.20 The age profile of the prison is relatively young, with around two thirds in their thirties (33%) and twenties (30%) and 11% aged 50 years and over.

3.21 31% of the prisoners surveyed in the most recent inspection of HMP Bullingdon considered themselves to have a disability.

3.22 The prison is ethnically diverse with more prisoners from BME groups than there are generally in the male prison population.

4 Contracted Health Care services

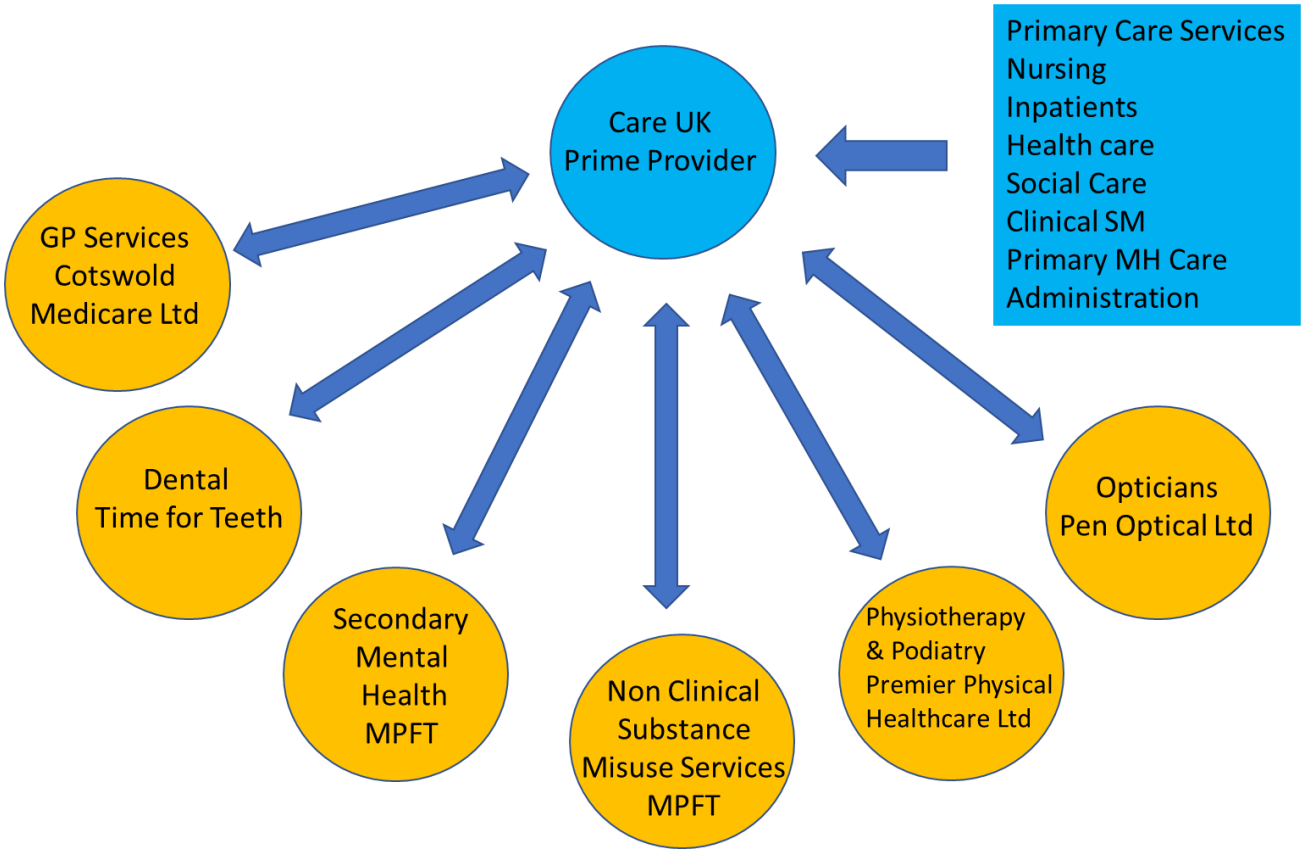
4.1 This section describes the healthcare service model for HMP Bullingdon and will address: the healthcare service model, availability of services, staffing, buildings and clinic spaces and healthcare's headline operational performance.

Health care service model

4.2 Care UK is the prime provider of healthcare services at HMP Bullingdon. Within this model there are a number of subcontracts in place. This healthcare model has been operational since April 2016. A breakdown is provided below:

- GP Services –Cotswold Medicare Ltd
- Secondary Mental Health and Non-Clinical Substance Misuse Services – Midlands Partnership Foundation Trust (MPFT)
- Dental – Time for Teeth
- Opticians – Pen Optical Ltd
- Physiotherapy & Podiatry – Premier Physical Healthcare Ltd

Chart 6: Care UK's Prime Provider Health Care Model



Service descriptions

4.3 HMP Bullingdon offers a full range of healthcare services. Along with community comparable healthcare provision, HMP Bullingdon also has a 24-hour inpatient department with 21 beds, managing a range of patients with complex needs (including palliative care and end of life). The unit, when possible, also acts as a step up to or step down from local hospitals, and also accepts complex patients from other Thames Valley establishments (with offender management agreement and where clinically appropriate).

Primary Health Care Services

4.4 HMP Bullingdon provide a wide range of healthcare provision including:

- Healthcare screening on admission to prison (used to identify immediate healthcare needs on a prisoner's reception to prison).
- Healthcare services provided on site (including primary and community care such as GP, dentist, optometrist) as well as some secondary care in-reach services (such as GUM services, mental health in-reach).
- Inpatient service (21 beds).
- Access to health care provided off the prison estate.

Services Provided

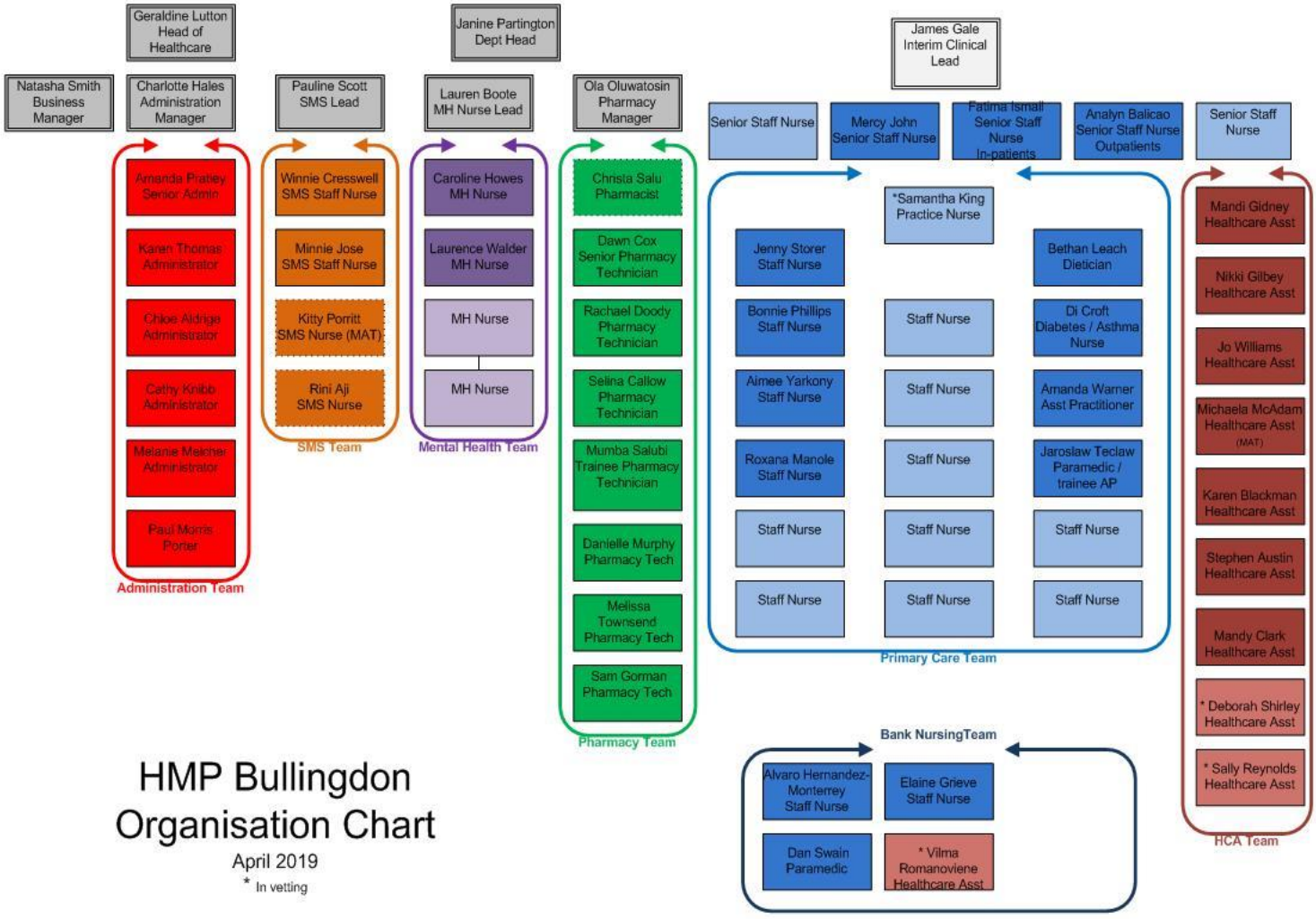
- General Practitioner (GP) Services
- Primary Care Mental Health Service
- General Dental Practitioners
- Optician Services
- Pharmacy Services
- Podiatrist
- Primary care services for all long-term conditions
- National Screening programme and NHS Health Checks
- Hepatitis B Vaccinations
- Hepatitis C Specialist Nurse
- Pain Specialist
- Sexual Health
- Physiotherapist
- Radiography
- Dressings clinics
- Smoking cessation
- Special Sick/Emergency Response
- Triage
- Asthma Clinics
- Nurse Practitioner
- Minor Operations
- Ultrasound
- Chronic Conditions (Nurse led)
- Endocrinologist (Consultant)
- Respiratory Consultant
- Geriatrician (Consultant)
- Urology (Consultant) Health Promotion and Wellbeing

Staffing Structure

4.5 Within their prime provider role Care UK has a diverse staff compliment.

- Through its contract with Cotswold Medicare Ltd, Care UK employs 3.75 GPs and 1.2 Consultants.
- Within HMP Bullingdon Care UK provides primary care and inpatient nursing services including; 1 RGN B7, 6x RGN B7 and 17 RGN B5 nurses, 7 x health care assistants, 0.2 diabetic nurse, assistant practitioner, 1.75 paramedics, 2 pharmacists and 5 pharmacy technicians, 1.27 medicines management technicians, and 0.4 of a dietitian.
- From a primary mental health function Care UK provide 1 RMN B7, 3 x RMN B5 and 0.6 RMN B5 (AP).
- From a clinical substance misuse function Care UK provide 1 ISMS clinical lead, 5 ISMS RGN B5.
- From a back-office perspective Care UK provide a head of healthcare, a deputy manager, a business manager, 0.8 admin manager, 1.4 administrators B4, and 0.8 porter.

4.6 The organogram below describes the core Care UK team:



4.7 Presently, the full complement of staff is not in place and agency staff substitute staff shortages. Care UK have experienced an ongoing difficulty in recruiting healthcare staff to the work in HMP Bullingdon and this is a concern not just in this establishment but across all of Thames Valley's prison estates, in part reflecting the high standards of living in the area. Nonetheless this is also a concern across all prison healthcare providers in the South and South East of England and in many other areas nationally.

4.8 Care UK are actively pursuing a recruitment programme to support the recruitment of staff across a number of healthcare posts.

Non-Clinical Substance Misuse services:

4.9 Inclusion

Clinical Lead: B8A
Team Leader B6 – DART
1 x Senior Recovery Worker (B6)
8 x Recovery Workers (B5)
1 x Admin (B3)

Secondary Mental Health Services

4.10 Secondary Mental Health staff provided by Inclusion (MPFT) include:

Clinical Lead: B8A
2 x RMS (B6)
1 x Psychologist (3 days)
Assistant psychologist (B4)
1 x admin (B4)
Psychiatry (5 sessions/week plus 2/3 junior Dr sessions/week.

Other key support services/resources

4.11 The wider prison community provides offenders specific services aimed at supporting their wellbeing and safety. These include:

- Safer custody (for those identified as vulnerable, under greater stress or in need of additional support due to recent life events)
- Assessment care and custody team (ACCT) for those at specific risk of suicide and self-harm
- Multi faith /chaplaincy service (spiritual support, pastoral support)
- Peer Champions (Wing based)
- OMU (including risk assessments / sentence plans)
- Education
- Gym service
- Employment
- Offenders also have access to the Listener service (peer group of offenders trained)

- Combat stress to support veterans
- Samaritans and a telephone service direct to the Samaritans
- Bereavement counselling
- Relationship counselling service provided by RELATE.

Buildings and clinic space

4.12 The health centre is a distinct block attached to the administration block. The facility is made up of an outpatients' clinic on the first-floor level, with an inpatient ward beneath, comprising of 23 beds on the ground floor level.

4.13 Within the prison's reception there are two healthcare rooms. Within F wing, the prison's first night centre, there are four healthcare rooms where patient are seen. On each wing there is a health suite where practitioners, mainly nurses, provide medication as well as carrying out triage assessments before offenders are referred to the health centre. Aside from the healthcare provision on each wing, all units are equipped with basic consulting areas as well as a dedicated PC to input case notes and reports onto SystmOne.

Outpatients

4.14 The facility runs off a single corridor giving the space a linear feel. There are limited waiting areas other than the immediate entrance where offenders will wait before they are called into their respective clinic space. The centre is made up of:

- 1 GP consulting rooms
- 5 nurse consulting rooms
- Dental suite
- Pharmacy and dispensing room
- Patient & staff toilet
- Staff/group room/small kitchen
- Health care Boardroom
- VP Waiting room
- Triage and dispensing suites on each wing

Administration office

- 1 Management office
- Senior nurses office
- HOHC Office
- Small waiting area at the entrance of the centre

Inpatients Ward

- 23 bed inpatient unit (5 are safer cells, of which 2 are constant watch cells)
- Washing facilities
- Communal rooms and an exercise yard
- Nurse office and consulting suites

Substance Misuse Services

4.15 Substance misuse services are based on A Wing, where there is a dedicated substance misuse supr. Their facilities include:

- 2 staff offices, 1 manager's office, doctor's meeting room, dispensing hatch, 3 group rooms
- Centre office space and space for case managers
- The primary care Mental Health team are also located in this office
- Staff toilet and kitchen

Secondary Mental Health Resources:

- Inclusion currently occupies two portacabins in the space behind healthcare between healthcare and E wing - this includes 1 large group room and 2 small offices
- Psychology office in outpatients

Operation performance

4.16 HMP Bullingdon's healthcare operates a range of core programmes, processes and clinics. One way of describing the needs of the local prison population is to assess the demands they place on services currently being provided. This also becomes, in part, a review of the way services respond to these demands and, in part, this assesses the capability and capacity of the prison to enable the delivery of services within the regime that they are operating.

4.17 A strong source of this performance and contract management information is captured by healthcare services and is monitored and reported on the HJIP register.

Major processing situations for patients

4.18 The **reception** function is critical for any prison; it provides the initial screening of patients' healthcare histories and needs. In many instances this is one of the few occasions prisoners come into contact with healthcare. As part of their induction to the prison there are essentially two screenings that, in most cases, take place - a first night screening process and a second day or second reception screening process.

4.19 HMP Bullingdon is a very busy local prison. This is likely to increase substantially when the prison goes through its reconfiguration process in the autumn. Nonetheless the current position for reception screening places a strong burden on the healthcare operation. Assessments completed suggests that it takes up to 12% of all healthcare resources and each week occupies approximately 282 hours of staff time. Receptions from courts and transfers from other prisons can come in throughout the day but predominantly in the evenings after their release from the

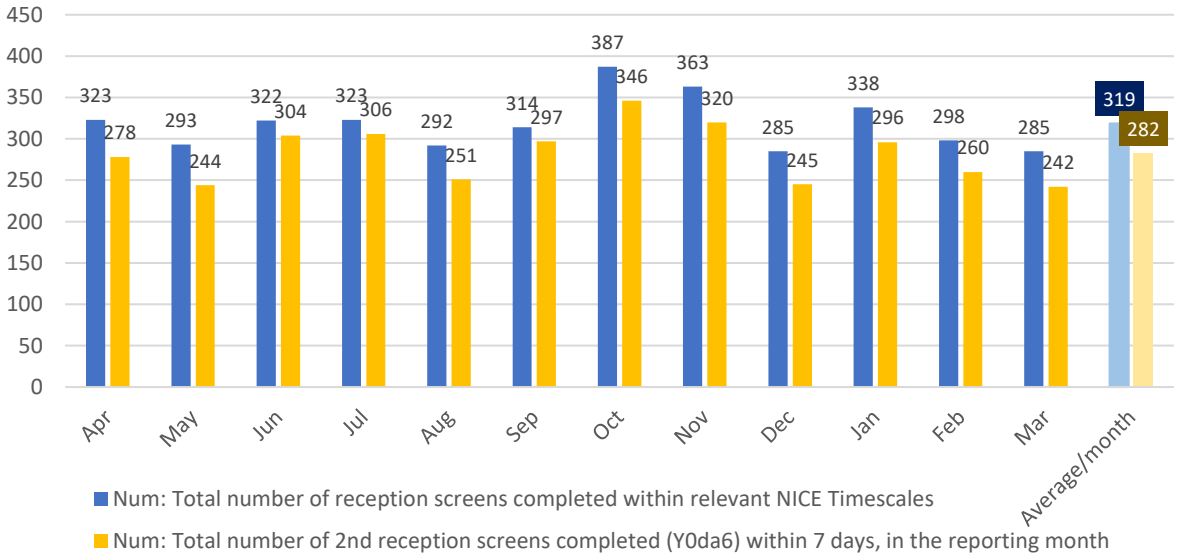
courts upon arrive in the prison usually from early evening and sometimes until late in the evening.

4.20 The prisons' reception function closes at 9pm but it is being proposed that this be extended to 10 pm, to fit into the prison reconfiguration process. Healthcare staff are represented by GPs, band 5 general nurses, and integrated substance misuse service (ISMS) nurses (to assess clinical substance misuse needs). Together they will review prisoners, after they have been 'processed' by the prison establishment reception. Prisoners are predominantly assessed and 'processed' as swiftly as possible to ensure that they have their immediate healthcare needs catered for.

4.21 A more detailed secondary examination is completed as a follow up, often on the prisoners' second or third day. This is either carried out in F wing (the prisons' first night centre) or in the healthcare centre, depending on the patient's needs. It is also at this point that patients' notes are sought and or that admin follow up with communication with patients' GPs in the community. The reception process in HMP Bullingdon is, in essence, a 6 day a week operation, with higher numbers during the week, although some receptions are taken on Saturdays for local magistrates courts.

4.22 The proportion of first and secondary screens carried out in HMP Bullingdon in the last financial year is set out in the chart below. Between April 2018 and March 2019 there was an average of 319 first reception screens completed a month and an average of 282 secondary screens completed a month - this sets an average of 14.6 screens per day.

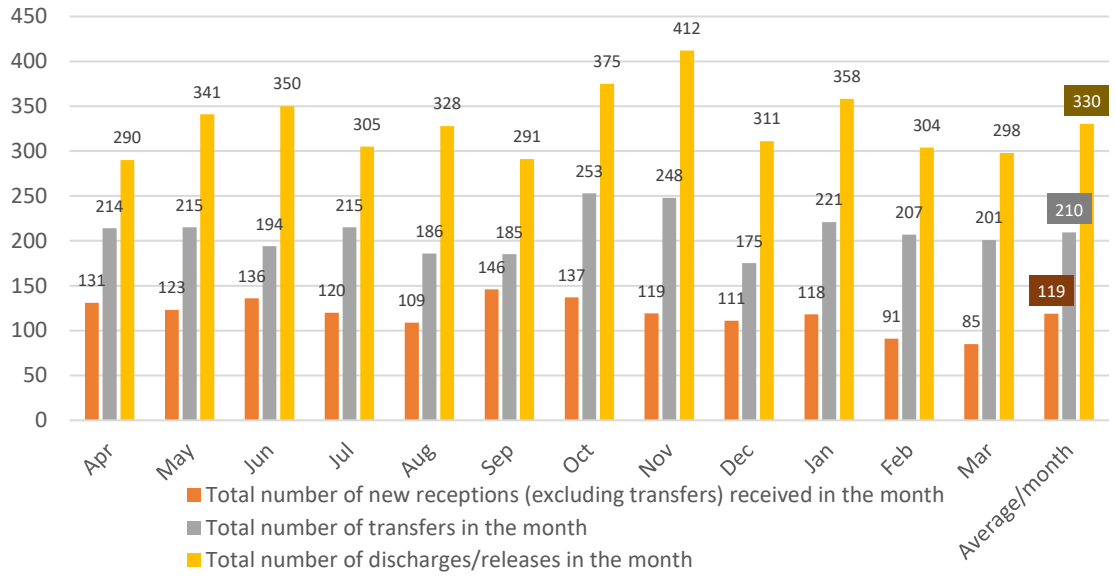
Chart 7: HMP Bullingdon Monthly First Night Screens and 2nd Reception Screens Apr 2018 to Mar 2019 (HJIP)



4.23 Within HMP Bullingdon the whole process of taking in new prisoners, taking receipt of transfers of prisoners to other prisons and transferring prisoners out to other prisons and or back into the community is a substantial function for the prison and

this has its impact on the operational delivery of healthcare. This reception and its associated screening is a critical element of healthcare's work and whilst being demanding on staff resources, it is essentially part of the way the regime in HMP Bullingdon operates. This will be accentuated with an increasing throughput in the prison, post reconfiguration. The chart below demonstrates the volume of receptions, transfers and discharges between April 2018-March 2019. HJIP reports that on average HMP Bullingdon have had 119 receptions per month, 210 transfers per month and 330 discharges per month, all of which have implications for healthcare to complete reception screening (first and second) and discharge/release planning.

Chart 8: HMP Bullingdon receptions transfers and discharge April 2018-Mar 2019 (HJIP)

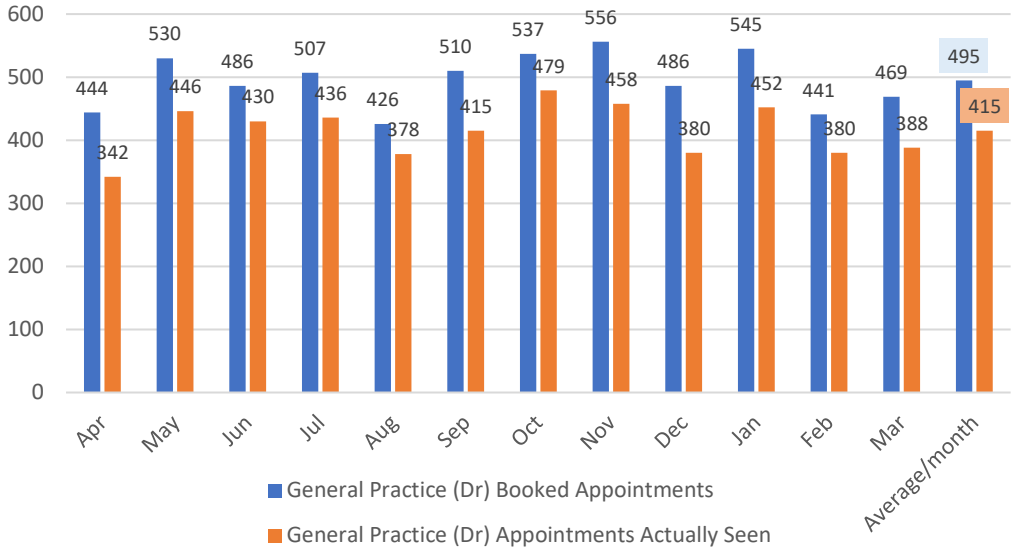


4.24 Healthcare's day-to-day operations in **outpatients** are broadly consistent with that of a local GPs surgery. Clinics are held by GP, nurses, and dentists and are generally triaged by nurses firstly on the wings and then appointments are made with healthcare. A strong priority as in any health setting is to maximise the utilisation of these clinics and this performance is set out in the HJIP register. This section below reviews the service utilisation and waiting times for GP, dental and nurse-based clinics.

General Practice – service utilisation, cancellations and waiting times

4.25 In the 12-months between April 2018 and March 2019, there were 5,937 booked appointments for general practice (GP) clinics of which 4,958 men were seen (an average of 495 appointments and 415 men seen per month respectively), giving an average service utilisation rate of 84%.

Chart 9: GP booked and seen appointments, service utilisation HJIP Apr 2018-Mar 2019

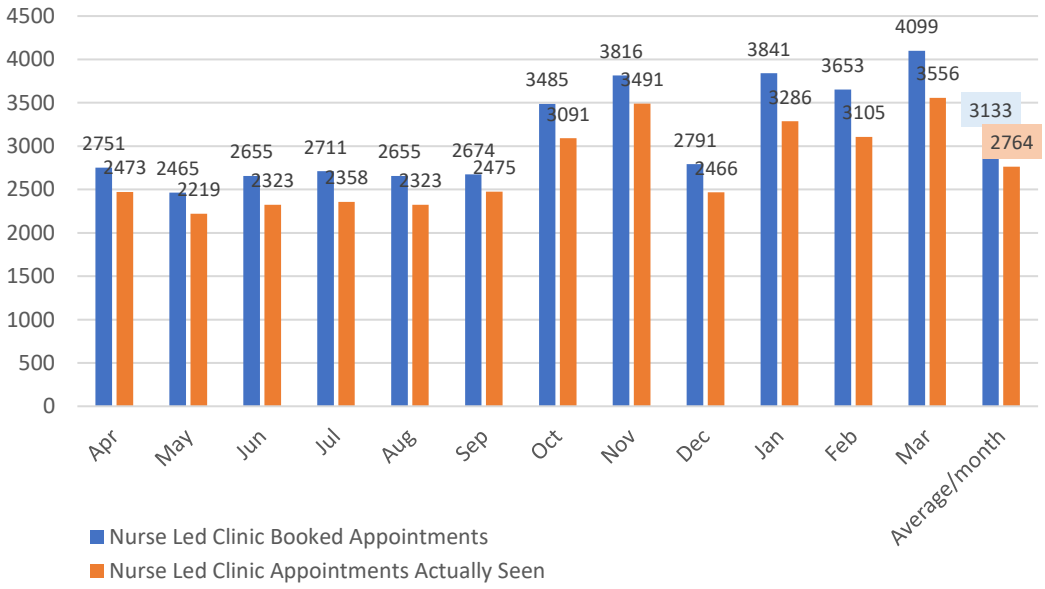


4.26 Between April 2018 and March 2019, 135 (14%) of GP clinic appointments were reported as cancelled by the patient. All non-attendance at appointments came to 16%. Between April 2018 and March 2019, the average days wait for a routine care GP clinic appointment was 6 days.

Nurse-led clinics – service utilisation and cancellations

4.27 Between April 2018 and March 2019, there were 37,596 booked appointments for nurse-led clinics, of which 33,676 men were seen (an average of 3,133 appointments and 2,764 men seen per month), giving an average service utilisation rate of 88%.

Chart 10: Nurse-led clinics booked appointments, Patients seen, service utilisation, HJIP Apr 2018-Mar 2019

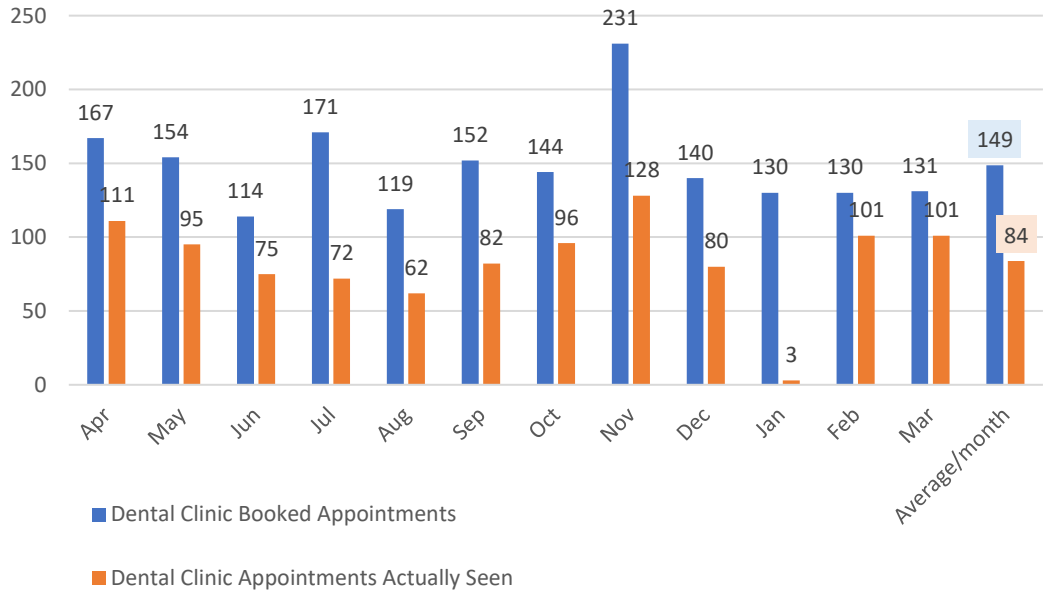


4.28 Between April 2018 and March 2019, 1,183 nurse-led clinic appointments were reported as cancelled by the patient. The non-completion of appointments booked was 12% although taking these cancellations out, the proportion of nonattendance to nurse led appointments was 9%.

Dental – service utilisation and waiting times

4.29 Between April 2018 and March 2019, there were 1,783 booked appointments for dental clinics of which 1,006 men were seen (an average of 149 appointments and 84 men seen per month), giving an average service utilisation rate of 56%.

Chart 11: Dental appointments booked, seen and service utilisation, HJIP Apr 2018-Mar 2019



4.30 Between April 2018 and March 2019, 430 dentist clinic appointments were reported as being cancelled by the patient. This figure is high, however potentially reflective of prisoners coming into and out of the prison. The non-completion of appointments booked was 43%, although not counting these cancellations, the proportion of nonattendance to dental appointment was 19%. In the same period, the average days wait for a routine care dental clinic appointment was 40 days and for an urgent care dental clinic appointment was 0 days with scheduled slots in the session plans for emergency dental care appointments.

Dental Provision

4.31 Dentistry in HMP Bullingdon is, as in the case of other critical services, influenced by the regime and the high volumes of throughput in the prison. Patients are often presenting with high levels of dental needs born of dental neglect, decay and disease often requiring acute dentistry.

4.32 Time for Teeth are currently commissioned for 5.5 sessions per week, this has grown from an original position of 4 sessions per week. This was seen as inadequate to meet the presented demand; this is now established at 5.5 and this includes dentist (4) and dental therapist (1.5) time. Time for Teeth would argue that this could be increased to 6 sessions per week.

4.33 In Bullingdon sessions have been stepped up since January 2019; DNA are seen as relatively high and time with patients is lost to the regime. Clinics run from 8.45 to 11.30am and then from 2.00 to 4.30pm. Much of the presentation is influenced by urgent care, which is often the case in local prisons. This is likely to increase with the reconfiguration of Bullingdon. This will need to be reviewed when the new reconfigured prison has been operating for at least 6 months.

4.34 Available clinic time is often compromised and this tends to be, in part, by DNAs, although much work can be done with lists to minimise the impact of this problem. Equally there is a proposition of time lost to regimes. The table below shows that in HMP Bullingdon, in the current year to date, there has been a 37.5% DNA rate and this represents a 25% loss to dentist's session time. Furthermore time is being lost to the prison regime - in the last year this equated to 16% of time. This meant that the available clinic time was 1 hour and 55 minutes. This is a relatively low level of time available, particularly when set against the 5.5 sessions per week that dentistry operates in the prison.

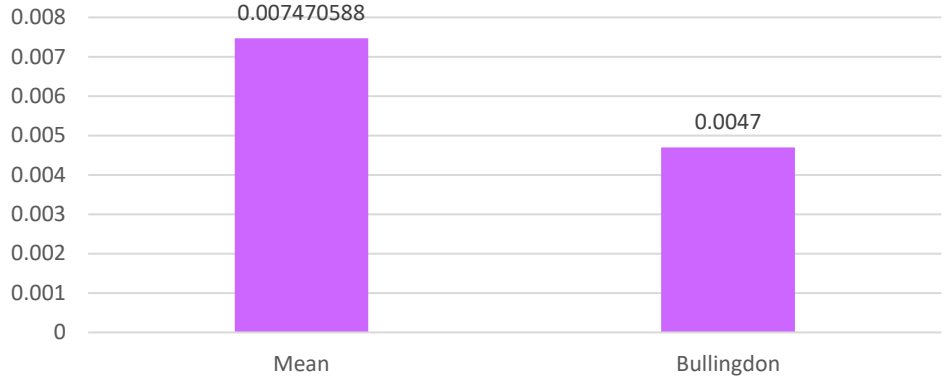
Table 4: Year to Date Analysis (Mean by Clinic): Dental DNA's and loss of Clinic time

Clinic	DNAs (%)	% Time Lost to DNAs	% Time Lost to Regime	% Time Lost to Provider Issues	Available Clinic Time (hrs, mins)
HMP Bullingdon	37.5	25	16	0	1,55

.

4.35 Another measure that Time for Teeth have established is the mean level of sessions per operational capacity across the 75 establishment they operate in. In Bullingdon for a Cat B Prison there is a ratio of 1:0047 sessions per op cap. This compares to a mean for all Cat B's of 1: 0.0078. This suggests that in comparison to other Cat B's, Bullingdon's dental offer is beneath the mean average and, per capita provides slightly less through its 5.5 dental sessions a week.

Chart 12: Comparable breakdown of No. Sessions Per Prison Dental Clinic HMP Bullingdon and other Cat B establishments (data provided by Time for Teeth, based on Commissioned Dental Sessions per Op Cap)



4.36 Clearly on some occasions there is a need to take patients out to undergo more complex dental surgery (wisdom teeth, difficult extractions, biopsies, trauma dental work and oral surgery). In these cases, HMP Bullingdon residents are escorted out to either the Royal Berkshire (Reading) or the John Radcliffe (Oxford).

DNAs

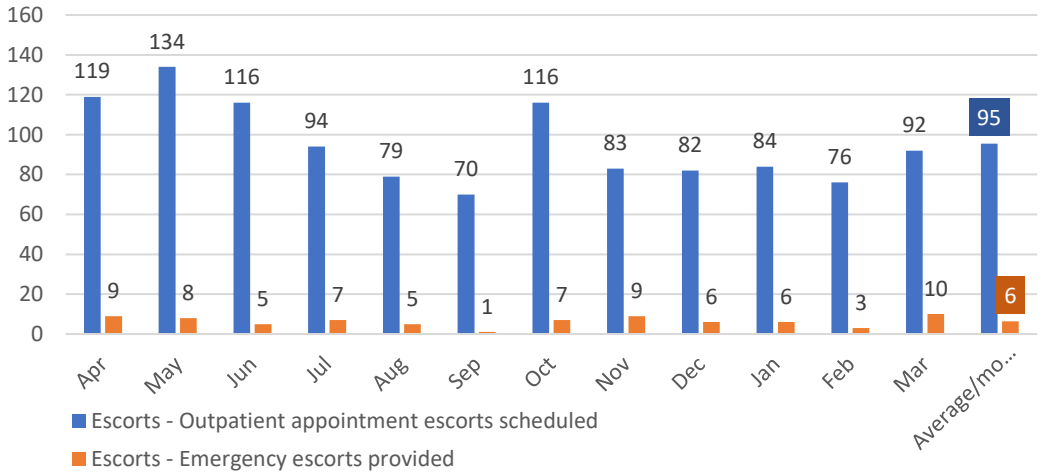
4.37 Based on calculations for HJIP the average levels of DNA for primary care appointments and dentistry from April 2018 to March 2019 are set out below:

4.38 GP clinics: 14%, Nurse led clinics: 9% and Dental clinics: 35%

Escorting

4.39 Secondary care appointments to specialists off site are a factor for the delivery of comprehensive healthcare in prisons. The number of outside appointments requiring officers (normally 2, sometimes 3) to accompany an offender was at an average of 95 per month for the period April 2018 to March 2019. The average number of emergency escorts delivered was 6. Emergency escorts represents 7% of those escorts booked.

Chart 13: HMP Bullingdon Escorts booked and Emergency escorts provided Apr 18-Mar 19 (HJIP)



4.40 It is clear that escorting for outside appointments and procedures, sometimes leading to bedwatch, still places a real set of challenges on the healthcare of patients. Equally there are clear risks to the prison. On average, six prison officers per day currently undertake these escorting and bedwatch duties.

4.41 There are high levels of outside appointments that are cancelled. Over this same period (April 2018 to March 2019), there were 542 cancelled, which represents approximately 47% of all booked appointments (therefore 53%, 603 were completed). These are cancellations that resulted in an escort being reorganised for various reasons, including, the prioritisation of an emergency over a routine appointment, staff unavailability, court or legal visits, patient refusal, operational emergency (i.e. prison lockdown), healthcare or hospital operational emergency.

Medication and medicine management

4.42 Prisoners have the right to access medications that will support their conditions and meet their healthcare needs. As in the community, doctors assess the health needs of their patients and medicines are prescribed accordingly. The governance of pharmacy services for prisoners is overseen by the Department of Health (DOH) and commissioned by NHS England at a national level. These policies, guidance and procedures are implemented at a local level.

4.43 The prescribing of medicines in the prison setting is influenced by the regime, environment, clinical guidance and legislation. The prison environment imposes clear constraints on prescribing and consideration is needed to ensure the safety and wellbeing and risk of providing medications to prisoners. Clearly there have been incidents where medications have been abused and used as a tradeable commodity in the prison. Equally there are prisoners who need their medications and who may be forced to divert these medications to others through peer pressure and bullying.

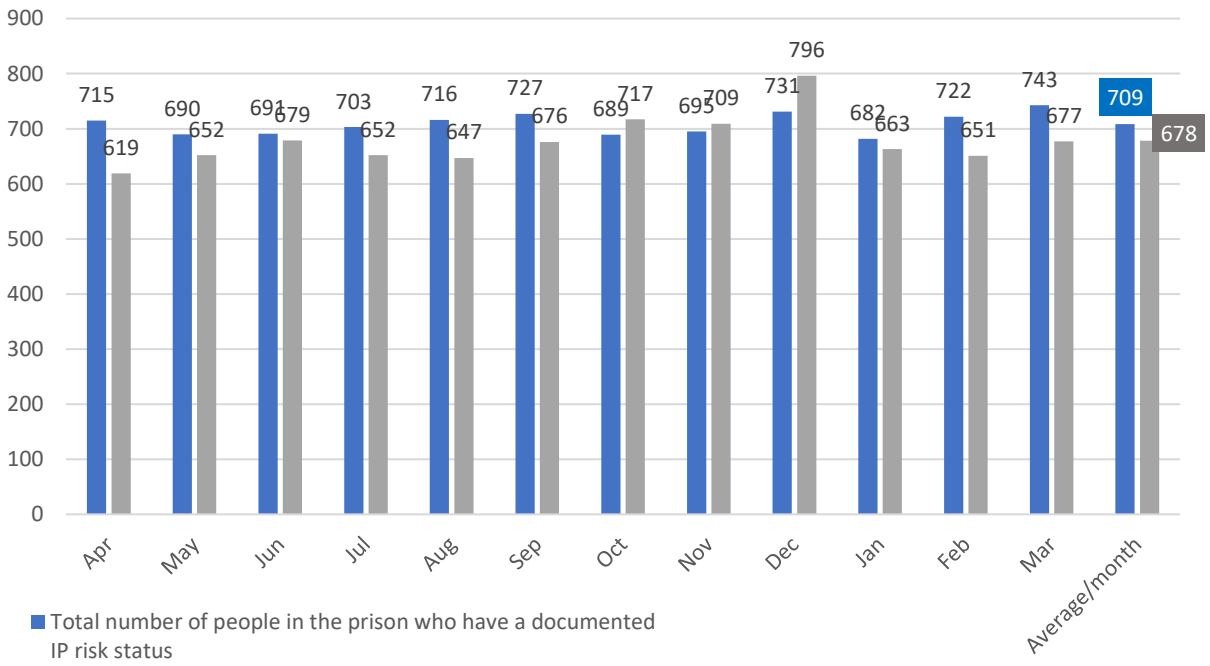
4.44 These are concerns for all and whilst it needs to be addressed, it must be balanced between the overriding commitment[18] that medicines should, where appropriate and safe, be held in possession by responsible patients. This matter of principle seeks to give prisoners responsibility for holding and using their own medicines, as they would do in the community. Managing this principle is delivered within the prison setting through the risk assessment process and the locally agreed protocols for medicines that are potentially harmful if not effectively supervised.

4.45 The levels of which medications are to be held in possession by prisoners are set out below. The chart shows that on average, per month, 709 prisoners are deemed to be in possession, following a risk assessment and 678 are required to

[18] DOH A Pharmacy Service for Prisons Recommendation 5

consume their medication in a supervised way. This suggests that between April 2018 and March 2019 the average proportion of those on supervised medications was 49% and those in possession was 51%.

Chart 14: HMP Bullingdon: In Possession Status and Supervised Population Apr 18-Mar 19



4.46 Understanding the medications that are being prescribed also supports a wider understanding of the health needs of the prison population. The profile for March 2019, taken from SystmOne, of medications prescribed is set out in the table below. The high level of central nervous system, musculoskeletal and joint drug groups reflects medication that is being prescribed to address pain management:

Table 5: Profile of prescribed medicines by drug group SystmOne Mar 2019

Drug Group - Current Prescriptions	Patient Count	%
Anaesthesia	4	1%
Immunological	6	1%
Skin	53	7%
Ear Nose & Oropharynx	17	2%
Eye	9	1%
Musculoskeletal and Joint	144	20%
Nutrition and Blood	11	1%
Malignant Disease & Immunosuppression	2	0%
Obstetrics gynaecology & Uriniary tract dis.	9	1%
Endocrine System	17	2%
Infections	21	3%
Central Nervous System	305	41%

Drug Group - Current Prescriptions	Patient Count	%
Respiratory System	43	6%
Cardiovascular	27	4%
Gastro-intestinal system	69	9%
Total of groups above	737	100%

Chart 15: Profile of prescribed medicines by drug group SystmOne Mar 2019 (count)

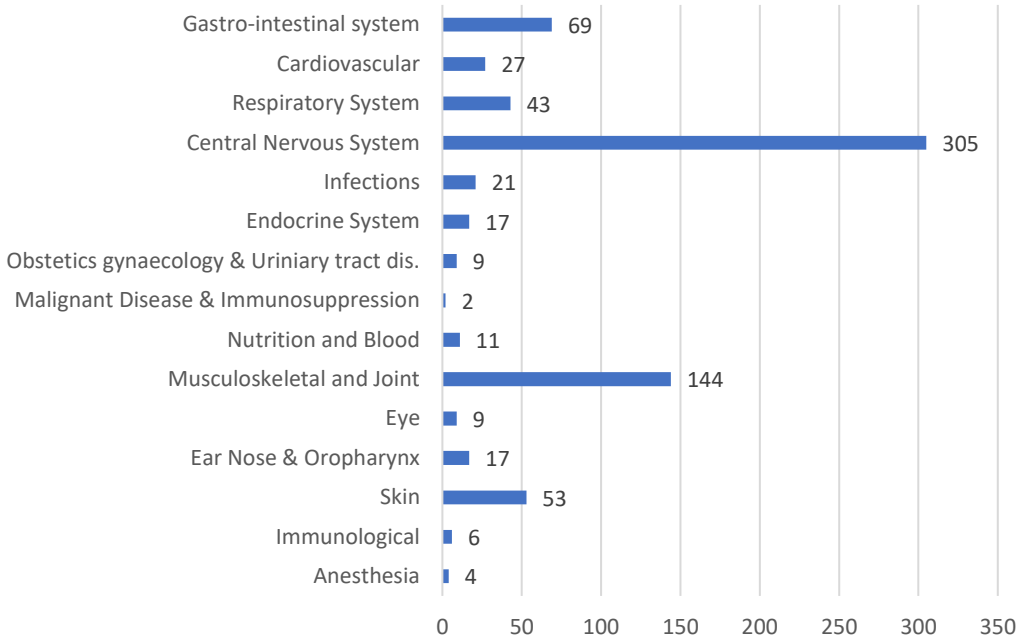
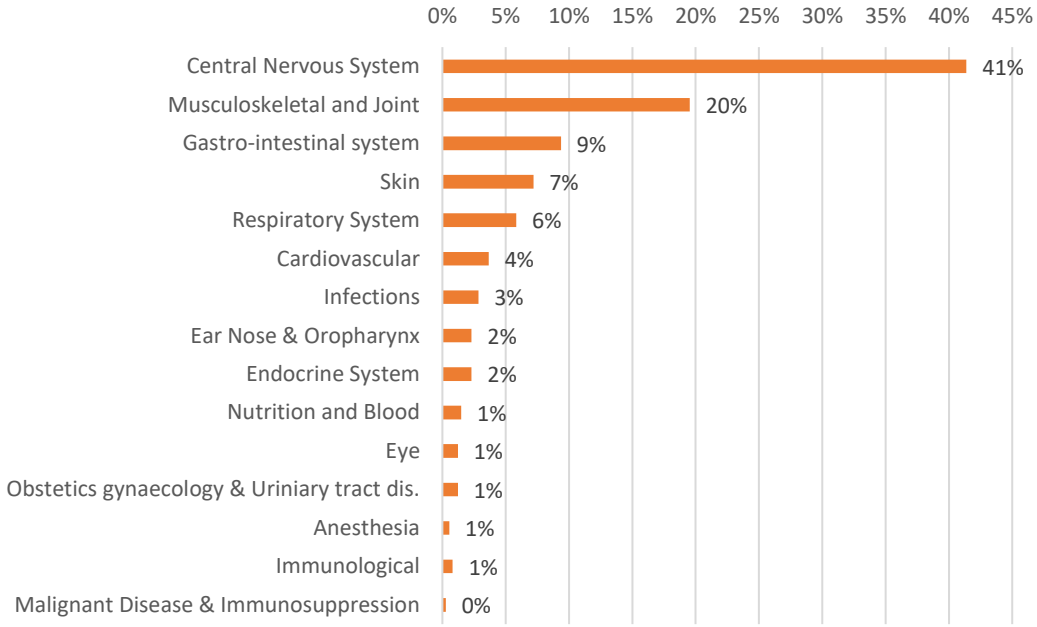


Chart 16: Profile of prescribed medicines by drug group SystmOne Mar 2019 (% ranked)



Section Summary

4.47 The healthcare provision seems robust in HMP Bullingdon. The volume of throughput in the prison significantly focuses the operation to the changing client base in the prison.

4.48 The volume of receptions is high at 14.6 per day and this is likely to increase. Resources need to be put in place to secure the increasing volumes of receptions and transfers post reconfiguration in the autumn.

4.49 The resources available to healthcare and its subcontracts seem to be relevant and proportional to the needs currently being presented. The stakeholder survey did however indicate strong views that staffing levels were low. However, resources will need to be reassessed post reconfiguration.

4.50 The take up of GP and nurse led clinics is high - 84% and 88% respectively. However, the take up of dental clinic appointment seem low at 57% and work could be done to improve this utilisation rate.

4.51 DNA averages across the year were for GP clinics: 14%, nurse led clinics: 9% and dental clinics: 19%

4.52 Dental healthcare is pressurized in HMP Bullingdon with the high flow of new patients, many of who have both urgent and routine care needs. The service operates on 5.5 sessions per week but arguably could increase to 6.

4.53 There seems to be a real need to maximise the external appointments booked for patients. The rate of only 7% of escorts being completed in 2018-2019 seems very low. Cancellations for whatever reason were 47%, this meant that some 46% of planned escorts were not completed and no reasons were given.

4.54 The proportion of the prison with in-possession status is 51% and prisoners on a supervised consumption regime represent 49% of the population.

4.55 The vast proportion of medications prescribed relate to the central nervous system at 41% of all prescribed medications (pain relief), followed by 20% musculoskeletal and joint and 9% gastrointestinal.

4.56 Service users felt that there is a need for:

- Improved access to all services through efficient and effective application processes
- Improved triage processes that works with regime and not against it.
- Additional services to reduce clear waiting lists
- Early intervention for simple conditions

4.57 Care UK need to sustain their efforts to maximise the filled positions in their healthcare workforce but will need to continue to supplement vacancies with agency staff until vacancies are met.

Section Recommendations

4.58 Care UK as the prime providers should aim to work with all healthcare staff to maximise clinic utilisation and to sustain the current strong profile of utilisation in the prison.

4.59 Review dental healthcare provision to assess the adequacy of current arrangements and further review services to assess the true impact of reconfiguration.

4.60 Care UK to sustain their efforts to maximise the filled positions in their healthcare workforce.

5 Physical Health need and demand

Introduction

5.1 This section sets out the prevalence of health needs in the population of HMP Bullingdon through an evaluation of profiles of health needs in relation to physical health, mental health, communicable diseases, drug and alcohol use and dental health. It will aim to set out the level of health needs that are being met and identify unmet health needs among the prison's population.

5.2 For each health indicator, data will be drawn from a variety of sources including; Health and Justice Indicators of Performance (HJIP) data, Public Health and NHS Outcomes Frameworks, Quality Outcomes Framework (QOF)[19] data, local performance monitoring and reporting to commissioners, data provided through the prison's and healthcare leads and others as identified through this needs assessment. Data has been used over a 12-month period to take into account the transient nature of the general prison population.

5.3 Across all areas of health, where data has been made available this HNA has reviewed:

Prevalence of health conditions:

- Prevalence estimates by type, trends over the last year, comparisons with the overall population, and comparisons with the general population
- Applying prevalence estimates to population (capacity and total population in the last 12 months, thereby taking account of the transient population)

National Screening Programme:

- First night reception screening
- Specific screening based on NHS eligibility for:
  - Cardiovascular Disease (CVD)
  - Bowel Cancer
  - Abdominal Aortic Aneurysm (AAA)

Prevalence of Health Conditions

5.4 In this section, disease prevalence for HMP Bullingdon has been calculated based on counts of disease seen as a proportion of the prison's population at five periods between April 18 and March 19. Moreover, where possible, general population prevalence data has been researched and used to enable comparisons to be drawn.

5.5 In addition, the overall prevalence (%) and expected number of prisoners with a condition has been calculated using age-specific data where possible. This

[19] Quality Outcomes Framework (QOF) prevalence is the number of patients on a centres clinical register which can be used to calculate measures of disease prevalence, expressing the number of patients on each register as a percentage of the number of patients on the practice (centre) list.

considers that certain diseases are more common in some age groups, i.e. long-term conditions are more prevalent in older populations, asthma is more prevalent in younger populations and some conditions occur across the whole population regardless of age.

5.6 Local data has been extracted from the SystmOne database where possible. SystmOne is used for health surveillance amongst prisoners and records QOF prevalence, which is benchmarked against national and regional prevalence rates.

5.7 Some caution should be applied in interpreting the local data, as it is reliant on correct and consistent coding of diseases by healthcare professionals, which has the potential to be incomplete and therefore likely to underestimate prevalence. Nonetheless, staff in the healthcare team are assured that where feasible the data has been reviewed and cleansed to resolve the vast proportion of miscoding.

Prevalence explained

5.8 Prevalence provides a measure of the population burden of a disease and therefore assists with service planning. There are two measures of prevalence: point prevalence and period prevalence. Point prevalence is the number of persons with a disease *at a single point in time*, whereas period prevalence relates to the number of persons with a disease *at any time over a specified period*. In this section point prevalence has been used.

5.9 QOF prevalence is the number of patients on a prison's clinical register, which can be used to calculate measures of disease prevalence, expressing the number of patients on each register as a percentage of the number of patients registered at the practice (prison) list.

5.10 The table overleaf sets out the position regarding prevalence as of March 2019. It makes comparisons with similar register-based prevalence in April 2018, July 2018, October 2018 and January 2019, thus effectively providing a years' worth of data.

5.11 From this prevalence table, it is clear that in general there are few presentations of major conditions in the population of HMP Bullingdon. Moreover, with small numbers on these registers there is a quite a volatile shift when new prisoners arrive, and others leave the prison:

- Asthma is a constant health condition in the prison, but higher than the general population prevalence.
- Chronic Obstructive Pulmonary Disease (COPD) is present as a health condition but sits just above the general population prevalence.
- Depression is above the national prevalence level.
- Hypertension is a steady prevalence.
- Obesity is a strong concern in the HMP Bullingdon population. At 14.5% it is well above the general population prevalence (9.8%). It is likely that this

is not being tested and the length of stay for detainees is too short to pick this condition up.

Table 6: HMP Bullingdon Summary Prevalence Table Apr 18 – Mar 19

Prevalence of Major Conditions	Apr-18	Jun-18	Sep-18	Dec-18	Mar-19	English Prevalence[20]
Asthma	11.6%	10.5%	10.7%	9.4%	10.3%	5.9%
Atrial Fibrillation	0.3%	0.4%	0.5%	1.0%	0.6%	1.9%
Blood Pressure	100.0%	94.9%	94.6%	93.8%	93.1%	
COPD	3.3%	2.2%	2.3%	1.5%	2.0%	1.9%
Cancer	0.5%	0.4%	0.4%	0.2%	0.4%	2.7%
Cardiovascular Disease	1.4%	1.0%	0.4%	0.3%	1.1%	1.1%
Chronic Kidney Disease	0.6%	0.4%	0.4%	0.3%	0.4%	4.1%
Dementia	0.5%	0.0%	0.1%	0.1%	0.0%	0.8%
Depression	14.2%	14.1%	13.1%	13.0%	16.1%	6.8%
Diabetes	4.9%	5.0%	4.8%	4.5%	3.9%	6.8%
Epilepsy	1.8%	1.9%	1.9%	1.9%	1.6%	0.8%
Heart Failure	0.1%	0.2%	0.2%	0.1%	0.3%	0.3%
Hypertension	8.5%	6.9%	7.4%	6.7%	7.4%	13.9%
Learning Disabilities	1.6%	1.5%	2.1%	2.0%	1.5%	0.5%
Mental Health	5.6%	6.6%	7.7%	6.3%	6.4%	0.9%
Obesity	14.7%	13.5%	12.1%	13.6%	14.5%	9.8%
Osteoporosis	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%
Palliative care	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%
Peripheral Arterial Disease	0.5%	0.5%	0.4%	0.5%	0.5%	0.6%
Rheumatoid Arthritis	0.3%	0.5%	0.2%	0.3%	0.4%	0.7%
Coronary Heart Disease	3.0%	2.8%	2.7%	3.0%	2.1%	3.1%
Stroke / Transient Ischaemic Attacks (TIA)	0.6%	0.4%	0.6%	0.5%	0.7%	1.8%

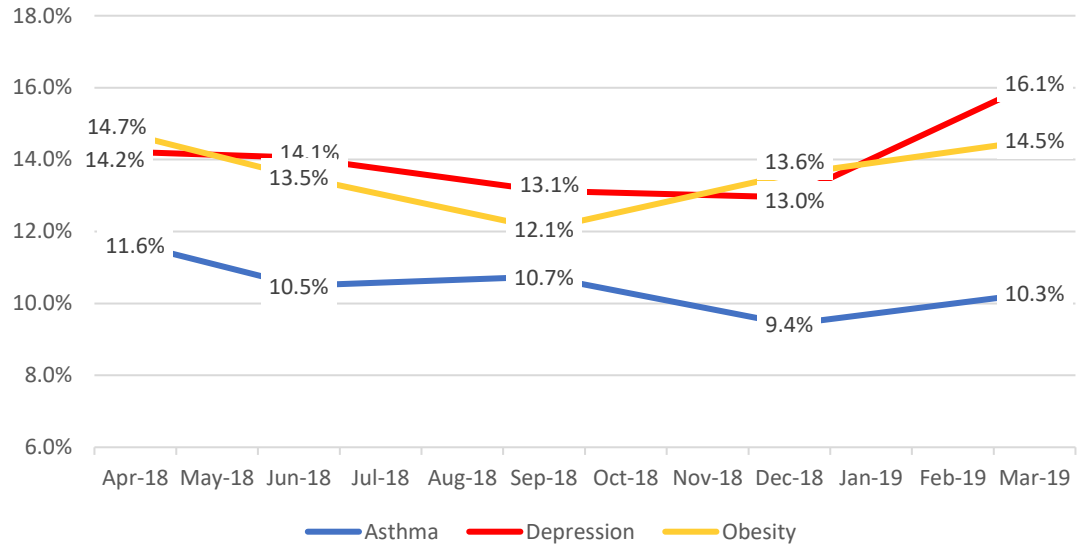
5.12 This data is based on SystmOne download reports. It is based on recorded readcodes and not a combination of medicines and readcodes. It should be noted that the overall population count will be affected by the registration deduction date issue.

5.13 In the five quarters reviewed (between April 2018 and March 2019), the data shows there have been some shifts in the prevalence of key conditions. The chart below shows that depression has increased from 14.2% to 16.1% of the prison's population, asthma has declined from 11.6% to 10.3%, and obesity has remained

[20] PHE Profiles QoF 2017-2018
https://fingertips.phe.org.uk/search/prevalence%20and%20risk#page/3/gid/1/pat/6/par/E12000008/ati/102/are/E10000025/iid/30315/age/226/sex/4

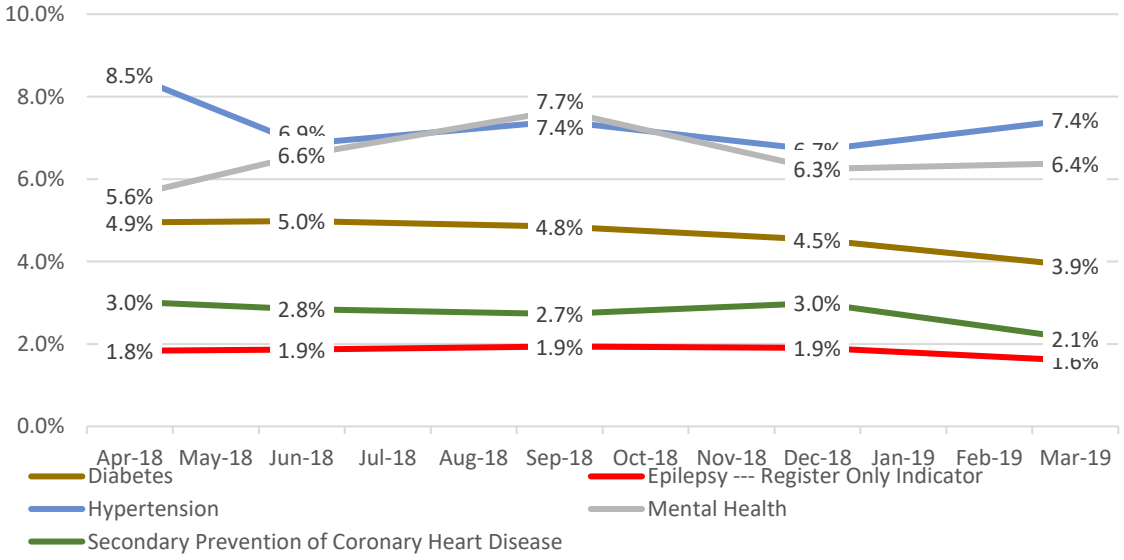
relatively static starting with a rate of 14.7% at the beginning of the period and ending on 14.5%.

Chart 17: HMP Bullingdon Asthma, Depression and Obesity Prevalence Apr 18- Mar 19



5.14 The chart below shows the trend in presentations for diabetes, epilepsy, hypertension, mental health and secondary prevention of coronary health disease (CHD). All these chronic conditions have remained relatively constant throughout the year.

Chart 18: HMP Bullingdon Diabetes, Epilepsy, Hypertension, Mental Health, Secondary Prevention of CHD Prevalence Apr 18- Mar 19



5.15 The section below will examine in more detail the prison's key chronic conditions, as described on the SystmOne chronic conditions register, which is the rate reported on QoF. These are then compared to the most recent QoF prevalence levels for England and the South East (Hampshire, Isle of Wight and Thames

Valley) NHS region. This enables as close to a like for like comparison as possible. Additionally, a further comparison is made between the prevalence in this prison and the researched prevalence held for immediate comparator prisons as defined by HMPPS.

5.16 In addition, a more detailed assessment of the age and ethnicity breakdowns of the main conditions listed above has been calculated for the June 2018 period. This is based on the age and ethnicity profiling of the population of the prison as per the records set in SystmOne.

Asthma

5.17 The table below describes the comparison of the HMP Bullingdon presentation for patients on the asthma register on SystmOne and this is compared to the prevalence profiles in England and the South East prevalence profiles. In short, the prison is showing a higher prevalence level of asthma than the national and regional comparators.

Table 7: HMP Bullingdon Asthma Prevalence Comparisons England, South East and other comparable establishments (SystmOne, and PHE QoF)

Prevalence	Asthma register	Bullingdon Variance
England (PHE Profiles 2017-18)	5.9%	4.4%
South East (Hampshire, Isle of Wight and Thames Valley) NHS region	6.0%	4.3%
HMP Bullingdon (SystmOne chronic conditions register) March 2019	10.3%	
Comparison with other similar prisons		
HMP Elmley (1299 population Jan 2017)	6.2%	4.0%
HMP Hewell (776) population June 2018)	17.8%	-7.5%
Population (1128)		
HMP Bullingdon QoF Presentations (Count)	116	
HMP Bullingdon as Proportion of English Prevalence	67	49
HMP Bullingdon as proportion of Thames Valley Prevalence	68	48

5.18 Based on the prevalence of asthma and the current population of HMP Bullingdon it would be expected to see between 67 and 68 prisoners on the SystmOne Register, as per the prevalence levels of asthma in England and the South East NHS Region. In reality the Bullingdon prevalence is 10.3%, which shows a higher level of prevalence than the national and regional population comparators, which results in some 49 to 48 additional patients on the register.

5.19 The presentation of asthma when contrasted to comparable prisons shows that HMP Bullingdon had a higher level of prevalence than in the HMP Elmley population (+4.0%) and a lower level of prevalence than in the HMP Hewell population (-7.5%).

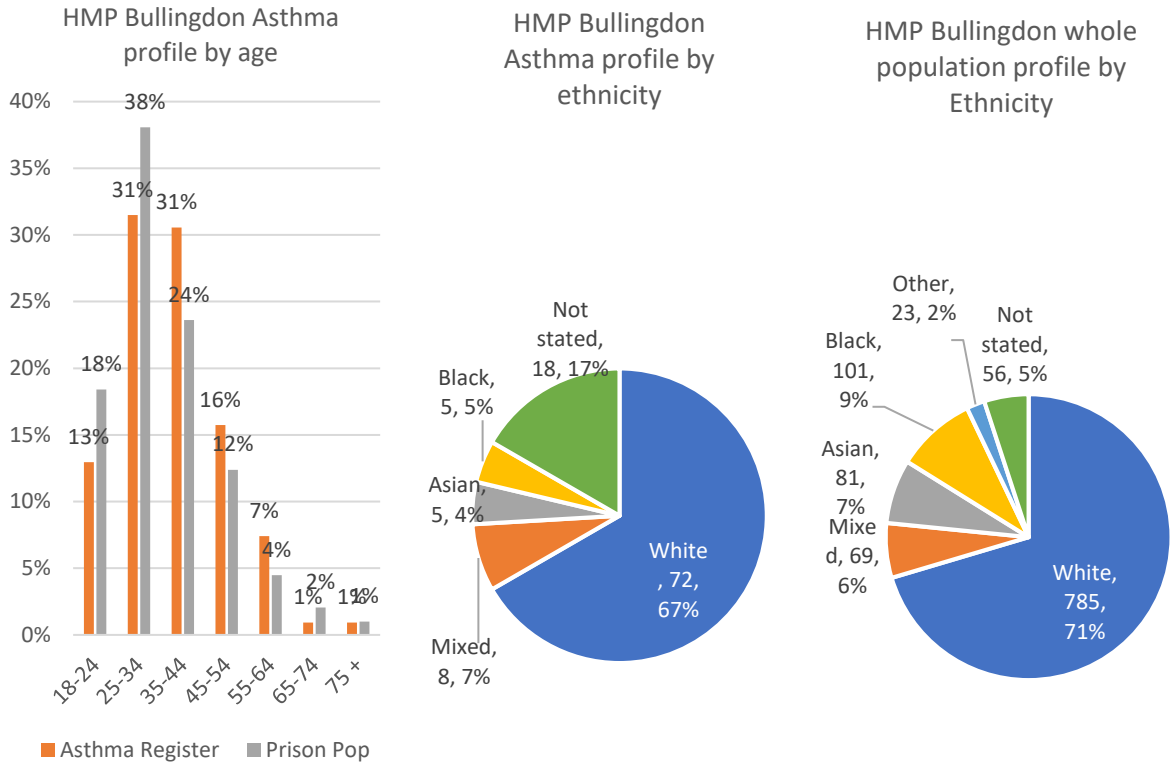
5.20 The prevalence profile of asthma in HMP Bullingdon in June 2018, the mid-point of last year, has been compared in terms of the age and ethnicity of those on the register to the age and ethnicity profile of the prison. These comparisons have been set out in the charts below.

5.21 At first glance the age profile of those on the asthma register is broadly comparable with the age profile of the prison population. However there seems to be a slightly

higher profile of older patients on the asthma register when compared to the prison population and a slightly lower proportion of younger prisoners on the register.

5.22 The asthma profile by ethnicity shows a broad comparability to the ethnic profile of the HMP Bullingdon population at March 2019.

Chart 19: HMP Bullingdon Asthma by Age compared to prison population and by Ethnicity compared to the prison population (SystmOne June 2018)



5.23 Operationally, asthma is reviewed at the first night screening and of those on the register 100% have asthma with measures of variability and or reversibility and 100% have had an asthma review within the preceding 12 months. All prisoners on the asthma register have been issued with inhalers, their use is reviewed through care and pharmaceutical plans for each prisoner.

5.24 Asthma has a higher than national and regional prevalence in the prison population of HMP Bullingdon as well a higher prevalence with its comparator prisons. However, healthcare has systems and practices in place and services are equipped to effectively address this need.

Depression

5.25 The table below describes the comparison of the HMP Bullingdon presentation for patients on the depression register on SystmOne and this is compared to the prevalence profiles in England and the South East. In short, the prison is showing a higher prevalence level of depression than the national and regional comparators.

Table 8: HMP Bullingdon Depression Prevalence Comparisons England, South East and other comparable establishments (SystmOne, and PHE QoF)

Prevalence	Depression register	Bullingdon Variance
England (PHE Profiles 2017-18)	9.88%	6.25%
South East (Hampshire, Isle of Wight and Thames Valley) NHS region	9.93%	6.20%
HMP Bullingdon (SystmOne chronic conditions register) March 2019	16.13%	
Comparison with other similar prisons		
HMP Elmley (1299 population Jan 2017)	26.94%	-10.81%
HMP Hewell (776) population June 2018)	20.00%	-3.87%
Population (1128)		
HMP Bullingdon QoF Presentations (Count)	182	
HMP Bullingdon as Proportion of English Prevalence	111	71
HMP Bullingdon as proportion of Thames Valley Prevalence	112	70

5.26 Based on the prevalence of depression and the current population of HMP Bullingdon it would be expected to see between 111 and 112 prisoners on the SystmOne register, as per the prevalence levels of depression in England and the South East NHS Region. In reality the Bullingdon prevalence is 16.13%, which shows a higher level of prevalence than the national and regional population comparators, which results in some 71 to 70 additional patients on the register.

5.27 The presentation of depression when compared to comparable prisons shows that Bullingdon has a lower level of prevalence than the HMP Elmley population (-10.91%) and a lower level of prevalence to the HMP Hewell population (-3.87%).

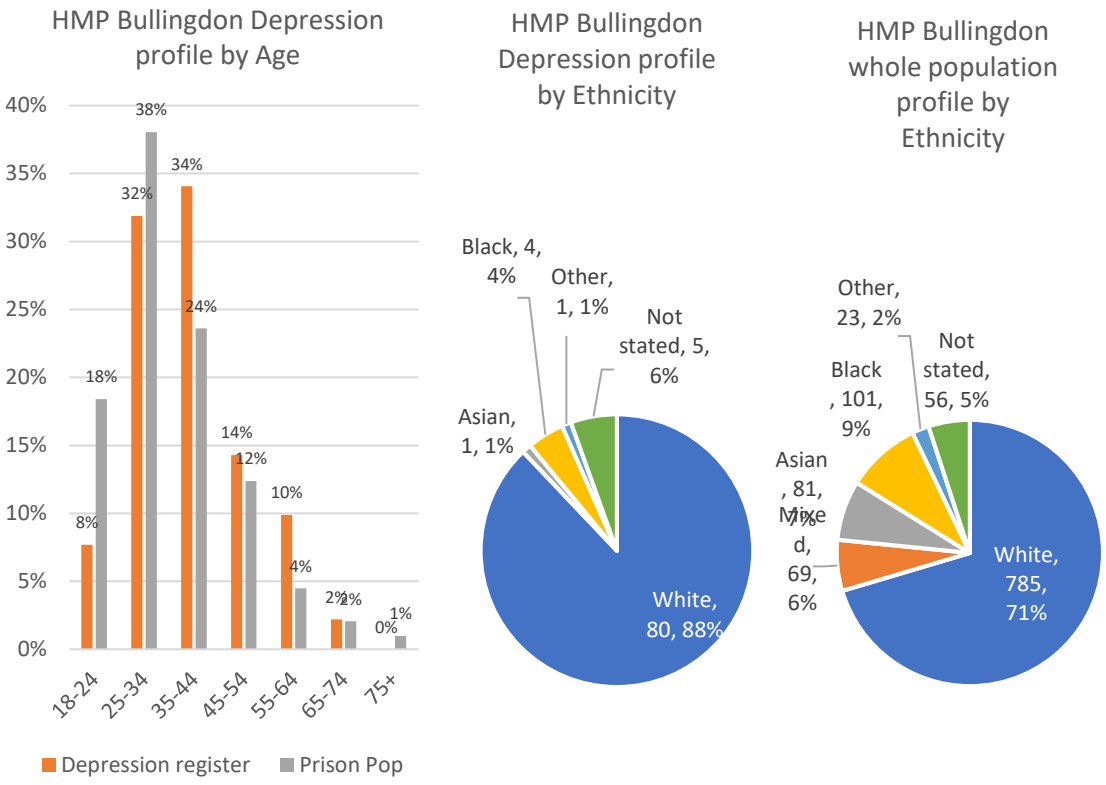
5.28 The prevalence profile of depression in HMP Bullingdon in June 2018, the mid-point of last year, has been compared in terms of the age and ethnicity of those on the register to the age and ethnicity profile of the prison. These comparisons have been set out in the charts below.

5.29 At first glance the age profile of those on the depression register is broadly comparable with the age profile of the prison population. However there seems to be a slightly higher profile of older patients on the depression register when compared to the prison population, particularly in the 35-44 age range and the 55-

64 age range and a lower proportion of younger prisoners in the 18-24 age range on the register.

5.30 Those on the depression register show a higher proportion from white ethnic groups on the register, a far lower proportion of Asian, black and mixed ethnic groups. This may be because these ethnic groups are reticent to present if they are feeling depressed. This does suggest a disproportionately low level of BAME representation on the depression register, which may be something that healthcare wish to examine in greater detail to ensure that there are no barriers to presentation.

Chart 20: HMP Bullingdon Depression by Age compared to prison population and by Ethnicity compared to the prison population (SystmOne June 2018)



5.31 The operational performance for depression as set out in the QOF for HMP Bullingdon in March 2019 showed that 40% of those on the register have had a depression assessment carried out.

5.32 Depression is a widespread health concern in HMP Bullingdon with a higher profile that the national and regional prevalence estimates, although lower than the two comparator prisons. Assessments are being carried out, GPs and primary mental health services have the systems and practices in place and services are equipped to effectively address this need. However, the volumes are worrying, and it is likely that upon the reconfiguration of the prison an increase in reception prisoners will mean that prevalence will increase. Effort is needed to support prisoners through

their experiences of reception to the prison and this needs to be sustained for prisoners on remand and those using the video courts that are being established as part of the prison's reconfiguration.

Obesity

5.33 The table below describes the comparison of the HMP Bullingdon presentation for patients on the obesity register on SystmOne and this is compared to the prevalence profiles in England and the South East. In short, the prison is showing a higher prevalence level of obesity than the national and regional comparators.

Table 9: HMP Bullingdon Obesity Prevalence Comparisons England, South East and other comparable establishments (SystmOne, and PHE QoF)

Prevalence	Obesity register	Bullingdon Variance
England (PHE Profiles 2017-18)	9.76%	4.78%
South East (Hampshire, Isle of Wight and Thames Valley) NHS region	8.54%	6.00%
HMP Bullingdon (SystmOne chronic conditions register) March 2019	14.54%	
Comparison with other similar prisons		
HMP Elmley (1299 population Jan 2017)	15.47%	-0.93%
HMP Hewell (776) population June 2018)	21.90%	-7.36%
Population (1128)		
HMP Bullingdon QoF Presentations (Count)	164	
HMP Bullingdon as Proportion of English Prevalence	110	54
HMP Bullingdon as proportion of Thames Valley Prevalence	96	68

5.34 Based on the prevalence of obesity and the current population of HMP Bullingdon it would be expected to see between 110 and 96 prisoners on the SystmOne Register, as per the prevalence levels of obesity in England and the South East (Hampshire, Isle of Wight and Thames Valley) NHS Region. In reality the HMP Bullingdon prevalence is 14.54%, which shows a higher level of prevalence than the national and regional population comparators, which results in some 54 to 68 additional patients on the register.

5.35 The presentation of obesity when compared to comparable prisons shows that Bullingdon has a lower level of prevalence than the HMP Elmley population (-0.93%) and a lower level of prevalence to the HMP Hewell population (-7.36%).

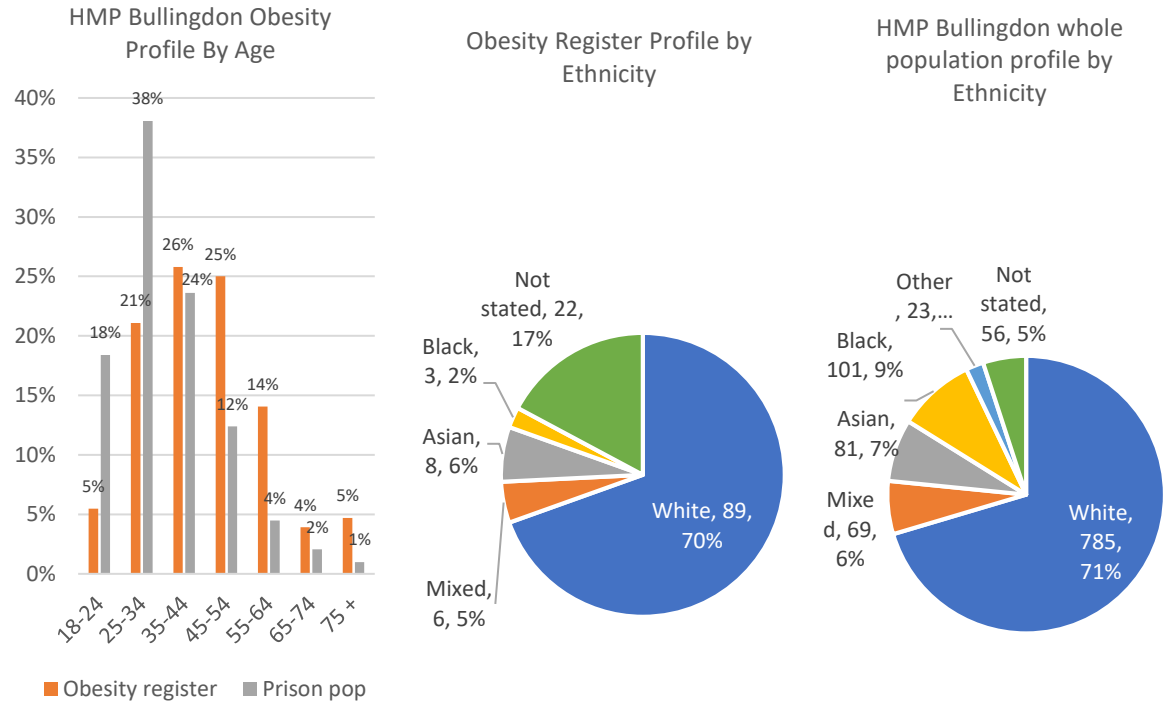
5.36 The prevalence profile of obesity in HMP Bullingdon in June 2018, the mid-point of last year, has been compared in terms of the age and ethnicity of those on the

register to the age and ethnicity profile of the prison. These comparisons have been set out in the charts below.

5.37 The age profile of those on the obesity register broadly shows a far higher proportion of patients in all age groups over 35. This is broadly consistent with the age-related factors of increasing weight and reduced levels of physical activity as well as poor diet.

5.38 From an ethnicity perspective the profile of those on the obesity register is consistent in terms of those white, mixed and Asian patients. Black patients are seemingly underrepresented and there are a large proportion of patients that have not stated their ethnicity. This latter point makes it more difficult to assess the full impact of obesity on the ethnic profile of those on the obesity register.

Chart 21: HMP Bullingdon Obesity by Age compared to prison population and by Ethnicity compared to the prison population (SystmOne June 2018)



5.39 Evidence from the QoF register shows that obesity is a strong and constant condition in the prison and is currently running above the national and regional QoF comparators.

Diabetes

5.40 The table below describes the comparison of the HMP Bullingdon presentation for patients on the diabetes register on SystmOne and this is compared to the prevalence profiles in England and the South East. In short, the prison is showing a lower prevalence level of diabetes than the English and regional comparators.

5.41

Table 10: HMP Bullingdon Diabetes Prevalence Comparisons England, South East and other comparable establishments (SystmOne, and PHE QoF)

Prevalence	Diabetes register	Bullingdon Variance
England (PHE Profiles 2017-18)	6.8%	-2.89%
South East (Hampshire, Isle of Wight and Thames Valley) NHS region	5.9%	-1.97%
HMP Bullingdon (SystmOne chronic conditions register) March 2019	3.9%	
Comparison with other similar prisons		
HMP Elmley (1299 population Jan 2017)	3.7%	0.20%
HMP Hewell (776) population June 2018)	3.2%	0.70%
Population (1128)		
HMP Bullingdon QoF Presentations (Count)	44	
HMP Bullingdon as Proportion of English Prevalence	77	-33
HMP Bullingdon as proportion of Thames Valley Prevalence	66	-22

5.42 Based on the prevalence of diabetes and the current population of HMP Bullingdon it would be expected to see between 66 and 77 prisoners on the SystmOne Register, as per the prevalence levels of diabetes in England and the South East (Hampshire, Isle of Wight and Thames Valley) NHS Region. In reality the HMP Bullingdon prevalence is 3.9%, which shows a lower level of prevalence than the national and regional population comparators, which results in some 22 to 33 fewer patients on the register.

5.43 The presentation of diabetes when compared to comparable prisons shows that HMP Bullingdon has a very slightly higher level of prevalence than the HMP Elmley population (0.20%) and a slightly higher level of prevalence to the HMP Hewell population (0.70%).

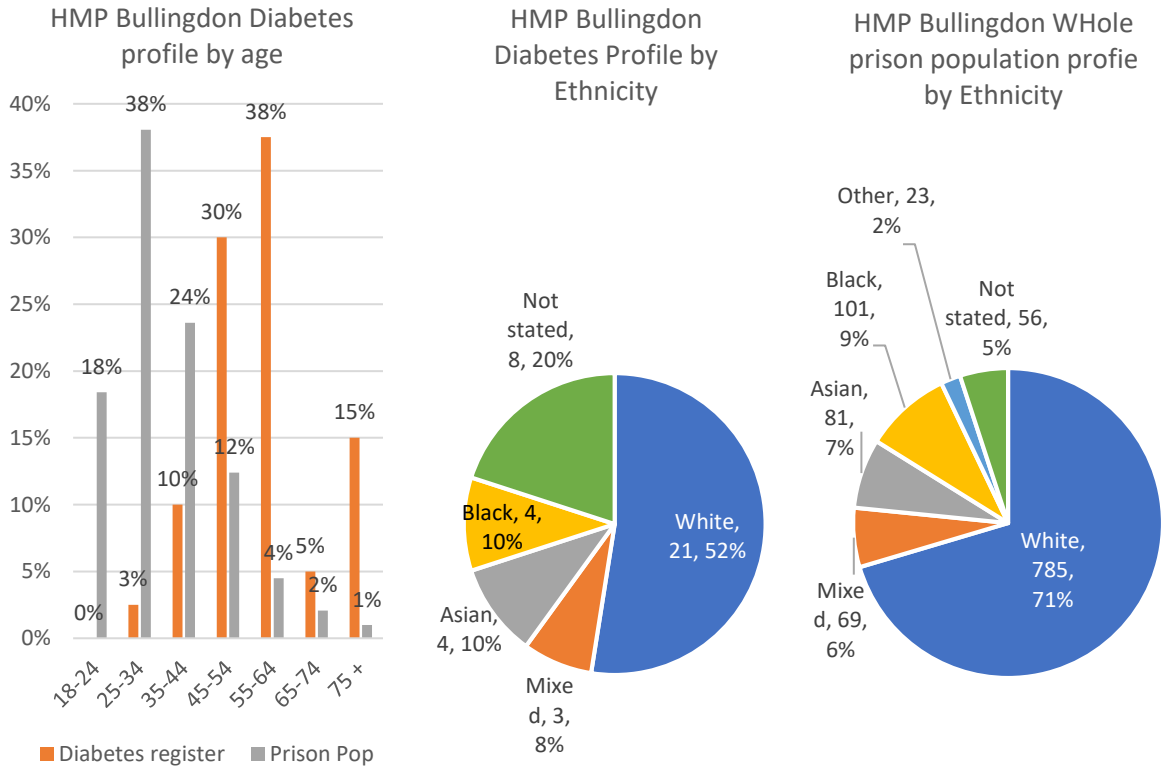
5.44 The prevalence profile of diabetes in HMP Bullingdon in June 2018, the mid-point of last year, has been compared in terms of the age and ethnicity of those on the register to the age and ethnicity profile of the prison. These comparisons have been set out in the charts below.

5.45 The age profile of those on the diabetes register shows that 83% of those on the register are over 45; with 30% aged 45-54, 38% aged 55-64 and 15% over 75. This demonstrates a consistency within this long-term condition and its predisposition with older age groups. This is broadly consistent in terms of age and

is likely to also reflect a slightly older age group in some parts of the prison, particularly E wing.

5.46 The ethnicity profile is clearly demonstrating that there is a higher proportion of BAME clients with an under representation of white patients, at 52% as opposed to 71%. There are a significantly larger proportion of patients that have not stated their ethnicity, moreover black, Asian and Mixed profiles are slightly higher.

Chart 22: HMP Bullingdon Diabetes by Age compared to prison population and by Ethnicity compared to the prison population (SystmOne June 2018)



5.47 Diabetes is showing a lower prevalence in the prison than its national and regional prevalence comparators. The condition is age related and is presenting in the older population at a proportionately higher rate than the prison population.

Epilepsy

5.49 The table below describes the comparison of the HMP Bullingdon presentation for patients on the epilepsy register on SystmOne and this is compared to the prevalence profiles in England and the South East. In short, the prison is showing a higher prevalence level of epilepsy than the English and regional comparators.

Table 11: HMP Bullingdon Diabetes Prevalence Comparisons England, South East and other comparable establishments (SystmOne, and PHE QoF)

Prevalence	Epilepsy register	Bullingdon Variance
England (PHE Profiles 2017-18)	0.8%	0.80%
South East (Hampshire, Isle of Wight and Thames Valley) NHS region	0.7%	0.86%
HMP Bullingdon (SystmOne chronic conditions register) March 2019	1.6%	
Comparison with other similar prisons		
HMP Elmley (1299 population Jan 2017)	1.5%	0.06%
HMP Hewell (776) population June 2018)	6.7%	-5.10%
Population (1128)		
HMP Bullingdon QoF Presentations (Count)	18	
HMP Bullingdon as Proportion of English Prevalence	9	9
HMP Bullingdon as proportion of Thames Valley Prevalence	8	10

5.50 Based on the prevalence of epilepsy and the current population of HMP Bullingdon it would be expected to see between 9 and 8 prisoners on the SystmOne Register, as per the prevalence levels of epilepsy in England and the South East (Hampshire, Isle of Wight and Thames Valley) NHS Region. In reality the HMP Bullingdon prevalence is 1.6%, which shows a higher level of prevalence than the national and regional population comparators, which results in some 9 to 10 more patients on the register.

5.51 The presentation of epilepsy when compared to comparable prisons shows that Bullingdon has a slightly higher level of prevalence than the HMP Elmley population (0.06%) and a lower level of prevalence to the HMP Hewell population (-5.10%).

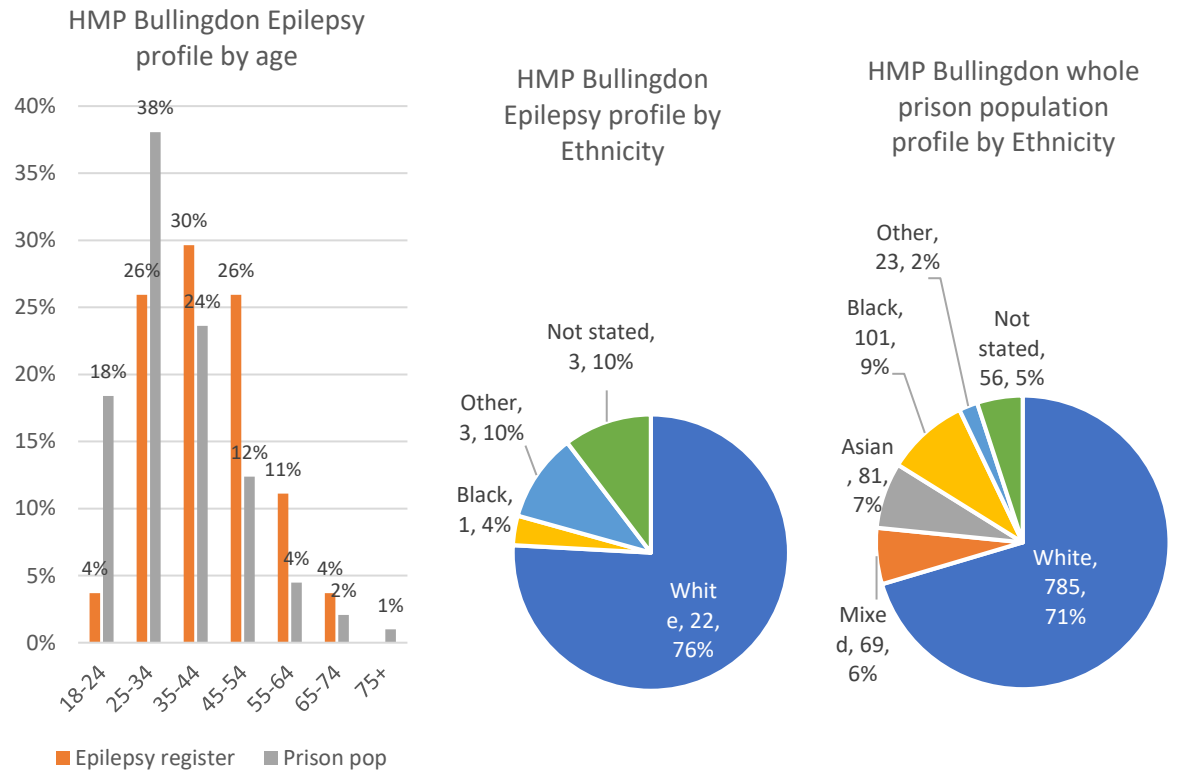
5.52 The prevalence profile of epilepsy in Bullingdon in June 2018, the mid-point of last year, has been compared in terms of the age and ethnicity of those on the register to the age and ethnicity profile of the prison. These comparisons have been set out in the charts below.

5.53 The age profile of those on the epilepsy register shows that all age groups included a representation of patients. Nonetheless, all age groups over 35 had a higher proportionate profile than the prison population and those age groups below 34

years of age had a lower proportionate profile, suggesting that there is an age-related presentation with a proportionately higher profile of epilepsy patients.

5.54 The ethnicity profile is clearly demonstrating that there is a lower proportion of BAME clients with an over representation of white patients 76% as opposed to 71%. Moreover, there are no mixed or Asian patients on the register and there is a significantly larger proportion of patients that have not stated their ethnicity. Furthermore, black, Asian and Mixed profiles are slightly higher.

Chart 23: HMP Bullingdon Epilepsy by Age compared to prison population and by Ethnicity compared to the prison population (SystmOne June 2018)



5.55 Epilepsy is showing a higher prevalence than the national and regional comparators and is presenting higher proportionately in the prison's older and white population.

Hypertension

5.56 The table below describes the comparison of the HMP Bullingdon presentation for patients on the hypertension register on SystmOne and this is compared to the prevalence profiles in England and the South East. In short, the prison is showing a lower prevalence level of hypertension than the English and regional comparators.

Table 12: HMP Bullingdon Hypertension Prevalence Comparisons England, South East and other comparable establishments (SystmOne, and PHE QoF)

Prevalence	Hypertension register	Bullingdon Variance
England (PHE Profiles 2017-18)	13.9%	-6.50%
South East (Hampshire, Isle of Wight and Thames Valley) NHS region	13.4%	-5.94%
HMP Bullingdon (SystmOne chronic conditions register) March 2019	7.4%	
Comparison with other similar prisons		
HMP Elmley (1299 population Jan 2017)	10.1%	-2.63%
HMP Hewell (776) population June 2018)	7.0%	0.45%
Population (1128)		
HMP Bullingdon QoF Presentations (Count)	84	
HMP Bullingdon as Proportion of English Prevalence	157	-73
HMP Bullingdon as proportion of Thames Valley Prevalence	151	-67

5.57 Based on the prevalence of hypertension and the current population of HMP Bullingdon it would be expected to see between 157 and 151 prisoners on the SystmOne Register, as per the prevalence levels of hypertension in England and the South East (Hampshire, Isle of Wight and Thames Valley) NHS Region. In reality the HMP Bullingdon prevalence is 7.4%, which shows a lower level of prevalence than the national and regional population comparators, which results in some 67 to 73 fewer patients on the register.

5.58 The presentation of hypertension, when compared to comparable prisons, shows that Bullingdon has a very slightly lower level of prevalence than the HMP Elmley population (-2.63%) and a higher level of prevalence to the HMP Hewell population (0.45%).

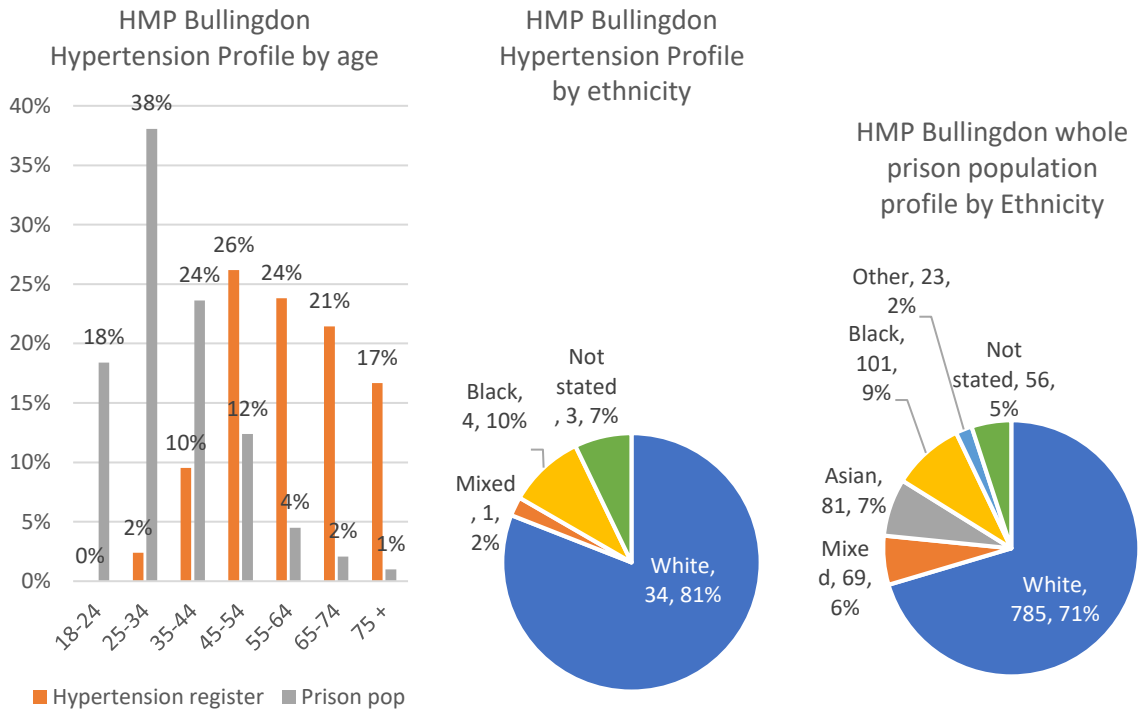
5.59 The prevalence profile of hypertension in HMP Bullingdon in June 2018, the mid-point of last year, has been compared in terms of the age and ethnicity of those on

the register to the age and ethnicity profile of the prison. These comparisons have been set out in the charts below.

5.60 The age profile of those on the hypertension register shows that 88% of all those on the register were over 45. This is unsurprising given the nature of this condition and its impact on older age groups.

5.61 The ethnicity profile is clearly showing a higher proportion of white patients, at 81% of the cohort compared to 71% of the population, a proportionate level of black patients but a lower level of mixed patients and no Asian or other ethnic patients.

Chart 24: HMP Bullingdon Hypertension by Age compared to prison population and by Ethnicity compared to the prison population (SystmOne June 2018)



5.62 Hypertension is showing a lower prevalence in the prison than its national and regional comparators and is presenting in a higher proportion of older patients and a higher proportion of white patients.

QoF Performance – Long-term conditions

5.63 HMP Bullingdon's QoF 'How am I Driving' report identified the number of eligible patients for different health interventions. From a long-term condition perspective, the headline position for asthma, COPD, diabetes, hypertension and CHD can be reviewed. The key data is set out in the table below has been extracted from HMP Bullingdon's May QoF 'How and I Driving' report.

Table 13: Key QoF indicators – treatment of long-term conditions HMP Bullingdon QoF May 2019

Indicators	Count	Percentage
Asthma Register 116		
Measures of variability or reversibility	69 of 75	92.0%
Review in previous 12 months	52 of 73	71.2%
COPD Register 23		
Diabetes Register 44		
BP controlled BP 150/90 or less	36 of 38	94.7%
Foot examination in last 12 months	20 of 20	100%
Influenza immunisation	29 of 29	100%
Hypertension register 84		
BP controlled BP 150/90 or less	48 of 55	87.2%
Coronary Heart Disease Register 24		
BP controlled BP 150/90 or less	20 of 20	100%
CHD therapy in last 12 months	14 of 14	100%
Obesity Register 164		15.6% of population

5.64 Long-term conditions are being overseen and the head of healthcare is mindful that they are committed to maintain this level of care beyond the proposed reconfiguration. To support this process the team has 0.16 of a diabetes nurse's time and 0.4 of a dietitian's time. This may need to be adjusted if the throughput of the new prison rises considerably and the prevalence and volume of long-term conditions increases.

Care for long-term conditions

5.65 Every prisoner who comes in with a long-term condition will be identified in reception or on second day screening. The practitioner for chronic conditions run reports to identify every prisoner with a long-term condition. The practitioner will then see patients in clinics, which are run most days, where the nurse will do basic observations and provide basic levels of health promotion around their condition. If needed the nurse will then refer on as appropriate to the appropriate specialist

(asthma, diabetes etc.) The specialist clinician will then see their relevant patient and give specific advice on their condition.

Palliative and end of life care

5.66 There are good established arrangements with external palliative care and end of life care services with Sobell House - the prison's local hospice. In addition, there are robust arrangements with local hospitals. There is currently no dedicated cell within the inpatient unit for palliative and end of life care.

Deaths from natural causes

5.67 Since April 2015 there have been 16 deaths in custody at HMP Bullingdon. Of these, nine were self-inflicted and seven were the result of natural causes. The national trend is showing an increase in the deaths in custody from natural causes, this is in part a reflection of the shifting patterns to older offenders coming into prison[21].

5.68 In HMP Bullingdon, deaths in custody from natural causes have been due to coronary artery thrombosis, carcinoma of lung and decompensated cirrhosis, gastrointestinal hemorrhage, severe pyelonephritis and bronchopneumonia, and the cause of more recent deaths are still to be determined.

5.69 When a death in custody happens, a report is drafted for the deceased. In fact, all deaths in custody described will be taken through a Prisons and Probation Ombudsman (PPO) report. Through this, recommendations for improved healthcare and prison processes (including risk assessments) are addressed. Where recommendations are made the head of healthcare takes these matters and puts them in the Health Improvement Plan.

Section Summary

5.70 HMP Bullingdon has a strong volume of prisoners coming into and out of the prison. This is likely to increase substantially following the prison's reconfiguration in October 2019. The current physical health needs are relatively stable and demonstrate an increasing prevalence of some chronic conditions. In several cases there is prevalence of chronic condition that is both above and below national and regional prevalence levels.

5.71 To summarise, the six most prevalent chronic conditions are set out in the table below and describe the prevalence trends on the register of the last 12 months and these are compared with national and regional QoF prevalence to highlight

[21] Prison Reform Trust Prison: the facts Bromley Briefings Summer 2018 (Page 4) http://www.prisonreformtrust.org.uk/Portals/0/Documents/Bromley%20Briefings/Summer%202018%20factfile.pdf

potential levels of met or unmet need by assessing those prevalence levels that are above and below national and regional expected prevalence levels.

Table 14: Major Conditions summary table HMP Bullingdon

Condition	HMP Bullingdon Trends[22]	HMP Bullingdon register[23]	HMP Bullingdon prevalence[24]	National prevalence[25]	SE Regional prevalence[26]	Above or below estimate
Asthma	Constant	116	10.3%	5.9%	6.0%	Above
Depression	Rising	182	16.13%	9.88%	9.93%	Above
Obesity	Rising	164	14.54%	9.76%	8.54%	Above
Diabetes	Declining	44	3.9%	6.8%	5.9%	Below
Epilepsy	Declining	18	1.6%	0.8%	0.7%	Below
Hypertension	Constant	84	7.4%	13.9%	13.4%	Below

5.72 There are some conditions that are suggesting a level of under representation, particularly from an ethnicity perspective. These include hypertension, epilepsy and depressions, where there are disproportionately higher presence of prisoners from white ethnic groups on the register and hence disproportionately lower levels of BAME prisoners. Age profiles of major conditions were consistent with nationally derived age-related prevalence.

5.73 The summary of comparisons with similar prisons has shown that HMP Bullingdon has a higher prevalence of asthma, epilepsy (more than HMP Elmley, lower than HMP Hewell) and diabetes, but a lower prevalence of depression, obesity and hypertension.

5.74 Deaths in custody from natural causes have been relatively constant in the last 5 years. This being the case, there may be a case for the prison to provide a dedicated cell in the inpatients unit to support palliative and or end of life care.

5.75 The management of long-term conditions and national screening programmes are in place however the volume of turnover in the prison often prevents these services from being fully maximised. This is likely to continue and or be exacerbated when the prison undergoes its reconfiguration in October.

Primary care recommendations

5.76 Healthcare to review the increasing prevalence of depression and obesity and to monitor the profile of asthma and hypertension.

5.77 Healthcare to review the management of long-term conditions and national screening programmes in the light of the reconfiguration plans for the prison.

[22] HMP Bullingdon SystmOne 5 quarter trend review
[23] HMP Bullingdon SystmOne Register March 2019
[24] HMP Bullingdon SystmOne Register March 2019
[25] PHE Profiles QoF 2017-2018
[26] PHE Profiles QoF 2017-2018

6 Mental health need and demand

Introduction

6.1 This chapter sets out the scale of need and prevalence of mental ill-health and learning difficulties or disabilities by using national estimates to show what this would look like for the prison population of HMP Bullingdon. This has been supported with a review of the demand for mental health treatment services through caseload and activity data. In addition, this chapter looks at the impact of self-harming including those prisoners that have been supported through the ACCT process.

6.2 Mental health, wellbeing and mental illness are significant issues in any prison establishment, be it lower level forms of depression and anxiety to higher level needs of psychosis, neurosis, psychiatric and severe psychological disorders. Offenders will present with a range of emotional and mental health difficulties from adjustment disorders, anxiety, stress, low mood, sleep disorders and mental illness. They can be wary of any service with 'mental health' in it and are more likely to present with somatic symptoms, behavioural problems or anger.

Estimating the scale of need

6.3 There are many measures used by different organisations to indicate the scale of mental health need, often these measures are based on 'mental health problems' or 'mental health illness' or a combination of both. It is, however, important to be aware that there is a continuum between lower level mental health needs and enduring mental illness and many step care models address this continuum.

6.4 The data NHS England collects on mental health conditions shows that 10% of the prison population in England is in treatment for mental health conditions at any one time, but there may be more prisoners in England receiving mental health treatment that are not accounted for in this data.[27] For example, 49% of adult prisoners first arriving in custody are at risk of suffering from anxiety and or depression.[28] If this proportion were to be applied to HMP Bullingdon this would amount to 520 men.

6.5 The table below sets out the prevalence of mental health conditions as they apply to the male prison population of England and Wales. This is compared to the number and proportion of the population of HMP Bullingdon where mental health needs are being met or have been identified through prisoners self-reporting. Most figures for the population of HMP Bullingdon are based on a May 2019 snapshot of the mental health caseload and QOF register. For reported emotional or mental

[27] Mental Health in Prisons (2017), HMPPS, National Audit Office, 2017
[28] As above and based on a survey of 1,300 prisoners who had recently arrived in prison

health problems and suicidal feelings when first arriving in prison, figures have been extrapolated from the findings of the prisoner survey from the most recent inspection of HMP Bullingdon. [29] These figures have been applied to the population of HMP Bullingdon to illustrate the likely demand.

6.6 These conditions are addressed in more detail below.

Table 15: Prevalence of mental health in the prison population of England and Wales and comparable indicators for HMP Bullingdon (sources: referenced in footnotes)

Prison population		Applying prevalence to HMP Bullingdon	HMP Bullingdon comparable indicators	Actual prevalence in HMP Bullingdon	
Prevalence measures	(%)	(n)		(%)	(n)
Proportion of men in prison reporting emotional health/mental health issues[30]	42%	444	Proportion of men in prison reporting emotional health/mental health issues[31]	49%	518
Proportion of prisoners reported at risk of anxiety and depression[32]	49%	243	Proportion of prisoners on the SystmOne depression register (QOF)[33]	17%	183
Proportion of male prisoners reporting symptoms indicative of psychosis[34]	15%	159	Proportion in treatment for a psychotic disorder[35]	2%	16
Proportion of male sentenced prisoners that have a personality disorder[36]	64%	677	Proportion of prisoners in treatment for a personality disorder[37]	1%	12
Proportion of men that said they had problems with feeling suicidal when they arrived in prison[38]	21%	222	Proportion of prisoners who stated they felt depressed or suicidal when they first arrived in prison[39]	27%	286

[29] Unannounced Inspection of HMP Bullingdon (2017), HM Chief Inspector of Prisons 2017
[30] HM Chief Inspector of Prisons for England and Wales (2017), Annual Report 2016-17
[31] Unannounced Inspection of HMP Bullingdon (2017), HM Chief Inspector of Prisons 2017, HMCIP 2017. This figure is based on the proportion of men that had reported an emotional or mental health problem from the sample that completed the prisoner questionnaire and applied to the whole population of HMP Bullingdon.
[32] Mental Health in Prisons (2017), HMPPS, National Audit Office, 2017. This measure is based a 2005 survey of 1300 prisoners who had recently arrived in prisons.
[33] This is the number reported in the depression register and applied as a proportion of the prison population, QOF Report March 2019 HMP Bullingdon
[34] Gender Differences in Substance Misuse and Mental Health (2013), Ministry of Justice. This measure is based on the prevalence of prisoners reporting symptoms indicative of psychosis from the results of the Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study of prisoners 2013
[35] This measure is based on the number of prisoners on the mental health caseload in May 2019 and applied as a proportion of the prison population
[36] Mental Health Care in Prisons, Prison Reform Trust
[37] This measure is based on the number of prisoners on the mental health caseload in the 3-months to May 2019 and applied as a proportion of the prison population
[38] HM Chief Inspector of Prisons for England and Wales (2017), Annual Report 2016-17
[39] Unannounced Inspection of HMP Bullingdon (2017), HM Chief Inspector of Prisons 2017. This figure is based on the proportion of men that had felt depressed or suicidal from the sample that completed the prisoner questionnaire at the last inspection and applied to the whole population of HMP Bullingdon.

Access to services

6.7 In HMP Bullingdon, primary care mental health services are provided by Care UK and secondary care mental health services are provided by Inclusion (mental health in-reach team, MHIT). Mental health services in HMP Bullingdon use a stepped care model approach to deliver mental health treatment interventions, where prisoners will step up and down according to their needs.

6.8 All prisoners that arrive at HMP Bullingdon,where mental health needs are identified will have a triage assessment completed during reception screening. These assessments are then sent to the primary care mental health team and where appropriate they will refer prisoners to the MHIT or retain and manage them under the primary care mental health services. This referral process from primary to secondary care mental health services was described by healthcare as effective and worked well. However it was highlighted that for some prisoners in need of mental health services, there is a risk that issues will not be picked up based on triage assessments alone.

6.9 For existing prisoners, self-referral routes are available as are referrals from wider health services and prison officers. However, it was felt that the referral process was not well embedded in the prison.

6.10 Both primary and secondary mental health services reported being under a lot pressure to assess and treat prisoners due to the high turnover the prison experiences. Mental health services were described as being in a constant state of "firefighting" and unable to meet the needs of the prisoners. This was also highlighted in the last inspection of HMP Bullingdon - the report stated that '*overall mental health services were not meeting need, staff were prioritising urgent care over more routine services such as group work or other psychological interventions and as such lower-level mental health needs were not being met sufficiently well.*'[40]

6.11 Mental health services are available seven days a week and for out of hours, there is mental health nursing available in emergency cases as well as access to the inpatient unit. This is in line with the requirements of the national service specification for Integrated Mental Health Service for Prisons in England.[41]

Service activity

6.12 This section describes the current caseload and activity based on data and information held by the mental health services and recorded on HJIP.

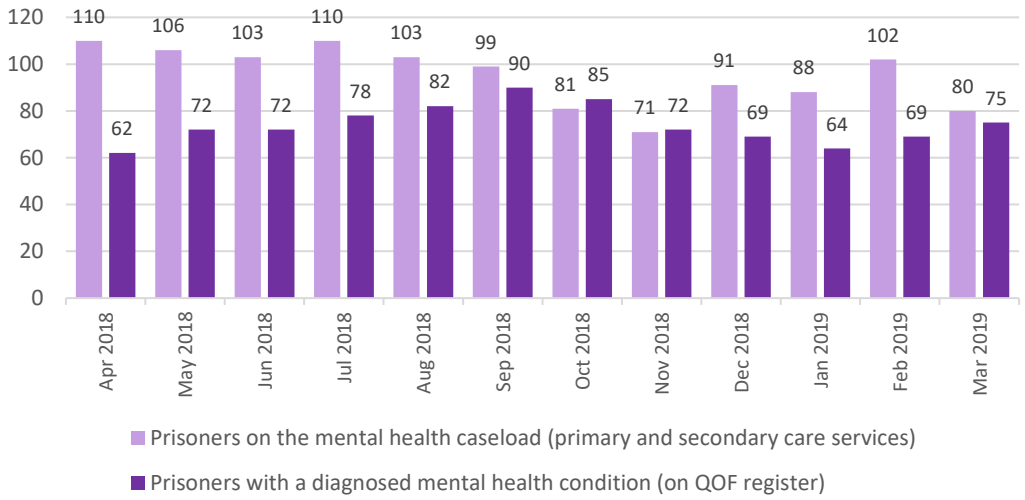
6.13 The chart below summarises the number of prisoners on the mental health caseload (combined primary and secondary care mental health services) and the number of prisoners with a diagnosed mental health condition at the end of each

[40] Unannounced Inspection of HMP Bullingdon (2017), HM Chief Inspector of Prisons 2017
[41] Integrated Mental Health Service for Prisons in England (2018), Service Specification, NHS England 2018

month. This is set out in the chart below and is based on data from HJIP for the 12-months ending March 2019.

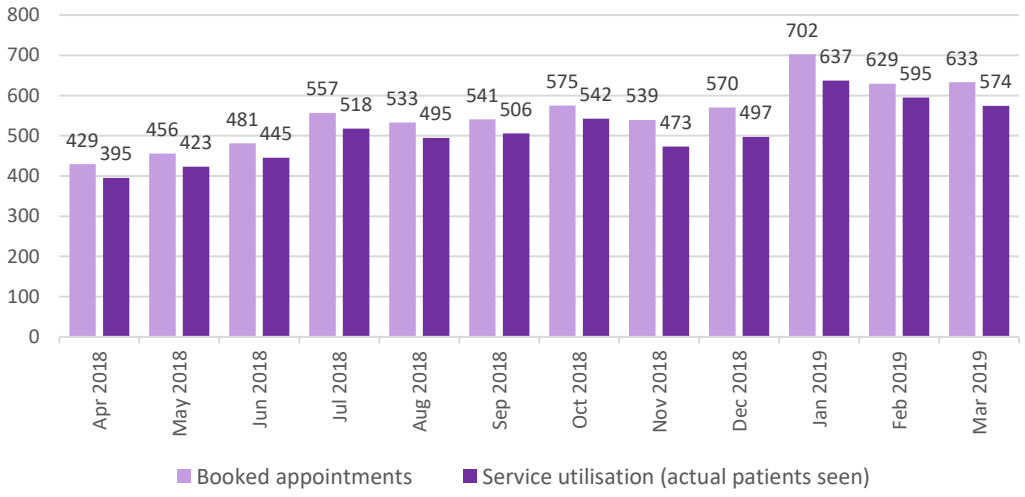
6.14 This shows there to be an average of 95 prisoners on the mental health caseload per month and on average 20 were diagnosed with a mental health condition on the QOF register. Based on this data, on average 9% of the prison population are on the mental health caseload and 2% have a diagnosed mental health condition.

Chart 25: Prisoners on mental health caseload (all mental health services) (source: HJIP April 2018 – March 2019)



6.15 The chart below shows the number of booked appointments and the number of prisoners seen in mental health treatment clinics. This shows, on average there are 554 mental health clinic appointments per month. Of these, 508 prisoners are seen, giving a service utilisation rate of 91%. The average DNA rate over this period was 6%.

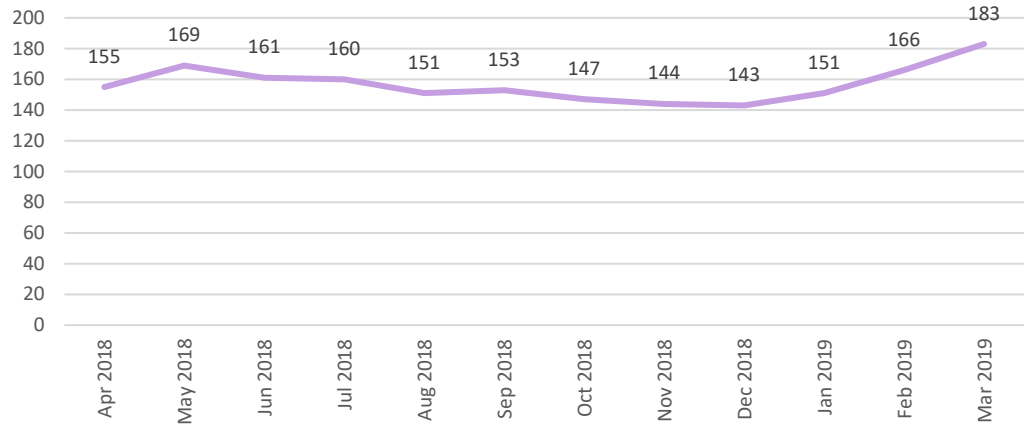
Chart 26: Mental health booked clinic appointments and service utilisation (source: HJIP April 2018 – March 2019)



Depression

6.16 Data from HJIP for the 12-months leading to March 2019 shows there is an overall upward trend in the number of prisoners on the QOF register with a diagnosed depression condition. In the past 12-months there has been an 18% increase - up from 155 in April 2018. However, the increase had been most notable since December 2018. In March 2019, there were 183 prisoners with a diagnosed depression condition on the QOF register. This represents 17% of the prison population.

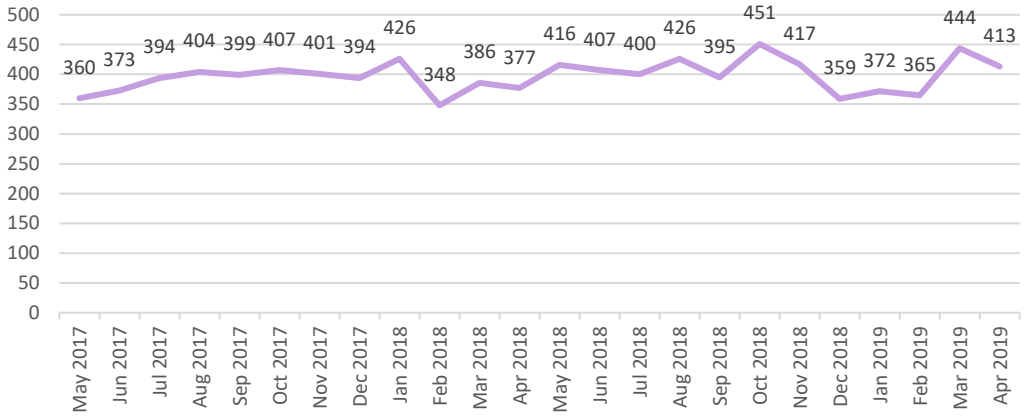
Chart 27: Prisoners with a diagnosed depression condition, 12-months to March 2019 (source: HJIP April 2018 – March 2019)



6.17 There are many prisoners with low-level mental health needs (including depression, anxiety, sleep disorders etc.) that are being managed by anti-depressant medication. Not all of these prisoners will be seen by or will access mental health services. Medications data provided by healthcare shows that in April 2019, 413 prisoners were prescribed anti-depressant medication, at this time this represented 32% of the prison population.

6.18 The chart below describes the trend in the number of prisoners who are being prescribed anti-depressant medication; over the two-year period between May 2017 and April 2019 there is an evident increase. Comparing the number of prisoners taking anti-depressants in April 2019 to the number in April 2018, there is a 4% increase.

Chart 28: Prisoners being prescribed anti-depression medications, May 2017 – April 2019 (source: Healthcare, Medications Dashboard May 2017 - April 2019)



6.19 Most anti-depressant prescriptions, in April 2019 were for mirtazapine, sertraline, fluoxetine or citalopram. Mirtazapine is an abusable drug and the high level of use is a concern for healthcare. Mirtazapine prescriptions, on average in the 12-months to April 2019, accounted for over half of all anti-depressant medications (52%, 210 prisoners). All prisoners on medications will have scheduled reviews with the GP and during this process prisoners are encouraged to reduce their use, if appropriate. Alternative methods to address their needs are available through relaxation and sleep hygiene programmes.

Personality disorder

6.20 National figures estimate that almost two thirds (64%) of male sentenced prisoners and 58% of remand prisoners in England and Wales have a Personality Disorder (PD) of some kind. Healthcare highlighted that the prevalence of PD in the prison population of HMP Bullingdon is high. The MHIT work with those who most at risk - there were 12 prisoners with PD seen by MHIT in the 3-months leading to May 2019. Some prisoners that healthcare considered to have a PD were being seen by the primary care mental health nurses, but at present there is no therapy pathway for prisoners with PD. This was also highlighted in the recent inspection report for HMP Bullingdon.

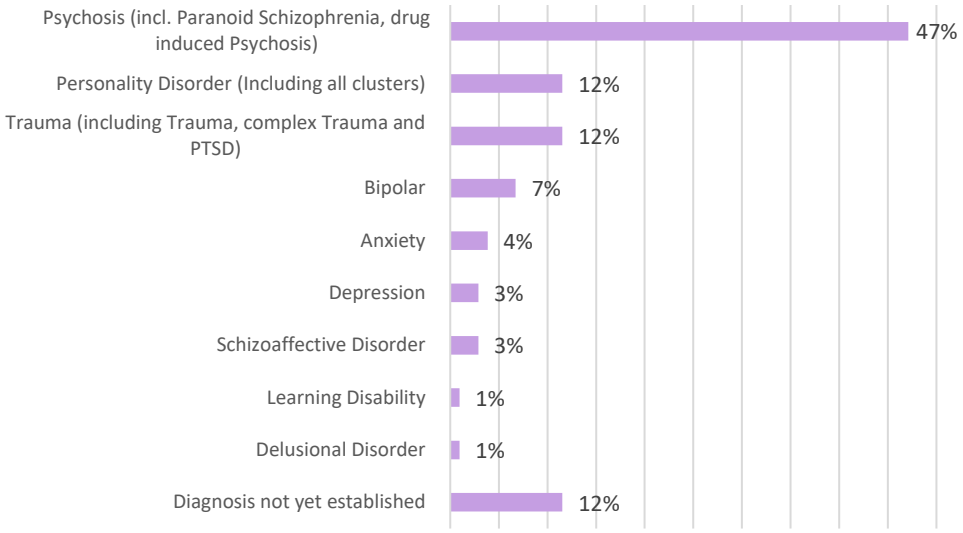
Severe and enduring mental health

6.21 The May 2019 snapshot of prisoners held on the secondary care mental health caseload, shows 4% of the prison population (44 prisoners) have a severe and enduring mental illness (including schizophrenia, psychosis) or their needs are complex and need to be managed through the MHIT, which also includes psychiatry

services. Almost one in three prisoners (64%) on the caseload are sentenced prisoners and the remaining 36% had been remanded to custody.

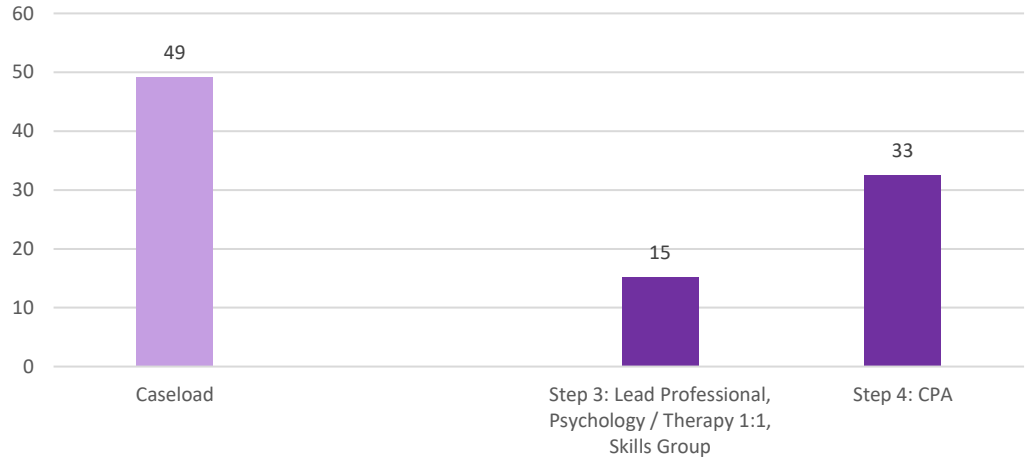
6.22 The chart below shows the breakdown of mental health conditions for prisoners on the secondary care mental health caseload, this is based on the average between March and May 2019 (of a combined 3-month caseload of 104 prisoners).

Chart 29: Secondary care mental health caseload, May 2019 (source: Inclusion, MHIT data)



6.23 In the period between June 2018 and March 2019, MHIT held an average caseload of 49 prisoners per month. There were on average 15 prisoners that received step-three interventions (including one to one and group therapy) and 17 receiving step-four interventions or Care Programme Approach (CPA) to support their recovery.

Chart 30: Secondary Care caseload, interventions – average over 8-months (source: MHIT, August 2018 – March 2019)



Hospital admissions

6.24 In the period between June 2018 and March 2019, 13 prisoners were subject to step-five interventions and were assessed for or were waiting for transfer to secure hospitals. Of these, 11 prisoners had a psychiatric assessment and as a result 4 prisoners were transferred under section 38 of the Mental Health Act (MHA). A further 5 were transferred under section 47 of the MHA and 2 were transferred under section 48 of the MHA.

Dementia pathway

6.25 There is no pathway for the treatment of prisoners with dementia and the need at present is low in the prison. MHIT have struggled to access services for prisoners with dementia at Oxford Health, as they are not commissioned to deliver services for the prison population.

Self-harm

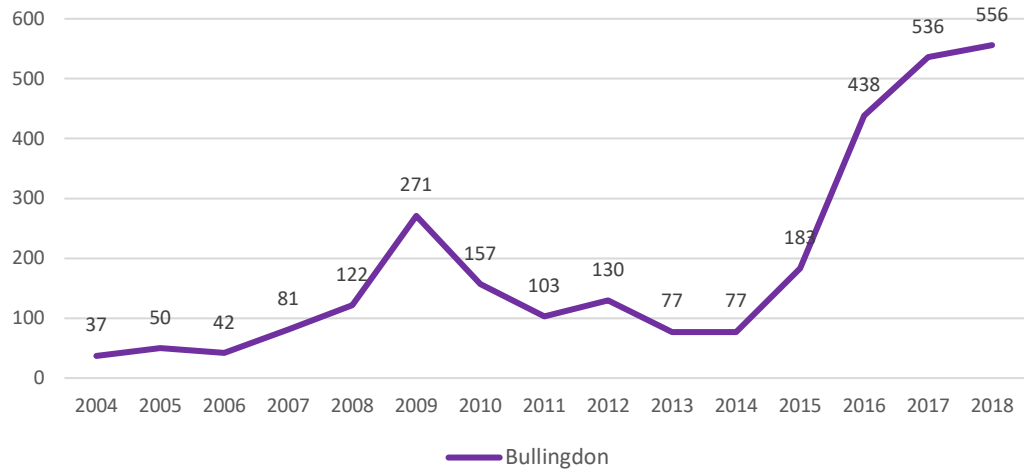
6.26 HMPPS define self-harm as '*any act where a prisoner deliberately harms themselves irrespective of the method, intent or severity of any injury*.'[42] This can include self-harm by cutting, scratching, head-banging, punching a wall, self-poisoning, fire setting, suffocation, swallowing and or insertion of objects and wound aggravation.

6.27 MOJ self-harm data, which reports on the number of self-harm incidents for all prisons in England and Wales, shows an increasing trend in the number of self-harm incidents amongst male prisoners. Since 2011 there has been a rise in self-harm among male prisoners, with 570 incidents per 1,000 prisoners in 2018, a 144% increase from 234 in 2015.[43]

6.28 The number of self-harm incidents in HMP Bullingdon since 2004 are set out in the chart below. Self-harm incidents since 2014 have been increased year on year, following the national trends. However, the increase in the past three years is highly significant, with a total of 556 incidents of self-harm reported in 2018.

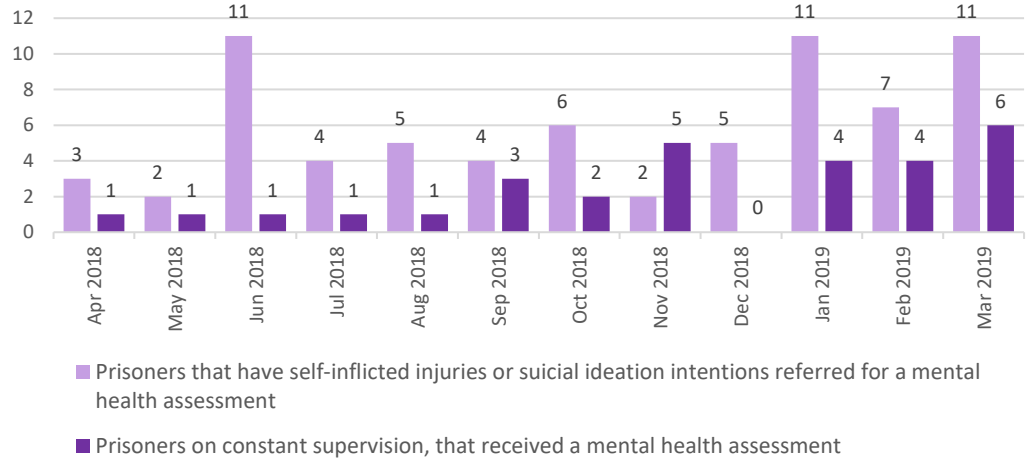
[42] Prison Service Instructions 2011 (PSI 64/2011)
[43] Safety in Custody Statistics (2018), MOJ

Chart 31: HMP Bullingdon, self-harm statistics 2004-2018 (source: MOJ Safety in Custody Statistics, December 2018)



6.29 Data from HJIP shows in the 12-months leading to March 2019, 71 prisoners that had self-inflicted injuries or felt suicidal were referred for a mental health assessment and a further 12 prisoners that were on constant watch had had a mental health assessment.

Chart 32: Self-harm and suicide prevention and constant watch, 12-months to March 2019 (source: HJIP April 2018 – March 2019)



6.30 Self-harm data provided by the prison shows there were 277 incidents of actual self-harm in the period between May 2018 and May 2019, on average 21 per month. In most cases the reasons offered by prisoners related to general issues they were having on the wings, being bullied or under threat, healthcare (including medications), family issues or mental health issues.

Assessment, Care in Custody & Teamwork (ACCT)

6.31 ACCTs apply to prisoners who, in the opinion of prison staff, are deemed at risk in the prison environment or those who may cause self-harm and even threat of suicide, thus potentially resulting in a death in custody. The ACCT regime is essentially a multi-disciplinary approach to review cases and to mitigate risk.

6.32 ACCT allows the prison to monitor the prisoner closely, engaging them in planning ways of addressing their problems and helping them to build up their own sources of support.

6.33 Prisoners are fully involved in the ACCT process. They will have an interview with a trained assessor, from which an individual care plan is drawn up. They then attend regular case reviews, where a case manager reviews the care and support they are receiving, via their care plan.

6.34 The ACCT document is a series of forms held together in a high-visibility orange folder, utilised in response to concerns that an individual in prison is at risk of self-harm or suicide. Any person can open the document to suspected risk (by completing the 'concern and keep safe form' (CKSF) within the ACCT folder), but once opened there are clear procedures that must be followed. This includes the completion of the 'immediate action plan' (on the back of the CKSF) by a unit manager within one hour, and an 'assessment interview and first case review' within 24 hours by a trained ACCT Assessor[44]. These forms are completed with the prisoner present and aim to determine the cause of the risk and to develop strategies to reduce the risk on both a short and long-term basis. Based on these forms a 'care map form' is completed in which a series of actions are considered. These include actions such as

- Disable any suicide plan
- Link the person to those who could provide support
- Build on strengths or interests that the person might have
- Encourage alternatives to self-injury
- Reduce emotional pain caused by practical problems
- Reduce vulnerability because of mental health or drug and alcohol problems.

6.35 The issues, action required (by whom and when), the status of the action and the date the actions are completed are dated and signed. The 'on-going record form' is where the conversations and observations concerning the person at risk are

[44] The First Case Review should involve a multi-disciplinary team (e.g., Unit Manager, Case Manager, Assessor, a member of staff who knows the prisoner, Healthcare, and any other member of staff who has or will have contact with the at-risk prisoner and who can contribute to their support and care.

recorded. These entries are supposed to be timed, dated and signed and should record significant events, observations and conversations.

6.36 An ACCT is closed when an individual is no longer considered 'at risk' and requires the completion of a post-closure interview, which is recorded (post-closure interview form). The ACCT is then held in a post-closure state for 7 days. If additional concerns arise in that time, the ACCT document is re-opened. However, if no further issues arise then the ACCT is archived and made part of the prisoner's core record.

6.37 Data provided by the prison shows that 950 ACCTs were opened in the period between May 2018 and May 2019, on average 73 ACCTs per month. Most of these ACCTs were due to mental health concerns or low mood, family issues, being in custody generally or for the first time and issues experienced on the wings including feeling under threat, in debt or bullying.

6.38 The primary and secondary mental health teams are integrated in the ACCT process, with an established pathway for their involvement in all ACCTs. MHIT will attend all ACCT meetings and reviews where prisoners are being managed under the MHIT caseload and primary care mental health services attend all other ACCT meetings and reviews.

Learning disability or difficulties

6.39 There is a lack of consensus in defining the boundaries between learning disability, borderline learning disability and learning difficulty. Most research uses a strict definition of learning disability based on IQ measures of 70 or below or focuses on conditions such as dyslexia with relatively limited reference to other learning difficulties.

6.40 A joint inspection by HMI Probation and HMI Prisons in 2015 highlighted that of the treatment of offenders with learning disabilities within the criminal justice system no clear definition or agreement existed across criminal justice and health organisations about what constitutes learning disabilities.[45] For example, between 20% and 30% of all prisoners have learning disabilities or difficulties that interfere with their ability to cope with the criminal justice system[46] and 20% of the prison population has a 'hidden disability' that will undermine their performance in both education and work settings.[47] Overall the inspection found that prisons had

[45] Based on the findings from 2 category B prisons, 1 category C training prison and 2 women's local prisons. A Joint Inspection of the Treatment of Offenders with Learning Disabilities within the Criminal Justice System, 2015
[46] Prisoners' Voices: Experiences of the Criminal Justice System by Prisoners with Learning disabilities and difficulties, 2008
[47] The Incidence of Hidden Disabilities in The Prison Population, 2005

extremely poor systems in place for identifying prisoners with learning disabilities. The estimated prevalence of learning disabilities is 2% in the general population.[48]

6.41 Applying the estimated 20% to 30% prevalence rate of learning disabilities or difficulties (LD) suggests there could be as many as 210 (20%) or 320 (30%) men in HMP Bullingdon with a LD.

Table 16: Prevalence of learning disabilities or difficulties in the prison population of England and Wales, general population and likely scales in HMP Bullingdon (sources referenced in footnotes)

Learning disabilities or learning difficulties	Prison Population	General Population	HMP Bullingdon Population	
Measure	(%)	(%)	(n)	(%)
Proportion of prisoners with learning disabilities or difficulties	20% - 30%[49]	2%[50]	210	20%

6.42 There was one prisoner in contact with the MHIT in the period between March and May 2019 with a learning disability or difficulty and 17 prisoners with LD reported on the QOF register in May 2019. This low level of LD could suggest there is under-identification.

6.43 LD provision has been subcontracted by Care UK to Inclusion, and at present there is no LD specialist in healthcare, and the care pathway for supporting prisoners with LD is yet to be established. Care UK are in the process of developing a regional LD specialist resource that will support all prisons in the Thames Valley region.

Mental health training

6.44 There is currently no mental health training being delivered to prison staff or wider healthcare services. At the time of this report, MHIT were in contact with the new Safer Custody team in HMP Bullingdon to plan for this to happen.

Section Summary

6.45 Based on national estimates of mental health need among prisoners, the table below summaries the expected and actual demand.

Table 17: Summary prevalence, expected and actual demand

[48] Prisoners' Voices: Experiences of the Criminal Justice System by Prisoners with Learning disabilities and difficulties, 2008

[49] This measure is based on the proportion of prisoners with learning disabilities or difficulties. Loucks, N. (2007) No One Knows: Offenders with learning Offenders with Learning Difficulties and Learning Disabilities. Review of prevalence and associated needs, London: Prison Reform Trust

[50] This figure is based on previous research commissioned by the Department of Health estimated that in 2004, 828,000 adults in England were likely to have learning disabilities. Applying these prevalence estimates to population predictions for 2015 suggests that 1,087,100 people in England have learning disabilities, of which 930,400 are adults (aged 18+). The latter is equivalent to 2.16% of the English adult population. Main report: Learning Disabilities Observatory People with learning disabilities in England 2015

Mental Health	Prevalence	Expected (rounded)	Actual
Male prisoners reported emotional or mental health	42%	445	518
Adult prisoner reported at risk of anxiety and depression	49%	245	183
Male prisoners reported symptoms of indicative psychosis	15%	160	16
Male prisoners have a personality disorder	64%	680	12
Male prisoners reported feeling suicidal on arrive to prisons	21%	220	286

6.46 On average, mental health services carry a caseload of 95 prisoners per month, representing 12% of the prison population. Service utilisation for mental health clinics is high at 91% with low DNA rates of 6%.

6.47 In the 12-months leading to March 2019, there were 52 prisoners diagnosed with a depression condition, representing 9% of the prison population. In the period between June 2018 and March 2019, there were 44 prisoners with severe and enduring mental illness - 4% of the prison population. In the past 12-months there have been 11 admissions to secure psychiatric hospitals.

6.48 Overall, it was felt the need for primary and secondary mental health services far outweighed the capacity either team had to deliver interventions. This was especially true of short interventions for those prisoners remanded to the prison. This perception was supported by both the stakeholder survey and the MH service users focus group.

6.49 There are no pathways for learning disabilities (LD), dementia or personality disorder (PD). This will need to be addressed particularly in the case of learning disabilities with the introduction of new national specifications.

6.50 Over the past three years there has been a significant increase in the number of self-harm incidents reported, with a total of 556 incidents of self-harm reported in 2018.

6.51 Data provided by the prison shows, 950 ACCTs were opened in the period between May 2018 and May 2019, on average 73 ACCTs per month.

6.52 Mental health services are integrated within the ACCT process and will assess all prisoners irrespective of whether they require mental health services.

6.53 Service users through their focus groups felt it was important to introduce:

- Increased service provision including counselling, groups and/or courses for stress, depression, anxiety and coping mechanisms
- Structured mental health and emotional wellbeing mentor/rep programme
- Increased health promotion including; mental health days and officer training.

Section Recommendations

6.54 The key recommendations for the improved mental health and wellbeing of prisoners in HMP Bullingdon are:

- Increase mental health awareness and training amongst prison staff and health care providers
- Review resources to meet the demand for services in line with the new national service specifications - this should be aligned to the recommendations from section 10 of this HNA
- Develop a pathway for the identification and assessment of Learning Disabilities
- Develop short-term interventions that will benefit those prisoners that are remanded and do not stay in the prison for long, such as managing emotions/emotional regulation
- Develop a dementia pathway to support older people coming into and or going through the prison
- Develop a review of counselling and talking therapies in the prison
- Maximise joint working between primary and secondary care mental health services.

7 Substance Misuse need and demand

Introduction

7.1 This chapter sets out the scale of need and prevalence of substance misuse by using national estimates of drug and alcohol use to show what this would look like for the prison population of HMP Bullingdon. This has been supported with a review of the demand for substance misuse treatment services through current caseload and activity data. In addition, this chapter looks at the impact of the supply and use of illicit drug and alcohol including the use of psychoactive substances (PS) use. Lastly there is a review of the current drug and alcohol strategy.

Estimating the scale of need

7.2 Drug and alcohol use among the prison population is considerably higher in comparison to drug and alcohol use in the general population. National prison estimates suggest 81% of prisoners reported using illicit drugs at some point prior to entering prison, including 64% within the month before entering prison.[51] Based on these estimates, it would suggest in HMP Bullingdon around 860 men have used drugs at some point prior to entering prison (around 680 using drugs within one month of entering prison). In the general population an estimated 4% of adults used drugs in the last month.[52]

7.3 Psychoactive substance (PS) use before going into prison was low relative to other substances, with 6% reporting they had taken spice or black mamba and 5% for other legal highs. Prisoners who said that they had used PS in the community before going into prison had generally used it with other drugs or with prescribed medication.[53]

7.4 In a recent HM inspectorate of prison report, 87% of male prisoners reported drinking alcohol in the four weeks before custody, of this 32% reported drinking daily.[54] In the general population 16% of men drank alcohol daily.[55] Harmful, hazardous and dependent drinking are relatively common problems among people entering prison. Of those prisoners who had consumed alcohol in the four weeks before custody, nearly half (46%) reported having some problems with their drinking, 39% felt that their drinking was out of control (sometimes, often or

[51] Gender Differences in Substance Misuse and Mental Health (2013), Ministry of Justice
[52] Drug Misuse: Findings from the 20167/18 Crime Survey for England and Wales, 2018
[53] Changing Patterns of Drug Misuse in Adult Prisons and Service Responses, 2015 HM Inspectorate of Prisons (survey of 1,376 - in eight prisons)
[54] Changing Patterns of Drug Misuse in Adult Prisons and Service Responses, 2015 HM Inspectorate of Prisons
[55] As above

always) and 35% said that they would find it quite difficult, very difficult or impossible to stop drinking.[56]

7.5 The chart below illustrates how these estimates of harmful, hazardous and dependent drinking would apply to the population of HMP Bullingdon.

Chart 33: Harmful, hazardous and dependent drinking estimates applied to HMP Bullingdon

7.6 Other national prevalence estimates suggest:

- 26% of men in prison reported that they had taken illicit drugs or medication in their current prison[57]. This equates to around 275 men in HMP Bullingdon.
- 13% of men in prison reported that they had developed a problem with using prescription medication meant for other people whilst in prison[58]. This equates to around 140 men in HMP Bullingdon.
- 11% of men in prison reported they had developed a problem with illegal drugs since they had been in prison[59]. This equates to around 115 men in HMP Bullingdon.
- 19% of adults in prison reported using heroin for the first time in prison[60]. This equates to around 200 men in HMP Bullingdon
- Cannabis is the most commonly reported drug used before going into prison, followed by cocaine. Of those who reported taking drugs before

[56] Substance Misuse Treatment in Secure Settings: Statistic 2017-18
[57] Changing Patterns of Drug Misuse in Adult Prisons and Service Responses, 2015 HM Inspectorate of Prisons (survey of 1,376 - in eight prisons)
[58] HM Chief Inspector of Prisons for England and Wales (2018), Annual Report 2017-18
[59] As above
[60] Gender Differences in Substance Misuse and Mental Health (2013), Ministry of Justice

prison 38% had taken cannabis and 29% had taken cocaine[61]. This equates to around 400 and 310 men respectively in HMP Bullingdon.

7.7 The National Drug Treatment Monitoring System (NDTMS) annual statistics on drug and alcohol treatment only report on those people that engage in programmes of structured clinical and or psychosocial interventions to address their substance use. This does not take account of those with problematic substance use that are not engaged with treatment services, including those with illicit drug and alcohol use. Nevertheless, these datasets do allow comparisons to be drawn between the prison population of England, general population and to assess how the treatment population of HMP Bullingdon differs.

7.8 Many prisoners would be presenting to treatment services to address their substance use prior to entering prison and in some cases as a result of illicit drug use in prison. The table below shows the proportion of adults in treatment thereby citing their problematic substances and this is compared with the substance misuse treatment population in the prisons in England, the general population and the population of HMP Bullingdon.

7.9 As people usually report more than one problematic substance, the number of clients will be less than the sum of the reported substances as an individual may present with more than one problematic substance and therefore will not be 100% in total. The data for HMP Bullingdon is based on the number of men in treatment in the 12-months leading to March 2019.

Table 18: Prevalence of substance use in HMP Bullingdon, average for prison population and the general population of England (NDTMS; Report for HMP Bullingdon 2018-19, Secure Settings Treatment Statistic 2017-18 and Treatment for Adults Statistics 2017-18)

HMP Bullingdon	**HMP Bullingdon[62]**	**Prison population of England[63]**	**General population[64]**
Measure	**(%)**	**(%)**	**(%)**
Measure	33%	47%	49%
Treatment Profile of alcohol use	11%	16%	29%
Treatment Profile of opiate use (not crack cocaine)	8%	6%	2%
Treatment Profile of crack cocaine use (not opiate)	15%	32%	20%
Treatment Profile of cannabis use	3%	9%	2%

7.10 In comparison to the prison population of England, a higher proportion of men in HMP Bullingdon are in substance misuse treatment citing the use of crack cocaine

[61] Changing Patterns of Drug Misuse in Adult Prisons and Service Responses, 2015 HM Inspectorate of Prisons (survey of 1,376 - in eight prisons)
[62] Data taken from the Adult Quarterly Treatment Report, NDTMS Year End March 2018
[63] Substance Misuse Treatment in Secure Settings (2018): Statistic 2017-18
[64] Substance Misuse Treatment for Adults (2018): Statistics 2017-18

(8% compared to 6%). The use of all other substance is comparatively lower in HMP Bullingdon than across all prisons.

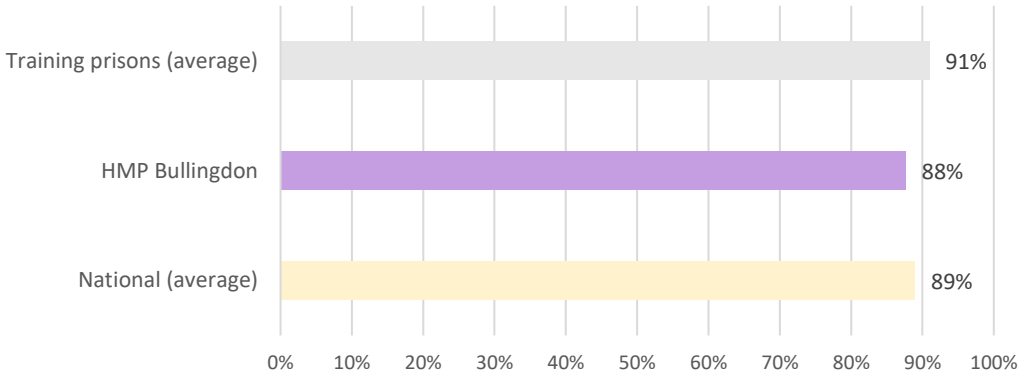
Prevalence, drug and alcohol use

7.11 Based on the substance misuse treatment caseload population reported on NDTMS, the prevalence of drug and alcohol use and actual demand and expected demand for drug and alcohol treatment can be calculated and is detailed in the section below. Those on the substance misuse treatment caseload are reporting recent or historic drug and alcohol use.

Proportion of the drug treatment population

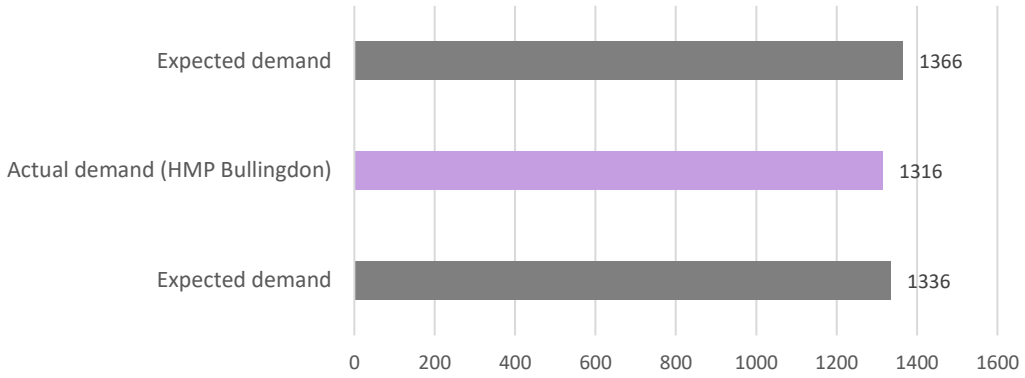
7.12 The proportion of drug use in HMP Bullingdon is set out in the chart below. In HMP Bullingdon, 88% of the treatment population for the 12-months leading to March 2019 was in treatment for drug use (this includes prisoners reporting the use of opiate, non-opiate or alcohol and non-opiate drugs). In comparison to the proportion of drug use in training prisons and in all prisons in England, the proportion of prisoners in substance misuse treatment for drug use in HMP Bullingdon is broadly comparable with prevalence across training prisons, at 91% and across all prisons in England, at 89%.

Chart 34: Drug use – treatment population (source: Adult Prison Quarterly Treatment Report, YTD 2018-19)



7.13 By applying the average prevalence of drug use across training prisons and all prisons in England, as set out above, it is possible to calculate the expected demand for treatment against the actual demand for treatment in HMP Bullingdon. This calculation estimates that the expected demand is likely to lie between 1,336 and 1,366 prisoners as the number of prisoners that would be expected to enter substance misuse treatment. Therefore, the current number of prisoners in treatment for drug use is lower than expected, at 1,316 prisoners.

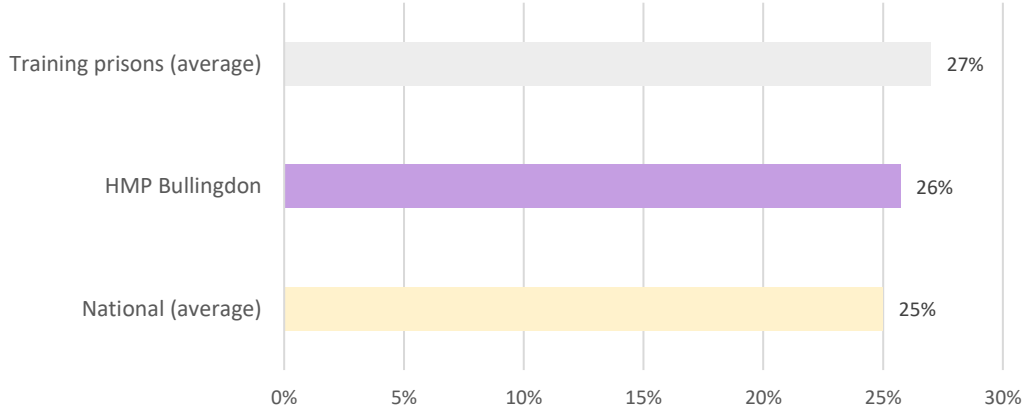
Chart 35: Drug use – actual and expected demand (source: Adult Prison Quarterly Treatment Report, YTD 2018-19)



Proportion of the alcohol treatment population

7.14 The proportion of alcohol use is set out in the chart below. In HMP Bullingdon, 26% of the treatment population is in treatment for alcohol use (this includes prisoners reporting the use of alcohol and non-opiate drugs).[65] In comparison to the proportion of alcohol use in training prisons and in prisons all over England, the proportion of prisoners in substance misuse treatment for alcohol use in HMP Bullingdon is broadly comparable with prevalence across training prisons, at 27% and across all prisons in England, at 25%.

Chart 36: Alcohol use – treatment population (source: Adult Prison Quarterly Treatment Report, YTD 2018-19)

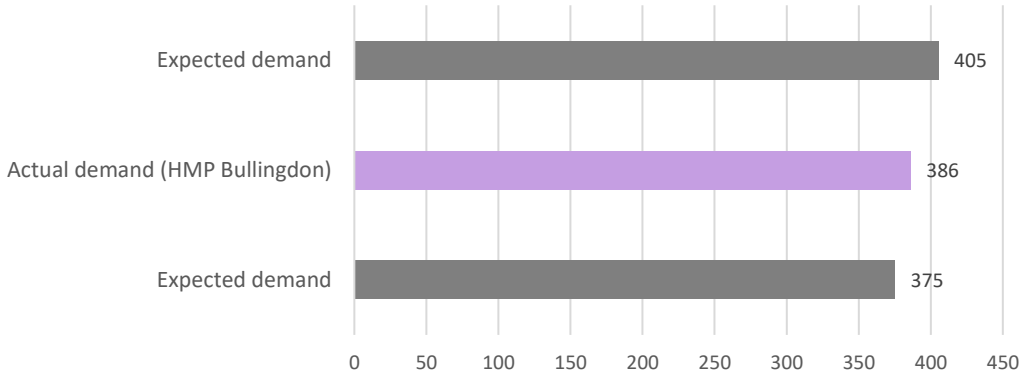


7.15 By applying the average prevalence of alcohol use across training prisons and all prisons in England, as set out above, it is possible to calculate the expected demand for treatment against the actual demand for treatment in HMP Bullingdon. This calculation estimates that the expected demand is likely to lie between 375

[65] It is important to note that due to the way in which NDTMS categorises substance misuse as all those that are opiate users are classified under 'opiate users' even if they also use alcohol as such they do not appear in the alcohol categorisations and therefore the true proportion of alcohol users is likely to be underrepresented.

and 405 prisoners as the number of prisoners that would be expected to enter substance misuse treatment. Therefore, the current number of prisoners in treatment for alcohol sits between these two levels, at 386 prisoners.

Chart 37: Alcohol use actual and expected demand (source: Adult Prison Quarterly Treatment Report, YTD 2018-19)



Access to services

7.16 In HMP Bullingdon, the drug and alcohol team (DART) provide the non-clinical (psychosocial) substance misuse services as part of Inclusion, while Care UK provides clinical substance misuse services. All prisoners are given the opportunity to access treatment for their substance misuse when they arrive at HMP Bullingdon, during their reception screening. Prisoners are also able to self-refer at any time during their stay. All prisoners that arrive with an immediate clinical need (opiate substitute treatment) will have their first night prescribing provided through the GP and subsequently will be managed by a healthcare nurse prescriber.

7.17 Since the two services were relocated, DART described the services as being more integrated and both services work well together, with the DART jointly participating in clinical meetings in order to engage prisoners with psychosocial interventions. This is one of the requirements of the national service specification for Integrated Substance Misuse Treatment Service for prisons in England.[66]

7.18 All entry-level prison officers will receive training and information about substance misuse, however, there is currently no formal information sharing with existing prison staff. However, the relationship between the substance misuse teams and the wider prison was described as good. Both clinical staff and recovery workers will see prisoners on the wings and have worked with individual prisoner key workers to deliver harm minimisation as well promoting the services and how referrals can be made. The DART attends all drug strategy meetings.

[66] Integrated Substance Misuse Treatment Service, Prisons in England (2018), Service Specification, NHS England 2018

Service activity

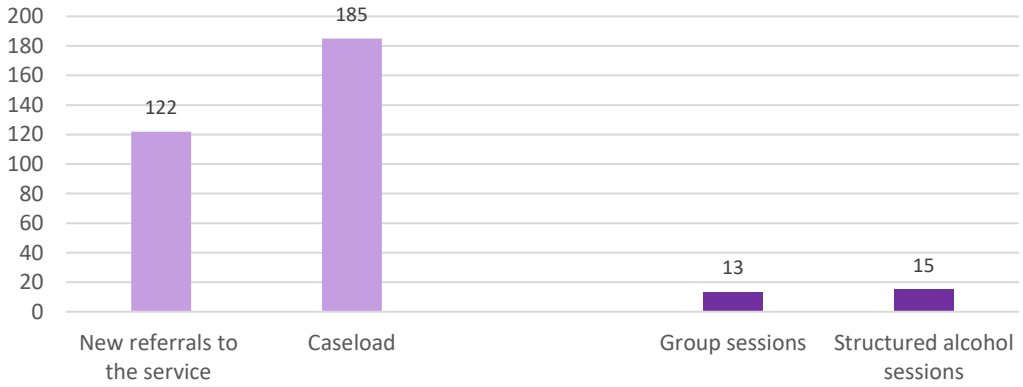
7.19 This section describes the current caseload and activity based on data and information held by the substance misuse service, drug and alcohol team (DART), recorded on the Health and Justice Indicators of Performance (HJIP) and NDTMS.

7.20 Data provided by the DART team, shows that in May 2019, there were 170 prisoners on the substance misuse clinical caseload (16% of the prison population) and 189 prisoners on the substance misuse psychosocial caseload (18% of the prison population). Of the latter, 72 prisoners were in treatment with both services.

7.21 HMP Bullingdon, with a high turnover rate experiences a high volume of throughout of prisoners that access substance misuse treatment services. On the current caseload, around 80% were prisoners on remand.

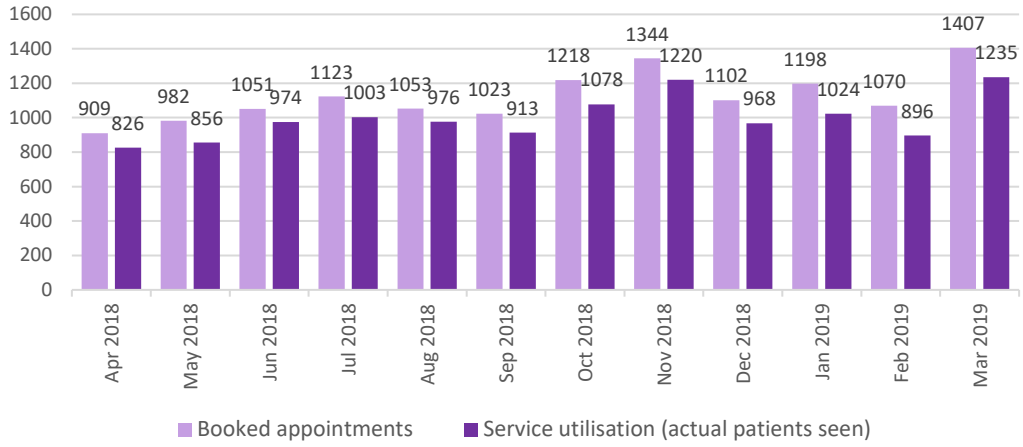
7.22 In the 12-months leading to March 2019, DART received, on average, 122 new referrals and held an average caseload of 185 prisoners per month. As well as providing one to one support and workbooks, the team delivered an average of 13 group sessions and 15 structured alcohol interventions per month.

Chart 38: Substance misuse, caseload, interventions – average over12-months (source: DART, March 2018 – March 2019)



7.23 The chart below shows the number of booked appointments and the number of prisoners seen in substance misuse treatment clinics. This shows, on average there are 1,123 substance misuse clinic appointments per month. Of these, 997 prisoners are seen, giving a service utilisation rate of 89%. The DNA rate over this period was 3%.

Chart 39: Substance misuse booked clinic appointments and service utilisation (source: HJIP April 2018 – March 2019)

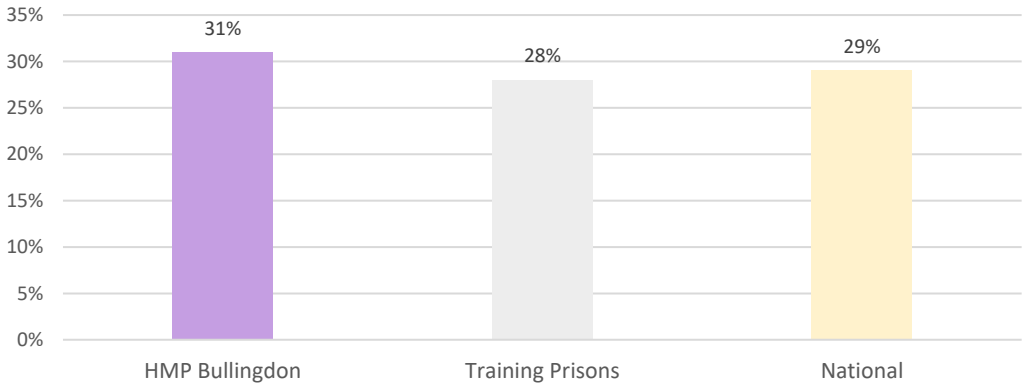


7.24 The DART team reported that DNAs for groups fluctuate. Groups are expected to have 12 prisoners participating. However, some group attendance has been half the expected level.

7.25 The NDTMS datasets record information about prisoners receiving substance misuse treatment and reports on: new treatment entrants, those in treatment and interventions received, age and ethnicity profile and discharges including onward referrals from treatment.-The data is this section relates to the substance misuse treatment population recorded on NDTMS for the 12-month period between April 2018 and March 2019.

7.26 HMP Bullingdon has a higher proportion of new receptions starting treatment, compared to the average across training prisons in England. During this period, 31% of new receptions started substance misuse treatment (1,197 prisoners), whereas the average for training prisons was 28% and nationally 29%. This suggests there are higher levels of need and effective identification of substance misuse at the earliest opportunity is crucial.

Chart 40: New receptions starting treatment, HMP Bullingdon, Training and National Prisons (average) (source: Adult Prison Quarterly Treatment Report, YTD 2018-19)



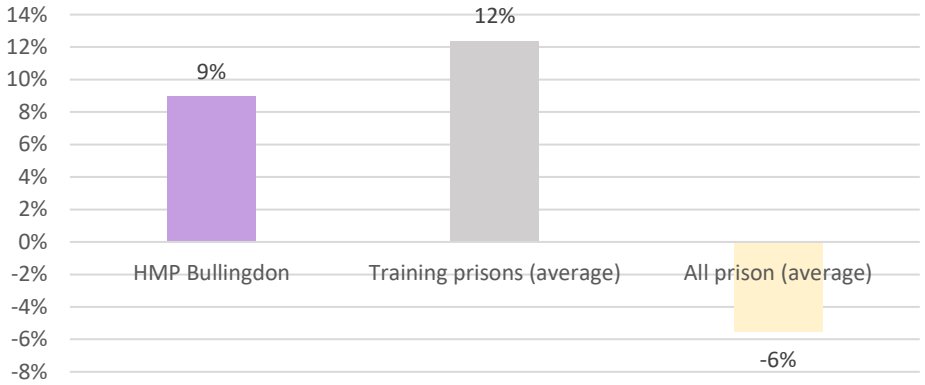
7.27 In total, 1,282 new prisoners starting treatment, 70% started treatment having been directly taken into custody, 17% were existing prisoners starting a new treatment episode after 3 weeks of being in prison and 13% had transferred from another prison and started treatment (within 3 weeks).

7.28 The number of prisoners in substance misuse treatment has increased by 9% in comparison to the previous 12-months, when there were 1,378 prisoners on the substance misuse treatment caseload (12-months to March 2018).

7.29 The substance misuse caseload in HMP Bullingdon consisted of 1,501 prisoners. Nationally, the number of prisoners in treatment across the whole estate has reduced in comparison to the previous 12-months (6% decrease), however there has been an increase in the number of prisoners on the substance misuse treatment caseload across training prisons (12% increase).

7.30 In HMP Bullingdon the number of prisoners in substance misuse treatment has increased by 9% (1,378 prisoners in substance misuse treatment in 2018), following the general upward trend within training prisons, albeit at a lower rate. The high proportion of new receptions that are starting substance misuse treatment could partly explain this.

Chart 41: Change in treatment population, 2018 to 2019, HMP Bullingdon, Training and National Prisons (average) (source: Adult Prison Quarterly Treatment Report, YTD 2017-18 and YTD 2018-19)

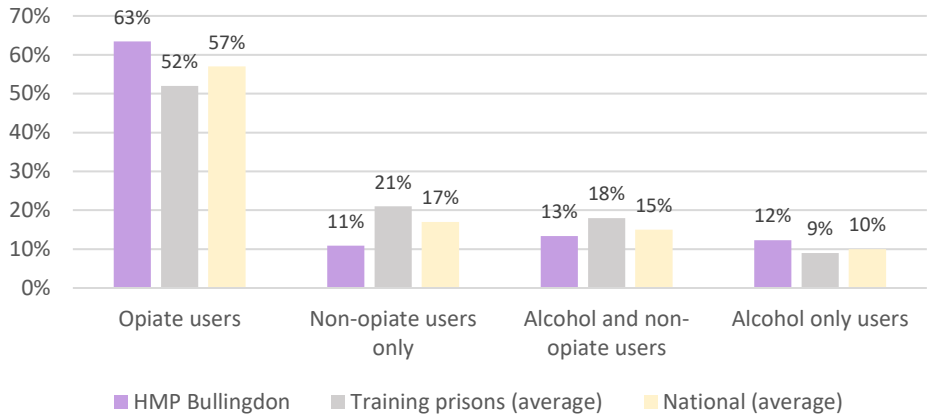


7.31 The chart below shows these prisoners grouped by categories of substance misuse.[67] When comparing the profile of substance use in HMP Bullingdon with the average in training prisons and all prisons in England, there are higher levels of opiate drug citations compared to all other drug and alcohol categories, at 63%. This is based on all substances reported as being problematic and can include more

[67] The treatment population is clustered into these four categories. Individuals are categorised on the substances they have used and will not necessarily be their primary substance use, for example any individual citing the use of an opiate drug will fall into the opiate user category even where their primary drug might be cocaine or cannabis.

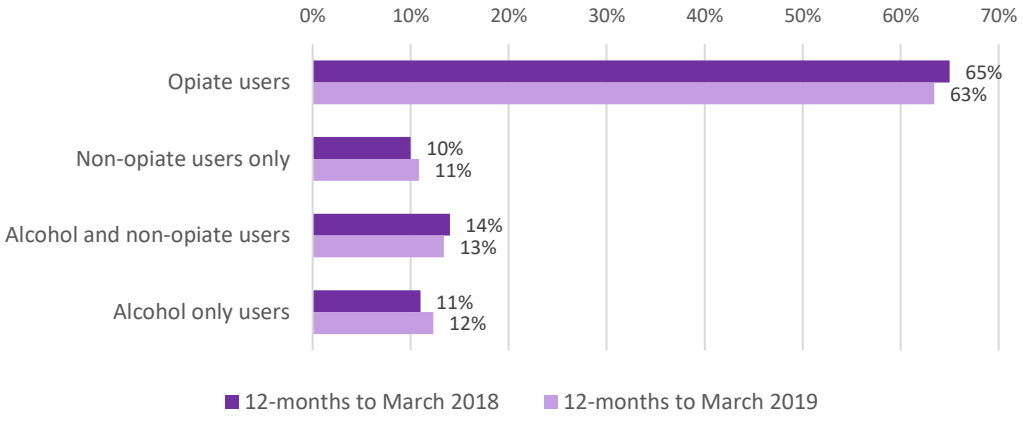
than one substance. One in five prisoners (25%) in HMP Bullingdon reported using alcohol (including alcohol and non-opiate drugs).[68]

Chart 42: Treatment population by substance categories, HMP Bullingdon, Training and National Prisons (average) (source: Adult Prison Quarterly Treatment Report, YTD 2018-19)



7.32 There has been little change in the substance use between the recent and past caseload in HMP Bullingdon.

Chart 43: Change in substance use, HMP Bullingdon (source: Adult Prison Quarterly Treatment Report, YTD 2017-18 and YTD 2018-19)



7.33 The main substances that prisoners report using and for which they are in treatment, are set out in the table below. Almost six in ten (58%) were in treatment reporting opiate drugs as their main substance (including heroin, methadone, methamphetamine or other opiate drugs), followed by alcohol (21%).

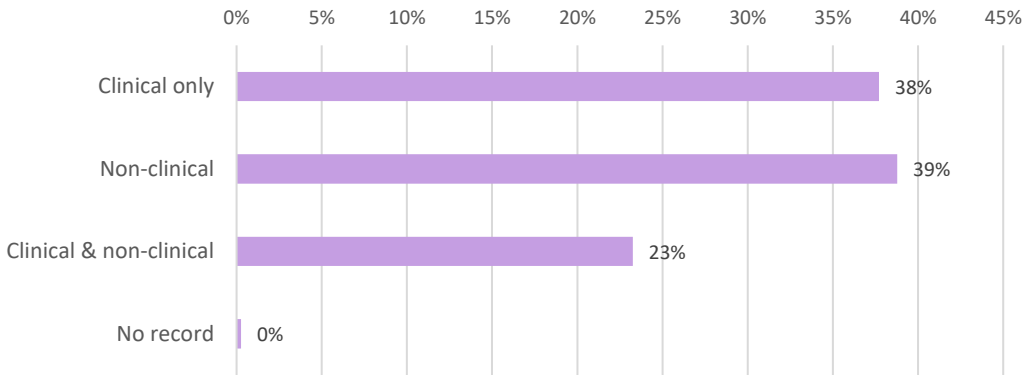
Table 19: Main substance use, 2018-19 (source: Adult Prison Quarterly Treatment Report, YTD 2018-19)

[68] It is important to note that due to the way in which NDTMS categorises substance misuse as all those that are opiate users are classified under 'opiate users' even if they also use alcohol as such they do not appear in the alcohol categorisations and therefore the true proportion of alcohol users is likely to be underrepresented.

Main substance use	(n)	(%)
Heroin	857	57.1%
Alcohol	312	20.8%
Cannabis	115	7.7%
Crack	87	5.8%
Cocaine	71	4.7%
NPS	29	1.9%
Other opiates	10	0.7%
Amphetamines	6	0.4%
Benzodiazepines	6	0.4%
Other	4	0.3%
Methadone	2	0.1%
Ecstasy	1	0.1%
Methamphetamines	1	0.1%
Total	1501	100.0%

7.34 NDTMS data relating to substance misuse treatment interventions shows, in HMP Bullingdon, 61% are receiving some level of non-clinical (psychosocial) interventions including those who are receiving clinical (pharmacological) interventions as well. Although, over one third (38%) are receiving clinical treatment only.

Chart 44: Clinical and non-clinical interventions (source: Adult Prison Quarterly Treatment Report, YTD 2018-19)

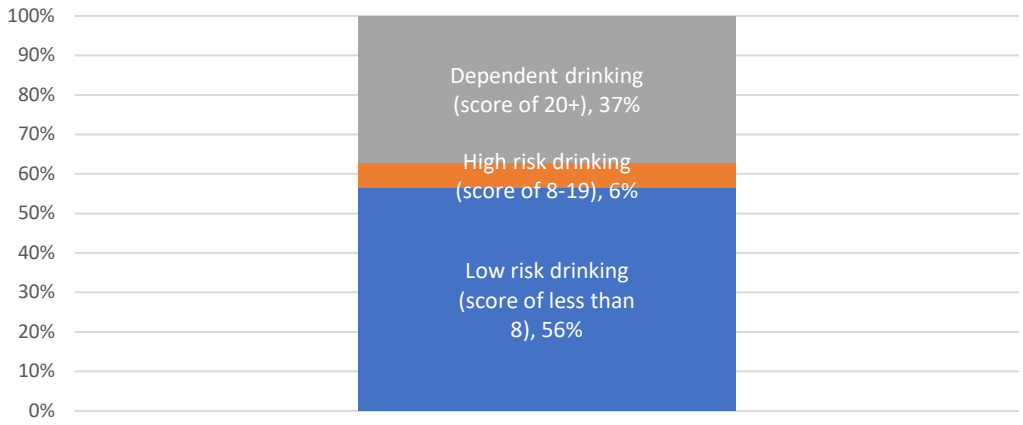


7.35 In addition, given the high proportion of prisoners that are remanded to HMP Bullingdon and therefore do not stay in the prison for long, the DART provide harm minimisation awareness including naloxone training for opiate users. This is mostly done through outreach. The DART felt they had insufficient resources to deliver a range of psychosocial interventions, as most of their time is spent in assessments.

7.36 One in five prisoners on the substance misuse caseload have reported the use of alcohol, and this figure is likely to be underrepresented. The alcohol audit score reported on NDTMS for HMP Bullingdon shows, of the treatment population

reported with an audit score, 37% scored in the range of dependent drinkers and 6% scored in the range of high-risk drinkers.

Chart 45: Alcohol Audit Scores (source: Adult Prison Quarterly Treatment Report, YTD 2018-19)

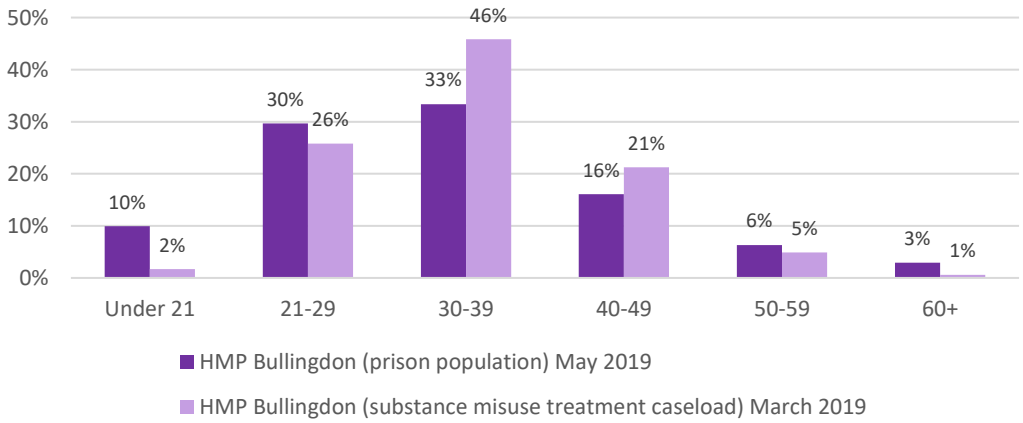


7.37 NDTMS provides demographic information about the prisoners on the substance misuse caseload. The charts below illustrate the age and ethnicity profile of the treatment caseload and compare this to the age and ethnicity profile of the prison population.

7.38 A higher proportion of the treatment caseload are in their thirties (46%) and forties (21%) in comparison to the age profile of the prison population, whilst fewer prisoners on the treatment caseload are under 30 years (26% compared to 41%) and a broadly similar proportion aged 50 and over.

Chart 46: Age profile of substance misuse treatment caseload and HMP Bullingdon prison population (source: Adult Prison Quarterly Treatment Report, YTD 2018-19, HMP Bullingdon)

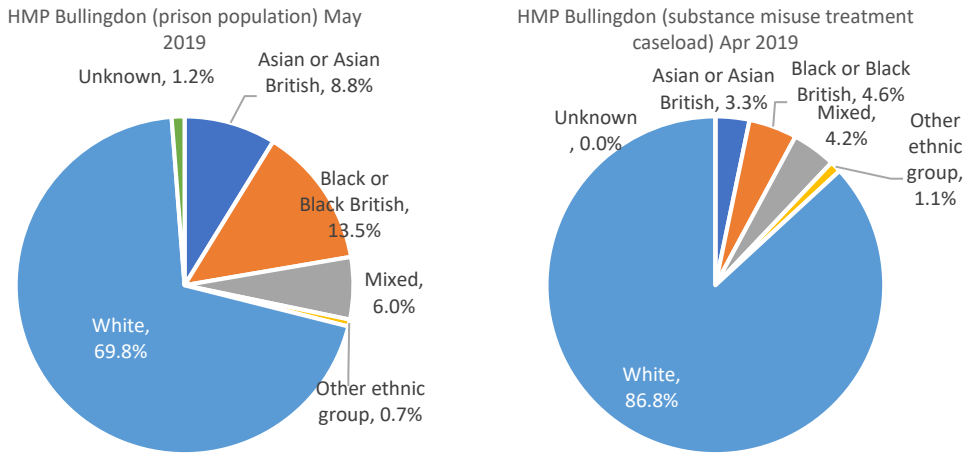
7.39



7.40 Prisoners on the substance misuse caseload are less ethnically diverse than the prison population, with prisoners from BME groups accounting for 13% of the

substance misuse treatment caseload whilst representing 30% of the prison population.

Chart 47: Ethnicity profile of substance misuse treatment caseload and HMP Bullingdon prison population (source: Adult Prison Quarterly Treatment Report, YTD 2018-19, HMP Bullingdon)



7.41 NDTMS data relating to discharges shows, 1,151 prisoners were discharged from substance misuse treatment in total. Of these, 87% (1,006 discharges) were planned treatment discharges, which include prisoners who left HMP Bullingdon, compared to 92% across all training prisons. The remaining 13% were unplanned discharges (145 discharges) and of this 7% dropped out of treatment.

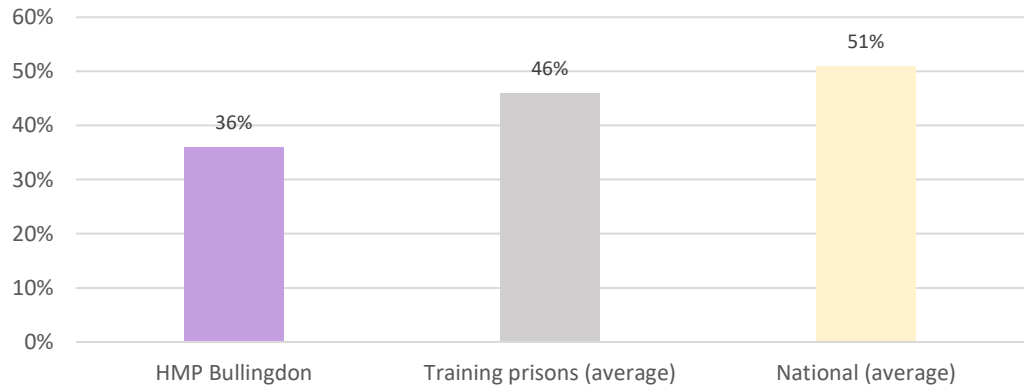
7.42 In total, 1,145 prisoners on the substance misuse caseload left HMP Bullingdon in the reporting period between January and December 2018. 74% were released and 25% transferred to another prison.

7.43 Of the total number of prisoners that left HMP Bullingdon, 621 prisoners were reported as having an ongoing structured treatment need and therefore requiring treatment in the community. Of these, 30% had started treatment in the community within 3 weeks. In comparison to the average for training prisons and the average across all prisons in England (42% and 34% respectively), HMP Bullingdon had fewer people continuing their treatment on leaving the prison.

Chart 48: Starting treatment in the community, HMP Bullingdon, Training and National Prisons (average) (source: Adult Prison Quarterly Treatment Report, YTD 2018-19)

7.44 There were 243 prisoners on the substance misuse treatment caseload that were transferred from HMP Bullingdon to another prison, where it was intended that they continue treatment. Of this, 36% started treatment in their onward prison within 3 weeks of being transferred. A much lower proportion continued their treatment upon leaving HMP Bullingdon, when compared to the average of training prisons and average across all prisons in England.

Chart 49: Starting treatment in a new prison, HMP Bullingdon, Training and National Prisons (average) (source: Adult Prison Quarterly Treatment Report, YTD 2018-19)



Supply of drugs and alcohol

7.45 A report by HM Inspectorate of Prisons set out the changing patterns of drug misuse in adult prisons.[69] The findings from this report suggest that illegal drugs, PS and illicit medications may get into prisons in a number of ways. The nature of the issue means that it is not possible to quantify this, and supply routes are likely to differ from prison to prison. In large training prisons, with long perimeters and relatively free prisoner movement, drugs may be thrown into the prison in small

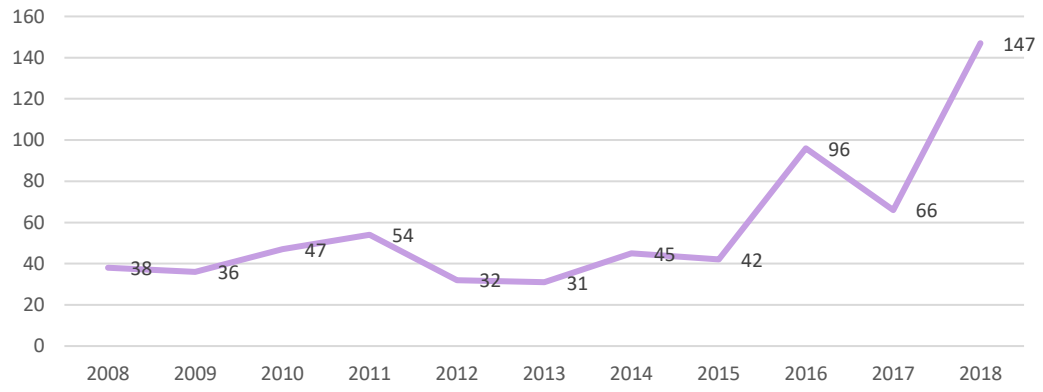
[69] Changing Patterns of Drug Misuse in Adult Prisons and Service Responses, 2015 HM Inspectorate of Prisons (survey of 1,376 - in eight prisons)

packages (in a tennis ball, for instance), in larger packages fired by catapults or, in some recent cases, dropped by drones. Easy access to illicit mobile telephones makes it possible to plan the drops carefully.

7.46 Across prisons in England and Wales, nearly half of men (47%) reported it was easy to get drugs into their prison, and nearly a quarter (23%) said it was easy to get alcohol into their prisons.[70] In the last inspection of HMP Bullingdon, of the prisoner survey respondents, 50% felt it was easy to get illegal drugs in the prison and 33% felt it was easy to get alcohol in the prison.[71]

7.47 Figures on the incidents where drugs are found in prisons are reported by the MOJ. This shows, in HMP Bullingdon, since 2015 there has been an increasing trend in the number of incidents involving drug finds. In the 12-months to March 2018, there were 147 incidents where drugs were found.

Chart 50: HMP Bullingdon, Incidents where drugs were found (source: Table 9, HM Prison and Probation Service Annual Digest, 2018)



Mandatory drug testing

7.48 Illicit substance use in most prisons is a serious threat to the security of the prison system, the health of individual prisoners and staff members. One way to measure the level of drug misuse in prisons is through the random Mandatory Drug Testing (MDT) programme. The aim of MDT is to test a random sample of 5% or 10% of prisoners each month (depending on prison capacity) and to monitor and deter drug misuse.

7.49 Figures on MDT outcomes in prisons are reported by the MOJ. This data shows, in the 12 months leading to March 2018, across all prisons in England and Wales the mandatory drug test (MDT) positive rate was 20% of which 12% positive test results were for psychoactive substances. The table below shows the MDT outcomes for HMP Bullingdon compared to the outcomes for all prisons. This shows, the overall MDT positive rate for HMP Bullingdon was higher in comparison

[70] HM Chief Inspector of Prisons for England and Wales (2017), Annual Report 2016-17
[71] Unannounced Inspection of HMP Bullingdon (2017), HM Chief Inspector of Prisons

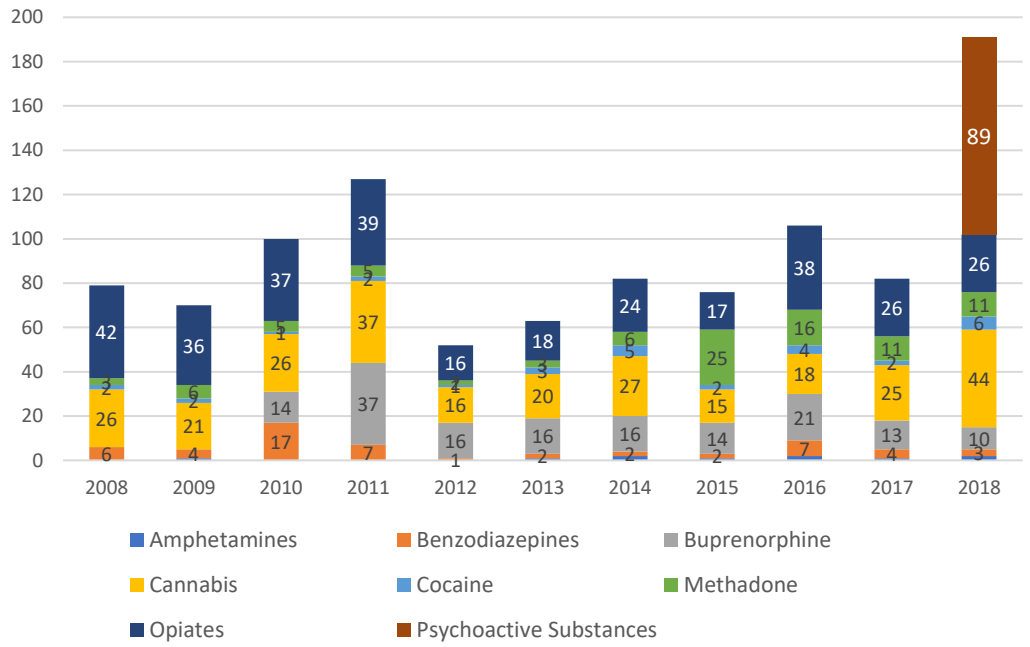
to the average of all prisons, at 24% and of this half were positive results for traditional drugs and the other half psychoactive substances.[72][73]

Table 20: Random MDT outcomes (source: Table 7, HM Prison and Probation Service Annual Digest, 2018)

Random MDT outcomes	HMP Bullingdon	All prisons
Tests administered	731	56303
Traditional drugs positive tests	91	5752
Traditional drugs positive tests percentage (%)	*13.1%*	*10.6%*
Psychoactive Substances Positive Tests	89	6636
Psychoactive Substances positive tests percentage (%)	*12.8%*	*12.2%*
All Positive Tests	167	11093
All positive tests percentage (%)	*24.1%*	*20.4%*

7.50 Over the past decade, most MDT results in HMP Bullingdon have been for opiate drugs (including methadone) and then cannabis. However, in 2018, this trend has shifted with the number of positive results for cannabis exceeding opiate drugs. With the inclusion of PS in the prison MDT testing programmes in September 2017, there is now a more accurate picture of drug misuse in prisons. Figures for 2018 show PS accounted for 87% of positive MDT results whereas the average across all prisons is just over half (54%).

Chart 51: Random MDT positive test results (trends) 2008 – 2018 (source: Table 7a, HM Prison and Probation Service Annual Digest, 2018)



[72] HM Prisons and Probation Service Annual Digest (2018)

[73] Traditional drugs include; amphetamines, barbiturates, benzodiazepines buprenorphine cannabis, cocaine, methadone and opiates

7.51 The DART reported the prevalence of illicit drug use was high throughout the prison. The substances were wide and varying and included heroin, crack cocaine, cocaine, PS (especially spice) as well as prescribed medications such as pregabalin.

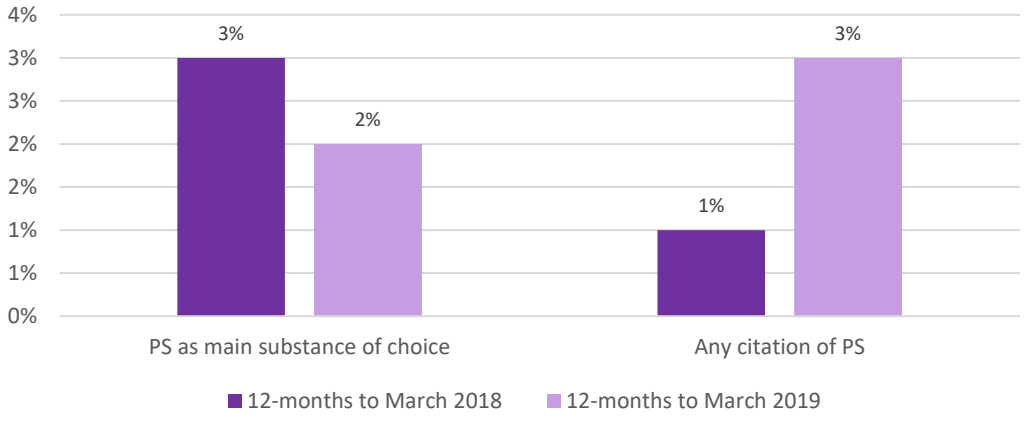
Psychoactive Substances

7.52 Across all prisons in England and Wales, there are real concerns about the use of psychoactive substances (PS). The level of PS use varies and fluctuates in each prison and the true prevalence is unknown as it can only in part be measured by the number of men presenting with the physical symptoms indicative of PS use or through PS finds during prison searches.

7.53 As reported above, in 2018, 87% of positive MDT results were for PS, a greater proportion in comparison to national figures where positive PS results account for 60% of all random MDT outcomes.

7.54 The proportion of prisoners on the substance misuse caseload reported on NDTMS, shows that 3% cited the use of PS as one of their substances used, lower than the national average across all prisons in England and Wales (9%), 2% had reported PS as their main substance of choice. In the previous year, however, there were a lower proportion of prisoners citing PS on the caseload (1%) but a higher proportion reporting PS as their main substance of choice (3%).

Chart 52: PS as main substance of choice and any citation of PS, 2018 and 2019 (source: Adult Prison Quarterly Treatment Report, YTD 2017-18 and YTD 2018-19)



7.55 The DART felt that PS use, particularly spice, was problematic in the prison.

Dual diagnosis

7.56 There is a strong focus on dual diagnosis within the national service specification for Integrated Substance Misuse Treatment Service for prisons in England.[74] In HMP Bullingdon, the relationship between substance misuse and mental health services

[74] Integrated Substance Misuse Treatment Service, Prisons in England (2018), Service Specification, NHS England 2018

was described as less effective than it could be and this in part was due to the two services being located quite far apart from one another. Usually the substance misuse service will carry out an assessment and wait until the prisoner is ready to engage, for example once their mental needs are being addressed. However, whilst there are only a few prisoners with dual diagnosis needs, there is no formal pathway for dual diagnosis.

Section summary

7.57 The table below summarises the estimates of drug and alcohol use among prisoners:

Table 21: Summary of estimates of drug and alcohol use

Drug and alcohol use	Estimates	Expected (rounded)
Prisoners that would have used drugs in the month prior to entering prison	64%	680
Prisoners that develop a problem with illegal drugs in prisons	11%	115
Prisoners that would have reporting drinking in the month prior to entering the prison, of this population:	87%	920
• Prisoners that would have reported having some problems with their drinking	46%	420
• Prisoner that felt their drinking was out of control	39%	360

7.58 In May 2019, 16% of the prison population of HMP Bullingdon was in clinical substance misuse treatment and 18% were in psychosocial substance misuse treatment (including some that are also receiving clinical treatment).

7.59 HMP Bullingdon is a prison with a high turnover rate, and as such it has a high throughput of prisoners accessing treatment, albeit in some cases for a short period of time. Much of the work of the DART is focused around assessment, harm minimisation and group work.

7.60 NDTMS data shows there are effective processes in place for early identification and engagement with treatment. In the 12-month period ending March 2019 there has

been a 9% increase in the number of prisoners in treatment, against the previous year.

7.61 The service utilisation rate for substance misuse clinics is 89%. Clinic DNAs are low, at 3%, though DNA rates for groups fluctuate and half the expected number has been known to attend clinics.

7.62 Prisoners on the substance misuse caseload are less diverse than the prison population, with prisoners from BME groups accounting for 13%, whilst representing 30% of the prison population.

7.63 Most of the prisoners in substance misuse treatment are in their thirties (46%) and twenties (41%) and are overrepresented when comparing to the age profile of the prison population.

7.64 Those on the substance misuse treatment caseload are reporting recent or historic drug and alcohol use.

7.65 30% of prisoners leaving HMP Bullingdon that had an ongoing treatment need started treatment in the community within 3 weeks, lower than comparable prisons.

7.66 36% of prisoners that were transferred from HMP Bullingdon to another prison that had an ongoing treatment need started treatment in their new prison within 3 weeks. This is also lower than comparable prisons.

7.67 A higher proportion of prisoners felt it was easy to get drugs or alcohol in the prison (50% and 33% respectively) compared to the average across all prisons (47% and 23% respectively). The DART reported the prevalence of illicit drug use was high and varied in the type of drugs. Moreover 44% of respondents to the stakeholder survey felt that more than 60% of the prison's population were using illicit substances whilst in prison.

7.68 Outcomes of the random MDT at the end of 2018 show the positive test results in HMP Bullingdon were 24%. This is higher compared to the average across all prisons (20%). However, 87% of all tests were positive for PS, whereas across all prisons this was 54%.

7.69 In the 12-months leading to March 2019, there were less prisoners in treatment reporting the use of PS compared to the previous year.

7.70 Through focus groups it was found that service users felt it was important to introduce:

- Supportive responses to positive MDTs in preference to punitive ones
- Structured mentor/rep programme
- Introduction of AA/NA
- Wider course content
- Group interventions or wing-based drop ins
- Recovery awareness days
- Additional Gym – more meaningful and purposeful activities

Section Recommendations

7.71 Key recommendations from a substance misuse perspective include:

- Incorporation of the DART activity data onto SystmOne to ensure data compatibility. This will require some supportive infrastructure.
- Continue to support the joint working between clinical and psychosocial substance misuse teams.
- Continue to raise awareness of substance misuse services among prison staff.
- Develop evidence-based interventions including psychological interventions as recommended by NICE and other relevant bodies. This should include a group programme and provide a dual diagnosis group.

8 Social Care need and demand

Introduction

8.1 The Care Act (2014) came into effect in April 2015 and made English local authorities responsible for assessing and meeting the social care needs of adult prisoners, for providing care and support where those needs meet the eligibility criteria and for transferring that care back into the community at the sentence end.

8.2 It places a duty on HMPPS to co-operate with local authorities to ensure the effective provision of social care. People in custody who have needs for care and support should have access to the care they require, and it should be equivalent to what they would receive as a member of the general population. Individuals in prison often have complex health and care needs and experience poorer health outcomes than the general population.

8.3 Oxfordshire County Council (OCC) are responsible for the provision of social care for prisons in the Oxford cluster. In April 2019, the prison, healthcare and OCC (Adult Social Care) finalised a memorandum of understanding (MOU) that is now in place, which sets out the roles and responsibilities and the management of social care among the partners. The MOU describes the care pathway for the referral, assessment and provision of social care for all prisoners that have a need, whilst ensuring each prisoners' continuity of social care is planned when prisoners are released to the community or transferred to another prison. All referrals for social care are sent by the safer custody team to OCC. The prison receives referrals from all health services, with most social care needs being picked up at reception.

8.4 OCC have a team that consists of social workers and occupational therapists that assess prisoners for their social care needs and provide the required equipment, adaptations and care packages (OCC assess and determine the care hours a prisoners is eligible for and have commissioned Care UK to deliver the care provision).

8.5 The HMCIP inspection of HMP Bullingdon in 2017 found the prison had developed an effective working relationship with OCC to assess prisoners with potential social care needs. OCC are in regular attendance at partnership board meetings in the Oxford prison cluster.

Care Packages

8.6 Previously, domiciliary care packages were delivered by external care providers when required, since April 2019, OCC have commissioned Care UK to provide domiciliary care for those prisoners that have been assessed and are eligible for

care packages. The team consists of 9.5 health care assistants employed through Care UK, who are responsible for delivering this care.

8.7 Prisoners through a buddy system are helping to support other prisoners. This was noted in the HMCIP annual report. It stated that many prisons had created 'carer' roles for men to support fellow prisoners with disabilities, but although this was an effective response to providing support, there was a general lack of training and a concerning lack of supervision to safeguard potentially vulnerable people.

8.8 In HMP Bullingdon, there is a buddy system in place with 'buddies' located on E wing. These buddies assist prisoners with disabilities in their day-to-day living activities, including cell cleaning and collecting meals but they cannot deliver any aspects of intimate care. The OCC felt there was a need to provide more training and support for prisoners that act as buddies.

8.9 OCC shared their views about the importance of supporting prisoners with disabilities to feel 'enabled' as a critical component of their care, especially in preparation for release, and that this could only happen where adequate support and training is in place. In the experience of OCC, too often the need of prisoners with disabilities are met by having their day to day tasks completed for them rather than being enabled to do some of these tasks with support where needed. In such cases individuals are not 'learning' to do more for themselves, which will have a significant impact on their ability to manage when they leave the prison.

8.10 On reflection through the research undertaken prisoners have stated a view that there is a distinct lack of social care provision particularly for older people and people with wider neurodiverse conditions. They recognised the 'buddy' system that is in place but felt that there needed to be more assessments, specialist care, and adaptations particularly for older patients.

Social care need

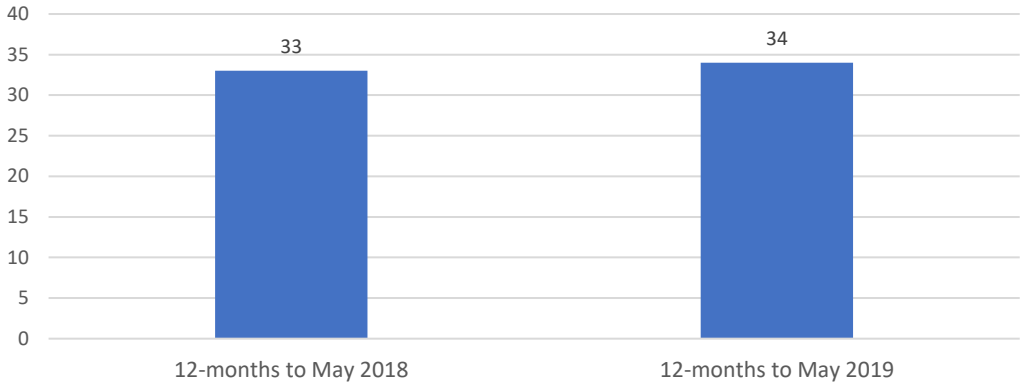
8.11 The age profile of prisoners in HMP Bullingdon is distributed across all age groups but overall is younger with 63% prisoners aged between 21 and 40 years (this age group represent 31% of the male prison population in England and Wales). Whilst an ageing prison population is associated with increasing demand for social care, social care needs are not limited to older prisoners. In HMP Bullingdon, 11% of the prison population are aged 50 years or over. Whilst this is a significant proportion, it remains below the average of 16% across all male prisons in England and Wales.

8.12 The survey results of the most recent inspection of HMP Bullingdon found that 31% of the prisoners surveyed considered themselves to have a disability. In the HMCIP annual report 2018, 29% of the male prison population had declared a disability.

The disabilities described included a range of physical, mental and learning disabilities.

8.13 Data provided by OCC shows there were 34 social care referrals in the 12-months leading to May 2019, and no significant increase or decrease compared with the previous 12-months.

Chart 53: Social care referrals to OCC (source: OCC 2019)



8.14 Of the 34 referrals, 41% (14 prisoners) were eligible for social care and a further 9% were awaiting assessment. Almost one in three (29%) were not eligible following assessment. A further 12% had left the prison prior to being assessed. . There was no outcome available for the remaining 9%.

Table 22: Referral outcomes, 12-months to May 2019 (source: OCC 2019)

Referral outcome	(n)	(%)
No appropriate (or no outcome provided)	3	9%
Not eligible	10	29%
Eligible	14	41%
To be assessed	3	9%
Left HMP Bullingdon	4	12%
Total	34	100%

8.15 Of those prisoners that were eligible, their social care needs were either for equipment including adaptations only (50%), care packages only (21%) or both equipment and care (29%).

Table 23: Social care needs, 12-months to May 2019 (source: OCC 2019)

Social care provision	(n)	(%)
Equipment only needs	7	50%
Care only needs	3	21%
Equipment & Care needs	4	29%
Total	14	100%

8.16 As HMP Bullingdon has a sex offender wing, with a capacity of 191 cells, this would indicate there would always be some level of social care needs for this largely older population.

8.17 Healthcare perceived that, where identified, social care needs are being met. However, there is a general lack of understanding among prison officers about what constitutes a social care need and sometimes the distinction between social care and healthcare is not made. This has become more apparent since April 2019 when healthcare was commissioned to deliver care packages, with most prison and wider healthcare services assuming all social care needs are being met by primary healthcare. The need to raise awareness or provide training to address this was highlighted. This was also raised as a concern by OCC.

Prisoners with physical disabilities

8.18 Most prisons having been built in past decades and are not designed to meet the needs of prisoners with physical disabilities, with little provision of access to disabled cells. In some cases, prisoners end up in inpatient units when there is nowhere suitable to meet their needs. There are two cells in HMP Bullingdon that can accommodate wheelchair users, however this is insufficient to meet their needs. At the time of this report, 4 prisoners were located in the inpatient unit, of which one had been resident there since 2015. This has an impact on healthcare, which as a result have less inpatient provision for prisoners with health needs. In addition to this, OCC reported the lack of storage facilities were equally problematic in HMP Bullingdon.

Section summary

8.19 Since April 2019, a MOU is in place for the management of the social care needs in the Oxford prison cluster, and Care UK have been commissioned to provide care for those prisoners eligible for care packages.

8.20 In the results of the most recent inspection of HMP Bullingdon - 31% of the prisoners that were surveyed considered themselves to have a disability. The disabilities described included a range of physical, mental and learning disabilities.

8.21 There have been 34 referrals to social care in the 12-months leading to May 2019 and 40% were eligible for equipment, care or both.

8.22 Findings from the stakeholder survey suggest that from a social care perspective there were concerns with respect to the adequacy of staffing, and social care provision generally and also the continuity of care arrangements on release back to the community. Findings from the primary care focus groups of service users

indicated that residents feel there is an increased need of social care for older adults with more adaptations required for their environment

Section Recommendations

8.23 Key recommendations from a social care perspective include:

- Implement training for all prison staff to better understand the social care needs arrangements and referral pathway for prisoners
- Establish formal training for 'buddy'/'enabler' scheme.

9 Screening, immunisation and health promotion

9.1 This section will review the prison's performance against national screening programmes and where feasible seek to identify specific health needs accordingly. This will also review the prison's wellbeing and health promotions programmes, many of which are seeking to prevent disease and its escalation.

National Screening Programmes

9.2 The table below shows the HJIP reporting of screening activity carried out in HMP Bullingdon during 12-month period between April 2018 to March 2019. Screening reports include, abdominal aortic aneurysm (AAA) screening, retinal screening, NHS Prison Physical Health Checks Screening, and tuberculosis screening. The details are based on the total numbers of eligible patients between April 2018 and March 2019 and the proportion of eligible patients that have been screened.

Table 24: Screening data Apr 18 Mar 2019 Abdominal Aortic Aneurysm (AAA) Screening, Retnal Screening, Chlamydia Screening, NHS Prison Physical Health Checks Screening, and Tuberculosis Screening (HJIP)

Denominator/Numerator	2018-19 Total	Average/month
Abdominal Aortic Aneurysm (AAA) - Number of patients screened	454	38
Abdominal Aortic Aneurysm (AAA) - Number of patients screened	14	1
%	3%	3%
Retinal Screening - total number eligible during the reporting g month - All patients with diabetes who have not been screened in the preceding 11 months	418	35
Retinal Screening - Number of patients screened in the reporting month	27	2
%	6%	6%
NHS Health Check - Total Number Eligible during the reporting month	3707	309
NHS Health Checks - Number of patients screened during the reporting month	34	3
%	1%	1%
Total Number of Receptions and transfers	4697	391
Tuberculosis (TB) Screening - Number of patients who underwent a medication check	454	38
%	10%	10%

9.3 From the HJIP records over this period there has been a 3% take up of AAA screening, 6% take up of retinal screening, 1% take up of NHS Health Checks and

10% of the intake undertook a TB screen. Clearly the screening programme is available in the prison, however it would seem there is a relatively low take up and prisoners are not responding to the service offer.

Communicable disease

9.4 The table below sets out the levels of Hepatitis B and Hepatitis C testing completed in the last year.

Table 25: Hep B and HC Screening April 18-Mar 19 (HJIP)_

Denominator/Numerator	2018-19 Total	Average/month
All new receptions and transfers (excluding those already vaccinated)	2460	205
Hepatitis B Testing - Number of patients offered testing	2160	180
%	88%	88%
All new receptions and transfers (less those already vaccinated, diagnosed with, or treated for Hep B [XaPEy])	1881	157
Total Number of Patients who have a HBsAG test	1021	85
%	54%	54%
Total number of receptions & transfers (in the period, less those already diagnosed with or treated for Hep C [XaPLI])	3771	314
Hepatitis C Offered - Number of patients offered testing	3354	280
	89%	89%
Total number of receptions & transfers (in the period, less those already diagnosed with or treated for Hep C [XaPLI])	3771	314
Hepatitis C HCV Ab - Number of patients tested	2210	184
%	59%	59%

9.5 A Hepatology nurse comes in from Oxford weekly to review patients who have tested positive for Hepatitis C or Hepatitis B. Since the April 'dry spot' testing has been implemented in the prison and this is carried out during prisoner's secondary screenings. Early indications suggest that this has significantly increased the volume of patients being screened positively.

Sexual Health

9.6 Sexual health screening activity is carried out and is recorded on SystmOne. This shows the levels of chlamydia screening between April 18 to March 19.

Table 26: Sexual Health Screening April 18-Mar 19 (HJIP)_

Denominator/Numerator	2018-19 Total	Average/month
Chlamydia screening - total number eligible during the reporting month	368	31
Chlamydia Screening - number of patients screened during the reporting month	59	5
%	16%	16%
HIV Testing - Total number of receptions & transfers (in the period, less those already confirmed HIV positive (43C3))	3863	322
HIV Testing - Number of patients who have been tested, Xalon (HIV screening test)	2234	186
%	58%	58%
HIV Testing - Total number of confirmed diagnosis of HIV	14	1
HIV Testing - Number of patients who were seen at hospital within 2 weeks of diagnosis	5	0.4
	36%	36%

Sexual Health Clinics

9.7 The sexual health nurse runs regular sessions to support patients with sexual health needs and is further supported by a staff member of the Oxford Health GUM who visits the prison fortnightly.

9.8 GUM staff previously saw all sexual health patients but since the increase in sexual health nursing provision, they now only see symptomatic patients and patients with positive test results.

9.9 Healthcare ran a report showing that 55 men were seen by the sexual health clinic from 1st April 2018 to the 1st April 2019. They were not wholly sure about the accuracy of this data but confirmed there is a high DNA rate for sexual health clinics.

Immunisations and Vaccinations

9.10 The HJIP reports cover the monthly numbers of patients eligible for, and receiving, certain immunisations. This is presented below. The healthcare team provides the full range of flu and pneumococcal vaccinations.

Table 27: Immunisations and Vaccinations April 18-Mar 19 (HJIP)

Denominator/Numerator	2018-19 Total	Average/month
Flu Vacs - Number of patients eligible during the reporting month	1056	88
Flu Vacs - Number of patients receiving a flu vaccination during the reporting month	153	13
%	14%	14%
MMR Uptake - number of patients eligible during the reporting month	4382	365
MMR Uptake - Number of patients vaccinated during the reporting month	164	14
%	4%	4%
Men C Uptake - Number of patients eligible during the reporting month	2273	189
Men C Uptake - Number of patients vaccinated during the reporting month	91	8
%	4%	4%
Shingles Uptake - Number of patients eligible during the reporting month	11	1
Shingles - Number of patients vaccinated	0	0
%	0%	0%
Hepatitis B uptake - Total number of patients eligible of Hep B vaccinations during the reporting month	1400	117
Hepatitis B - Uptake - Number of patients receiving a vaccination, within the reporting month	158	13
%	11%	11%

9.11 Across 2018-2019 the proportion of patients eligible for immunisations and vaccinations seems quite variable and generally quite low. In part this may be because of the volume of prisoner movement throughout the year and the seasonal nature of some of these immunisation programmes. In addition, low levels are often a result of nurses not having the appropriate training. Moreover, it is difficult to get patients to take up these vaccination offers in spite of eligibility and this has often resulted in nursing staff pursuing patients on the wings to help increase the level of completed vaccinations.

Infection control audit

9.12 Care UK is now implementing a rolling audit to meet compliance in a wide range of priority areas, including infection control. Different aspects of an infection control audit are reviewed as part of a monthly rolling programme. The last time a complete audit report was available was in September 2018. At this time, it identified that improvements have been made to those areas previously below full compliance, particularly with respect to standard precautions including isolation, TB management and outbreak management. The full table is set out below:

Table 28: Infection control audit findings September 2018 and May 2019 (Care UK)

Infection, prevention and control	Sep-18	Subsequent Audit to May 2019
IPC 01 Strategy and scope	100%	Not yet audited
IPC 02 Standard precautions including isolation	83%	100%
IPC 03 Hand Hygiene	67%	Not yet audited
IPC 03 Patient Led Hand Hygiene audit	100%	Not yet audited
IPC 04 Decontamination of equipment	93%	Not yet audited
IPC 05 Sharps management	89%	86%
IPC 09 Infection risks associated with waste and body fluids	79%	Not yet audited
IPC 10 Assessment of the Care Environment (including cars)	75%	Not yet audited
IPC 13 Aseptic technique	97%	Not yet audited
IPC 19 Tuberculosis management	93%	100%
IPC 21 Outbreak management	97%	100%

Wellbeing and Health Promotion

9.13 The table below sets out the prison's health promotions campaigns calendar.

Table 29: HMP Bullingdon Health promotions Campaign Calendar 2019

Month	Health Promotions activity
January	Dry January Obesity awareness week
February	National Heart Foundation month World Cancer Day
March	Prostate Cancer Awareness Month Self-harm awareness
April	Bowell Cancer awareness
May	National walking and smile month Mental Health awareness Action on Stroke
June	Healthy eating week Men's health week Diabetes week
July	Samaritans awareness
August	Psoriasis awareness
September	Suicide prevention day Sexual health week World Heart Day
October	Stoptober World mental health day World hand washing day
November	Lung cancer awareness day Pancreatic cancer awareness World diabetes day
December	Epilepsy awareness Anger awareness

9.14 Throughout all these health promotion activities, healthcare work with the prison and jointly develop programmes, which are supported with leaflets and relevant educational materials. In some cases, sessional activities and exhibitions are put in place to enable prisoners to undertake testing and screening as well as to raise awareness of these conditions.

Smoking

9.15 HMP Bullingdon went smoke free in 2018. Nonetheless being a local prison, it still takes in receptions and transfers of prisoners who are smokers. Public Health England's health profiles show that smoking prevalence in England is 17% of the

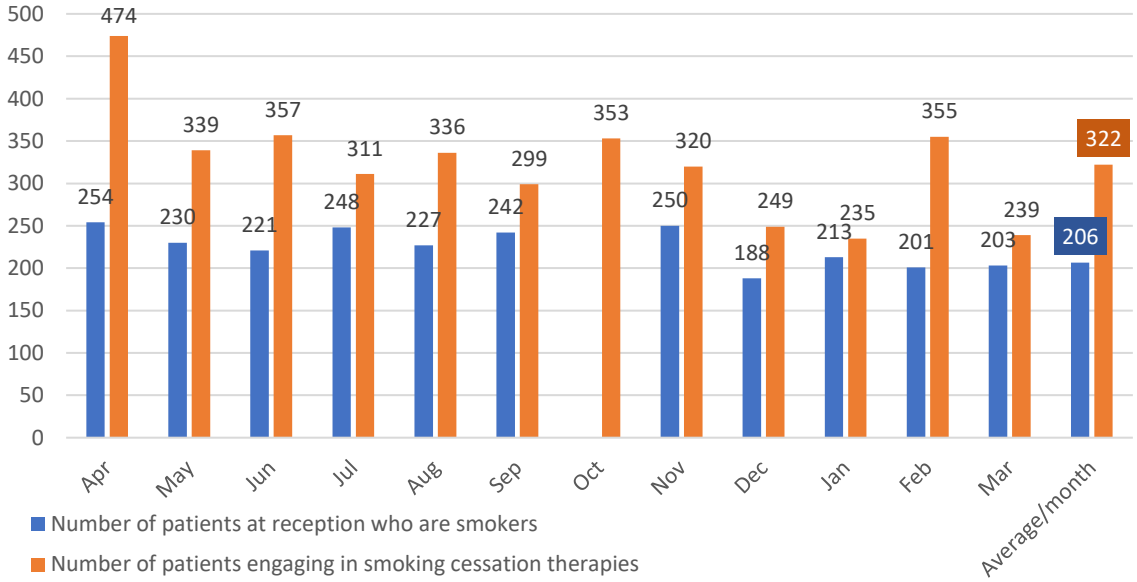
population, whereas for the South East (Hampshire, Isle of Wight and Thames Valley) NHS region it was 15%.

9.16 The situation in prison is quite different with 51%[75] of the national male prison population stating they are smokers. On a local basis of the 3,940 receptions and transfers taken by HMP Bullingdon between April 2018 and March 2019, 2,477 reported as smokers. This results in a smoking prevalence of 63%.

9.17 Clearly there is a real disparity between the volumes of smokers nationally and regionally and the proportions of smokers in the prison. This proportion is likely to be sustained post reconfiguration although with increasing numbers coming into the prison there is likely to be more prisoners in total who are smokers.

9.18 On average per month there were 962 smokers and of these 322 undertook smoking cessation therapies, which represents 33% of smokers.

Chart 54: HMP Bullingdon Smokers & Smoking cessation Apr 18 to Mar 19



Smoking cessation/reduction

9.19 In terms of smoking cessation, each prisoner is asked about their smoking status in the first 72 hours. Every prisoner that identifies as a smoker is offered smoking cessation services. Prisoners who engage with smoking cessation services are placed on an 8-week course. The most complex patients with severe mental health issues or complex co-morbidities will have one on one sessions with a pharmacy technician trained in smoking cessation provision and will receive nicotine replacement therapy.

[75] HJIP National Report 2018/19 Q4

Mental health promotions and well-being

9.20 In May 2019, there was a physical and mental health awareness month for staff and prisoners which included:

- Interactive workshops for prisoners and all staff
- Forums for prisoners and staff
- Mental Health and Wellbeing days
- Mental Health awareness training
- Personality Disorder awareness training

Health eating

9.21 The healthcare dietitian has been extremely active in working with the kitchens to ensure that the food offers in the prison are healthy. There is a healthy option indicated on every menu sheet which prisoners with concerns about their weight or health are encouraged to choose. A weight management clinic has been set up with dietary advice provided to prisoners on this course. Diabetics have had opportunities to meet with appropriate clinicians who will advise them on the appropriate diet to control diabetes. The Dietitian also works with senior officers on the wings to ensure that prisoners get access to healthy food.

9.22 Healthcare's dietician is in frequent correspondence with the kitchens. The healthcare department especially gives advice on diabetic patients; with the prison supplying "diabetic packs" with sugar replacements, jam alternatives and an extra sandwich for overnight consumption. Healthcare also makes recommendations to the kitchens about varying health conditions that may require special diets.

Oral health promotion

9.23 Oral health promotion is a strong commitment from Time for Teeth and the service's dental nurse works within the prison to support oral health promotion.

Physical Activity

9.24 The weight management clinic is linked with the gym department and provides advice on physical activity. A back-pain clinic is run between the gym and the healthcare department to try and improve back pain through physical activity. However, currently, physical activity opportunities are somewhat limited.

Health Promotion Literature

9.25 Health promotion literature is provided in the main healthcare centre and on the wings. It covers a wide variety of topics including; sleep problems, HIV, back pain, hepatitis, TB, arthritis, gout, strokes, healthy eating and looking after your health. All leaflets are provided in English and literature in other languages is also available.

Health Champions/Peer led services

9.26 Every wing has a prisoner healthcare rep. Their duties include delivering slips and collecting people for medication and triage. However, a major part of their role is health promotion. They are given information about communicable disease, hepatitis B vaccinations and some other basic health information. They then share this information with prisoners in a way that healthcare professionals might not be able to, to try and increase the uptake of screening and vaccination services.

Section Summary

9.27 Healthcare has many pressing throughput priorities, which often draw it away from many of the core activities that are critical to supporting disease prevention and escalation.

9.28 Being a busy local prison the most significant points at which national screening and disease screening are most likely to be addressed is at the second reception session with new patients.

9.29 Currently there is a low take up of AAA screening (3%), retinal screening (6%), NHS health checks (1%) and TB Screening (10%).

9.30 From a communicable disease perspective there has previously been a relatively strong take up of hepatitis B and hepatitis C testing and this is likely to improve significantly with the introduction of dry spot testing which was introduced in April.

9.31 HIV screening is also relatively effective, with 58% of reception prisoners being tested. However, the figure of 36% of those that test positive being seen in hospital within 2 weeks of diagnosis is potentially a concern, although this may clearly be because prisoners are either released or transferred to other establishments post sentencing.

9.32 At 16% the level of chlamydia screening does seem relatively low but this is relatively typical for a prison that is focused on reception. The national average for prisons is 16% which is the same as HMP Bullingdon.

9.33 Bullingdon's Infection control audit is strong and is showing improvement with the introduction of a rolling programme of audits enabling healthcare to focus on embedding improvements.

9.34 The level of smokers in the prison, as they enter, is high at 63% of new receptions. This is likely to remain constant as a percentage however with the increasing

numbers coming into the prison this figure of prisoners needing support for smoking cessation will increase.

9.35 From a health and well being perspective there are a range of campaigns and health promotions activities that are being run by healthcare and jointly with the prison.

9.36 The healthcare team dietitian supports the programmes for dietary wellbeing.

9.37 The development peer mentors will be important going forward, particularly in light of the prison's reconfiguration and in particular the need to retain prisoners with these skills to support men living on each wing.

10 Impact of HMP Bullingdon's potential reconfiguration

10.1 In November 2016, the Prison Safety and Reform White Paper was released outlining the vision for the future of the prison estate. The paper includes giving governors more power and accountability as co-commissioners and joint accountability for access to health services.

10.2 The Prison Estate Transformation Programme (PETP) is responsible for delivering the vision of the estate set out in the White Paper. The change will result in a simplified estate with Reception, Training and Resettlement Prisons (See below).

10.3 To support prisons in understanding their population and delivering their function, PETP has developed Models for Operational Delivery (MOD). The MOD brings together for the first time a comprehensive analysis of the latest evidence for the types of prisoner that will be held in each prison type in the reconfigured estate; it sets out the nature of the services and activities a prison should deliver; includes design (or redesigns) processes integral to the change in function; and can be used to help inform resourcing decisions.

10.4 HMP Bullingdon is in the second phase of this process of prison estate reconfiguration. The main change that reconfiguration will bring will be in the proportion of sentenced and remand prisoners. Currently the population is split 75% sentenced and 25% remand but post reconfiguration this is expected to change to 45% resettlement (sentenced) and 55% receptions (including remand and transfers). E-wing which houses 191 men convicted of sexual offences would remain irrespective their status. This would require the same level of primary care services (long term conditions and frailty support that is currently available). HMP Bullingdon's receptions would be based on its current feeder courts and those from HMP Woodhill.

10.5 The likely impact of these changes will be;

- An increase in the churn of the population
- A larger number of prisoners on short sentences, increasing the number of unknown and unpredictable men being screened and in need of immediate stabilisation on medication. The remand population is higher risk and requires increased intervention including overnight support.
- The age profile is likely to decrease even further with the removal of the longer sentenced prisoners.
- We anticipate fewer court attendances, as video link will be introduced. This will require a modified pathway to identify and assess those who have had a significant change in status.
- Higher number of unstable new receptions with both mental health and substance misuse needs.
- Anticipated increase in violence necessitating medical intervention.
- An increase in the number of escorts required.

- An increase in the volume and variety of medication dispensing, due to the increase in numbers of drug users who will require immediate stabilization as well as an increase in those suffering with both long term and acute mental health issues who require assessment and medication.

10.6 To better understand the impact of this process of reconfiguration on the health provision at HMP Bullingdon this HNA has been tasked with supporting a modelling exercise of the likely changes in the service provision in the prison. As part of this brief, lessons learnt from the first phase at HMP Durham have been considered in this model and, where possible, applied to a local review of resources. This it to ensure that commissioners are best placed to make their case for additional resources to support this process of reconfiguration. Finally, it was important within this exercise to ensure that the health, safety and wellbeing of prisoners are maintained, both to secure NHS England standards and to meet future contract specification requirements.

The modelling methodology explained

10.7 To establish this model, data has been taken from P-Nomis and HJIP and compared to review the numbers of prisoner receptions and transfers currently coming into the prison. In particular this aims to identify the current baseline levels of first night and secondary screenings undertaken.

10.8 From this baseline a number of assumptions were reviewed by the prison, healthcare and NHS England. This was done to establish what was most likely to be the proportionate levels of activity needed going forward. The assumption (referred to as 'assumption 3') that was chosen to predict the post reconfiguration baseline was taken by establishing the current average number of court receptions that the prison takes from those courts that feed in to HMP Bullingdon, coupled with the average monthly number of receptions taken by HMP Woodhill. Currently this figure is 352 per month. This would generate 4,224 receptions a year.

10.9 To support this baseline, it is recognised that there will still be a proportion of transfers coming into HMP Bullingdon from other prisons and this is estimated at 11% of the total of receptions. This estimate was taken from the experiences of HMP Durham, who were in the first phase of the reconfiguration programme. The table beneath sets out the profile of the projections for the future reconfiguration of HMP Bullingdon as a reception and resettlement prison based on the 55%-45% ratio.

Table 30: HMP Bullingdon Baseline receptions and transfers and throughput (sources: HJIP, P-Nomis, CPS Healthcare)

Current Position 2018-2019		
Key Indicators (HJIP)		
OP Cap (Fixed)	1,114	
Total of 2018-2019 Population (at last day of month)	13,534	
2018-2019 Receptions	1,426	
Receptions as % of Receptions and Transfers	36%	
Average receptions/month	119	
2018-2019 Transfers in	2,514	
Transfers as % of Receptions and Transfers	64%	
Average Transfers in/month	210	
Reception and Transfers in as a % of Total pop	29%	
Total reception and transfers	3,940	

Discharges	3,963	
Discharges as a % of total pop	29%	

2018-2019 1st Reception Screens	3,857	
Average 1st Reception Screens/month	321	
Average 1st Reception Screens/day (Based on a 5-day week)	14.6	
2018-2019 2nd Reception Screens	3,405	
Average 2nd Reception Screens/month	284	
Average 2nd Reception Screens/Day (Based on a 5-day week)	12.9	

Throughput	3.54	to 1
Receptions and Transfers as % of total pop	29%	

Monthly Population across prison

E Wing Sex offenders' unit	191	17%
Receptions/month	119	11%
Remaining Population	804	72%
Total whole prison	1,114	

10.10 This baseline shows a throughput of 3.54:1 for the prison, an average number of reception screens of 14.6/day and an average volume of 2nd reception screens of 12.9/day.

Table 31: Post reconfiguration assumptions (sources: HJIP, P-Nomis, CPS Healthcare)

Assumption 3		
Assumption Based on the Average monthly both Bullingdon and Wood Hill Courts	352	
Annual Bullingdon and Wood Hill Courts	4,224	
Proposed from October 2019 (Based on full year data)		
Key Indicators (Estimates/Projections)		
OP Cap (Fixed)	1,114	
Total of 2019-2020 Population at end of month (Op Cap x12)	8,518.64	
2019-2020 Receptions at 55% of total annual population	4,224	
Receptions as % of Receptions and Transfers	90%	
Average receptions/month	352	
2019-2020 Transfers in	465	
Transfers as % of Receptions and Transfers	10%	
Average Transfers in/month	38.72	
Reception and Transfers in as a % of Total pop	55%	
Total reception and transfers	4,689	
Discharges	4,685	
Discharges as a % of total pop	55%	
2019-2020 1st Reception Screens	4,689	
Average 1st Reception Screens/month	391	
Average 1st Reception Screens/day (Based on a 5-day week)	17.8	
2019-2020 2nd Reception Screens	4,126	
Average 2nd Reception Screens/month	344	
Average 2nd Reception Screens/Day (Based on a 5-day week)	15.6	
Throughput 2019-2020	4.21	to 1
Receptions as % of total pop	55%	
Reception Population	613	55%
Resettlement Population	501	45%
E Wing Sex offenders' unit (Fixed)	191	17%
Resettlement Population not on E Wing	310	28%
Total reception and resettlement	1,114	

10.11 This projection identifies a throughput of 4.21:1 and an average volume of 1st night reception screens of 17.8/day and an average of 2nd reception screens of 15.6/day.

10.12 This model is based on a static perception of what will happen using evidence from past experience with the additional element of the Woodhill courts being processed through to HMP Bullingdon. What it does not address is the likely increases in the pace with which new the receptions come into the prison. In the case of HMP Durham a similar approach was taken to projecting new receptions, however, the

pace of actual reception prisoners coming into that prison increased significantly and this manifested itself with more transferred prisoners coming into the prison and a general increase in the overall volume of receptions. In reality the increase against the project volumes for HMP Durham were 65% above this initial projection.

10.13 This modelling exercise for HMP Bullingdon is mindful of this likelihood and to this end, transfers have been included in this assumption. However, a series of three further assumptions have also been applied that calculate the potential for a 20%, 40% and 60% uplift on this assumption. This is set out in the table below.

Table 32: Post reconfiguration assumption 3 plus 20%, 40% and 60% (sources: HJIP, P-Nomis, CPS Healthcare)

Assumption 3 + 20%, 40% and 60%	20%	40%	60%
Key Indicators (Estimates/Projections)			
OP Cap (Fixed)	1,114	1,114	1,114
Total of 2019-2020 Population at end of month (Op Cap x12)	10,222	11,926	13,630
2019-2020 Receptions at 55% of total annual population	5,069	5,914	6,758
Average receptions/month	422	493	563
2019-2020 Transfers in	558	650	743
Average Transfers in/month	46	54	62
Reception and Transfers in as a % of Total pop	55%	55%	55%
Total reception and transfers	5,626	6,564	7,502
Discharges	5,622	6,559	7,496
Discharges as a 5 of total pop	55%	55%	55%
2019-2020 1st Reception Screens	5,626	6,564	7,502
Average 1st Reception Screens/month	469	547	625
Average 1st Reception Screens/day (Based on a 5-day week)	21.3	24.9	28.4
2019-2020 2nd Reception Screens	4,951	5,776	6,602
Average 2nd Reception Screens/month	413	481	550
Average 2nd Reception Screens/Day (Based on a 5-day week)	18.8	21.9	25.0
Throughput 2019-2020	5.05	5.89	6.73
Receptions as % of total pop	55%	55%	55%
Reception Population	613	613	613
Resettlement Population	501	501	501
E Wing Sex offenders' unit (Fixed)	191	191	191
Resettlement Population not on E Wing	310	310	310
Total reception and resettlement	1,114	1,114	1,114

10.14 These assumptions, based on an increasing volume of reception and transfers coming into the prison, are in place to provide commissioners and service providers with the information needed to assess a series of different throughput scenarios. These scenarios can be used to identify the potential resources needed to meet these different levels of patient arrivals.

10.15 What is clear is that at 20% above the baseline assumption, the volume of receptions screens per day rises to 21.3, at 40% this rises again to 24.9% and at 60% this rises to 28.4%. What is interesting is that these are average numbers of receptions per day and as such there will be greater volumes as well as lower volumes of receptions and transfers. To put this into context on the 6th June 2019 there were 25 receptions that came into the prison. This shows a potential volume quite akin to the baseline assumption, plus 40%.

Resource implications for 1st and 2nd Health Screening

10.16 The impact on resource needs for healthcare's adjustment to the increasing volume of receptions and transfers is set out below. This relates purely to those members of the primary care healthcare team that work on receptions and transfers and assess the increase in staff hours that will be a result of the reconfiguration of HMP Bullingdon.

10.17 The projection calculation has been made by: establishing a unit value for the current baseline hours per week and multiplying this by the increasing proportion of receptions. Then for the 20%, 40% and 60% options of the calculation are to simply multiply this increase against the baseline. This way reviews the volumes of 1st and 2nd receptions screens and by multiplying the baseline unit value of staff hours/reception hours that are utilised to meet the current reception process one can arrive at the likely staffing levels going forward.

10.18 The total volume of staff hours used a week, based on the establishment allocations, is 2,370.4 hours per week. The number of hours currently allocated to the 1st night reception and 2nd day screening process is 282 hours. Assuming that this responds to the current average of screenings, which is set at 14.6 per day, it is possible to calculate the number of staff hours needed to respond to an increasing length of screening process time.

10.19 The table below shows that Care UK will need to increase their staff compliment by some 61 hours per week to meet the increased numbers of receptions per day for the assumption referred to as 'assumption 3'. Thereafter Care UK will require 129.4 additional staff hours for the +20% options, 197.9 additional staff hours for the +40% options and 266.6 additional hours for the +60% option.

10.20 Bearing in mind the growth that was experienced in HMP Durham there is a strong chance that an additional 266.6 hours of staff time will be needed to meet the increase in receptions and transfer prisoners.

Table 33: Assumed growth in staff hours needed to respond to the growth of 1st and 2nd Screenings (OSM Modeling)

Baseline (2370.4 hours per week)	Current	Post reconfiguration Assumption	20%	40%	60%
Staff complement available for 1st night and second day screening (Hours/week)	282	343	411.4	479.9	548.5
Average receptions per day	14.61	17.76	21.3	24.9	28.4
Unit value calculation	19.3				
Percentage of all staff hours	12%	14%	17%	20%	23%
Required increase in staff hours	0	61	129.4	197.9	266.5

Additional resource requirements

10.21 It is likely that the increasing volume of prisoners coming into the prison, particularly those with a remand status, will generate more prisoners who require **substance misuse services**, both clinical and psychosocial. This will require more staff to take on the clinical 5-day reviews and to support the proportionally increasing numbers of prisoners who are arriving with clinical substance misuse needs. This is likely to require an additional clinical ISMS staff nurse.

10.22 There is a strong likelihood that there will be an increasing level of **mental health** needs being presented as a result simply that more people are coming into the prison. This may also be further enhanced by the addition of Video Court conferencing facilities that will be available – particularly as someone's mental health can rapidly deteriorate if there is a change in legal circumstance. It is likely that this mental health need will be a primary mental health need rather than secondary, although this is not exclusively the case.

10.23 From a primary **healthcare** perspective there is little evidence that the prevalence of patients with LTC and other chronic conditions will change. What will change is the potential numbers of patients with these conditions, hence increasing the volume of GP and nurse led clinics. With an increasing throughput there is a strong likelihood that needs will be more acute and or urgent/emergency by nature, as much of the longer term healthcare will need to be done once the prisoner is

sentenced and hence either in their receiving prison or back in the community should they be released.

10.24 The growth of people coming into the prison will require an increase in **medications management** to ensure that new patients are on the right meds and that they have their medication histories properly researched and assessed.

10.25 There is a strong likelihood that there will be a requirement to increase the resources for health **administration**. Not simply within the core work that is undertaken with an increasing number of people coming into the prison, but equally for the increasing volume of discharge requirements both onto other prisons and back to the community and the release planning that takes. This is likely to require at least one more additional administrator.

Care UK's estimates of additional staff requirement for reconfiguration

10.26 Current preparatory work carried out by Care UK to review their assessment of the need for additional resources was set out in a paper to commissioners drafted in 2018 and updated in 2019. This identified a wide range of staffing requirements including those set out in the table below:

Table 34: Additional resources proposed for the Reconfiguration process for HMP Bullingdon (Care UK 2018/19)

Additional posts	Grade	FTE required	Total funding requested
Nurses for First Night Centre	RGN Band 6	2.00	111,612
	RMN Band 6	1.00	55,806
Second day screening	RGN Band 6	1.00	55,806
	HCA	1.00	30,987
Mental Health - VCC nurse	RMN Band 6	1.00	55,806
Coordinator nurse for Reception FNC	Band 7	2.00	126,696
Additional night nurse	RGN Band 6	1.00	55,806
Additional GP sessions	7 sessions per week	0.70	108,150
Mental Health provision	RMN Band 6	2.00	111,612
Social worker	Band 5	1.00	48,231
Administrator	Band 3	1.00	31,574
Pharmacy	Pharmacy Technician	2.00	85,464
Additional non-staff costs			
Dentistry	1 additional session per week	22,100.00	22,100
Escorts and Bedwatch	8 additional escort per week (3.5hrs)	100,330.88	100,331
Medical consumables	£5,000 a month	60,000.00	60,000
Excluding			
Drugs			
Controlled drugs			
NRT			
Total			948,368

10.27 In essence this sets the current perceptions of additional resource needs from the service providers perspective. Indeed, it was completed without the modelling findings identified above, however Care UK were directly involved in supporting this model and are familiar with the assumptions used to develop the model.

Response to the new Mental Health and Substance National specifications

10.28 As part of the modelling brief it was identified that the identification of additional resources needed to take account of the national specifications for mental health and substance misuse are currently not included in the HMP Bullingdon healthcare contract.

10.29 In 2018 NHS England produced its new Mental Health and Substance misuse specifications. These have a potential impact to increase the depth and range of service provision for prisoners in all establishments.

Table 35: Key differences between Local and National Mental Health and Learning Disability, and Substance Misuse Service Specifications

Mental health and Learning Disability Specification Outcomes	Substance Misuse Specification Outcomes
• Improve mental health and emotional wellbeing • Patients report opportunities to comment on their experiences of using the service, and user comments are responded to appropriately • Contribute to the rehabilitation of people in prisons through improving mental health and contributing to sentence planning where appropriate	• Freedom from dependence on drugs and alcohol • Preventing people from dying prematurely • Enhancing quality of life for people with long term conditions • Supporting 'recovery' helping people recover from episodes of ill health or following injury • Enhancing quality of life for people with long term conditions • Improve the health of the most vulnerable - reduce health inequalities • Improved throughcare; focus on entry and exit, continuity of care • Strengthening the voice and involvement of those with lived experience
Differences from previous specifications	**Differences from previous specifications**
• Stronger outcome orientation from the perspective of prisoners, clinicians and partnerships and defining how providers can show evidence of this • Clear service standards with potentially greater levels of detail than previously • Weekend services not clearly mentioned but 24 hours and out of hours services are critical for the service (these arrangements may need to be made locally) • No direct mention of payment by results	• Clear sense of co-production against outline objectives of the specification • Clarity of the providers experience and capability to deliver the contract • Integration of SM services both clinical and psychosocial • Weekend services not clearly mentioned but 24 hours and out of hours services are critical for the service (these arrangements may need to be made locally) • No direct mention of payment by results

• Strong emphasis on meeting national and local specification requirements • Locally determined to be based on needs assessments	• Strong emphasis on meeting national and local specification requirements • Locally determined to be based on needs assessments

10.30 Within HMP Bullingdon work has been undertaken to address the likely impact of this changing workload. This has been completed by Care UK as part of its prime provider role. In total it is anticipated that there will be the requirement for an additional 9.2 members of staff to fulfil the additional requirements of the new specification. The specific roles are set out in the table below:

Table 36: HMP Bullingdon Additional staff requirement to reflect the new Mental Health and Substance Specifications. (Care UK)

Prison	FTE	Cost Base	Roles
HMP Bullingdon	1.00	Staff costs	Band 6 - OT
HMP Bullingdon	3.00	Staff costs	Band 6 RMN
HMP Bullingdon	1.00	Staff costs	Band 6 L&D
HMP Bullingdon	0.20	Staff costs	Psychologist
HMP Bullingdon	2.00	Staff costs	Band 4 Assistant Psychologist
HMP Bullingdon	1.00	Staff costs	Band 3 Admin
HMP Bullingdon	1.00	Staff costs	Band 6 RMN SMS
HMP Bullingdon		Non staff costs	Training - Reflective practice
HMP Bullingdon		Non staff costs	Training (8 People)
HMP Bullingdon		Non staff costs	MH Awareness course for prison staff (7 sessions)
HMP Bullingdon		Non staff costs SMS	Training
Total	9.20		

10.31 What is clear is the current healthcare contract will need to be amended to address both the reconfiguration of HMP Bullingdon from a Cat B Local to a Reception and Resettlement prison as well as the additional growth that will be needed to fulfil the transition to the new national specifications for mental health and substance misuse.

Section summary

10.32 A key component of the HNA has been the need to support commissioners and service providers to address the likely increases in service demand and hence need, as a result of the reconfiguration of HMP Bullingdon from a Cat B Local to a Reception and Resettlement prison.

10.33 A modelling exercise has been completed that assumes the prison to be based on a 55% reception and 45% resettlement establishment.

10.34 The health needs of the prisoners coming into the prison are assumed to be the same as currently recorded, although there is an established argument that prisoners in reception will present higher demands for substance misuse and mental health services. The critical difference will be the increased volume of prisoners that will pass through the prison as part of the reconfiguration process.

10.35 The current rate of receptions completed per day is, on average 14.6. This is based on a throughput figure of 3.54 to 1, with the increase of receptions also coming in from Woodhill courts - this number will shift to 17.8 reception per day and a throughput of 4.21 to 1. This is a static calculation and does not take account of any increase in the way courts are processing prisoners into the prison. In the first phase of the national reconfiguration programme HMP Durham experienced a 65% increase against its projected figures for reception. This potential growth has been taking into consideration by including a further set of assumption of 20%, 40% and 60% growth.

10.36 These increased assumptions identify potential average of first night receptions of 21, 25 and 28 per day respectively - with increased throughputs of 5.0 to 1, 5.9 to 1 and 6.7 to 1 respectively.

10.37 These growth rates have been applied to the required additional staff hours needed to fulfil this reception process. These staff hours are based on the roles of GPs, RGNs B5, RGN ISMS, and HCAs. Therefore, for the baseline reconfigured growth in first night and second day receptions this would require 61 additional staff hours per week. However, based on a 20% growth in flow this would require a further 130 hours per week, with a 40% growth in flow this would require a further 198 hour per week and with a 60% increase in flow this would require a further 267 hours per week.

10.38 NHS England and Care UK will need to compute how this converts to staff hours. They will also need to address the impact of discharges or transfers onto other prisons and the overall administration and management of resources to secure a safe and secure reception process, meeting the specification requirements for this critical process in a prisoner's healthcare experience.

10.39 Care UK have identified the need for 15.7 staff plus a further £182,431 for additional dentistry sessions, escorts and bedwatches and medical consumables, to support the reconfiguration process for HMP Bullingdon.

10.40 In addition, Care UK have proposed a growth of mental health and substance resources of 9.2 FTE to secure the compliance with the new NHS England national specifications.

10.41 Collectively, the additional resources for the reconfiguration and the new mental health and substance misuse specifications come to an equivalent of 24.9 FTEs. This will need to be reviewed by NHS England against their budgetary capability and their perceptions of the way these services will be delivered within the prison. Additionally, the modelling exercise has identified likely growth to 267 hours per week. This needs to be translated into staff costs and compared to the proposal set out by Care UK.

Section recommendations

10.42 Healthcare and commissioners will need to adapt provision to meet the needs of a reconfigured HMP Bullingdon to a reception and resettlement population.

10.43 Healthcare and commissioners to address the likely increasing staff load that will be a requirement post reconfiguration. This is currently modelled at 15.7 FTEs.

10.44 Healthcare and commissioners to agree, develop and recruit to a new staffing model to ensure the best skill mix is in place for the services provided.

10.45 Healthcare, Inclusion and commissioners to agree the additional resources needed to meet the new specification for mental health and substance misuse services in the prison. This figure currently comes to 9.2 FTEs.

Appendices

11 Anacronyms

Abbreviation	Description
ACCT	Assessment, Care, and Custody Teamwork
ADHD	Attention Deficit Hyperactivity Disorder
BME	Black Minority Ethnic
EMDR	Eye Movement Desensitisation and Reprocessing therapy
CBT	Cognitive Behavioural Therapy
DBT	Dialectical Behaviour Therapy
CHD	Chronic Heart Disease
IAPT	Improved Access to Psychological Therapies
MHA	Mental Health Act
CPA	Care Planned Approach
CQC	Care Quality Commission
DNA	Did Not Attend
HMIP	Her Majesty's Inspectorate of Prisons
HMPPS	Her Majesty's Prison and Probation Service
HNA	Health Needs Assessment
NHS	National Health Service
NICE	National Institute for Care and Health Excellence
NPS	New Psychoactive Substances
MHFA	Mental Health First Aid
MOJ	Ministry of Justice
PHE	Public Health England
QOF	Quality Outcomes Framework
NDTMS	National Drug Treatment Monitoring System

12 Primary research

12.1 This Appendix highlights the main findings from the primary qualitative and quantitative research carried out as part of this HNA. Primary research included:

- Online stakeholder survey
- Service user survey
- Service user focus groups

12.2 Core elements of these findings have already been addressed in the main report.

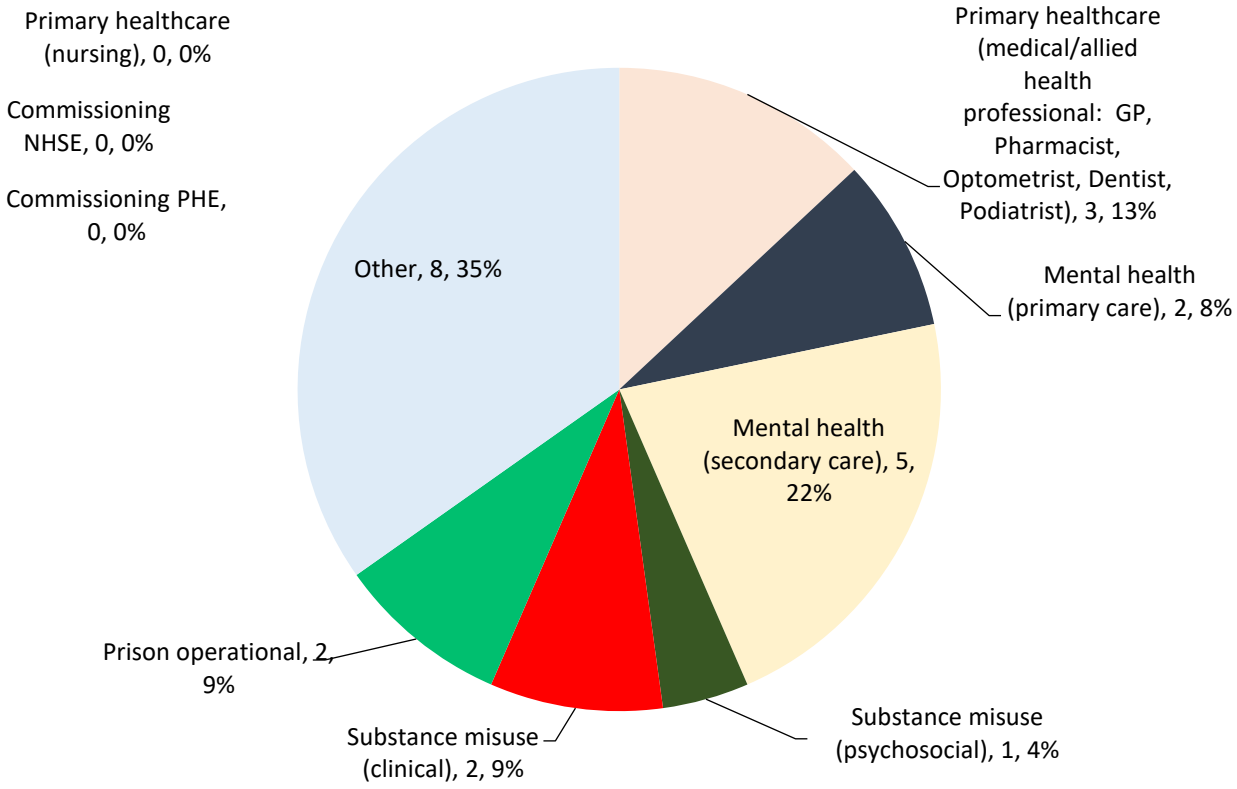
Stakeholder surveys

HMP Bullingdon Stakeholder Survey Headline Findings

12.3 This survey was offered to staff and stakeholders at HMP Bullingdon and was open from the 28th May through to the 21st June. In total 24 people took the time to respond to this survey.

12.4 Respondents came from a range of roles within the prison as set out in the pie chart below:

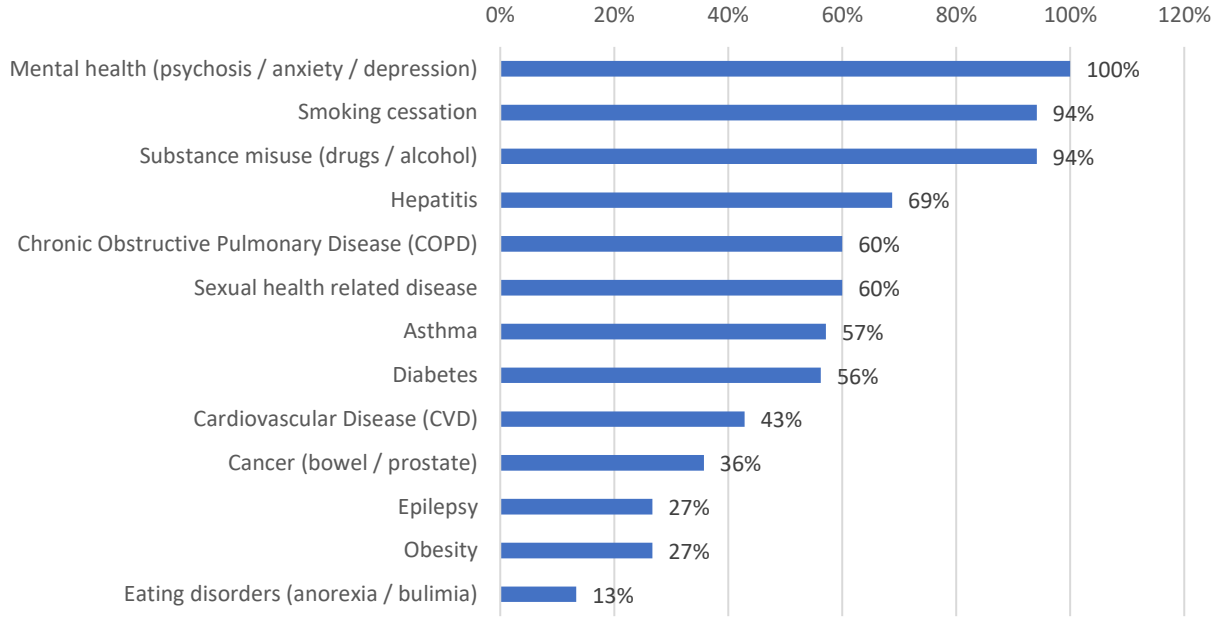
Chart 55: Roles respondents undertake in HMP Bullingdon (Stakeholder survey 2019)



12.5 Those that answered other were prison staff, administrators, sexual health staff and public protection staff.

12.6 The first main question of the survey sought to identify what respondents felt were the highest levels of health needs in the prison. The survey gave people the option to score the following conditions out of 10 with 10 being the highest. For the purpose of this chart the '6 to 10 responses' have been consolidated thus describing those conditions that people felt were the highest prevalence levels and thus the highest levels of health need in the prison. It is clear that from these responses that mental health, smoking cessation and substance misuse were the highest priorities, followed by Hepatitis, COPD, sexual health, asthma and diabetes.

Chart 56: Highest level so of health needs as perceived by respondents, 6 to 10 scores (Stakeholder survey 2019)



12.7 The next question sought to identify perceptions about the provision of primary healthcare services in the prison. A series of statements were offered, and respondents were asked if they agreed, disagreed or were not sure about the responses

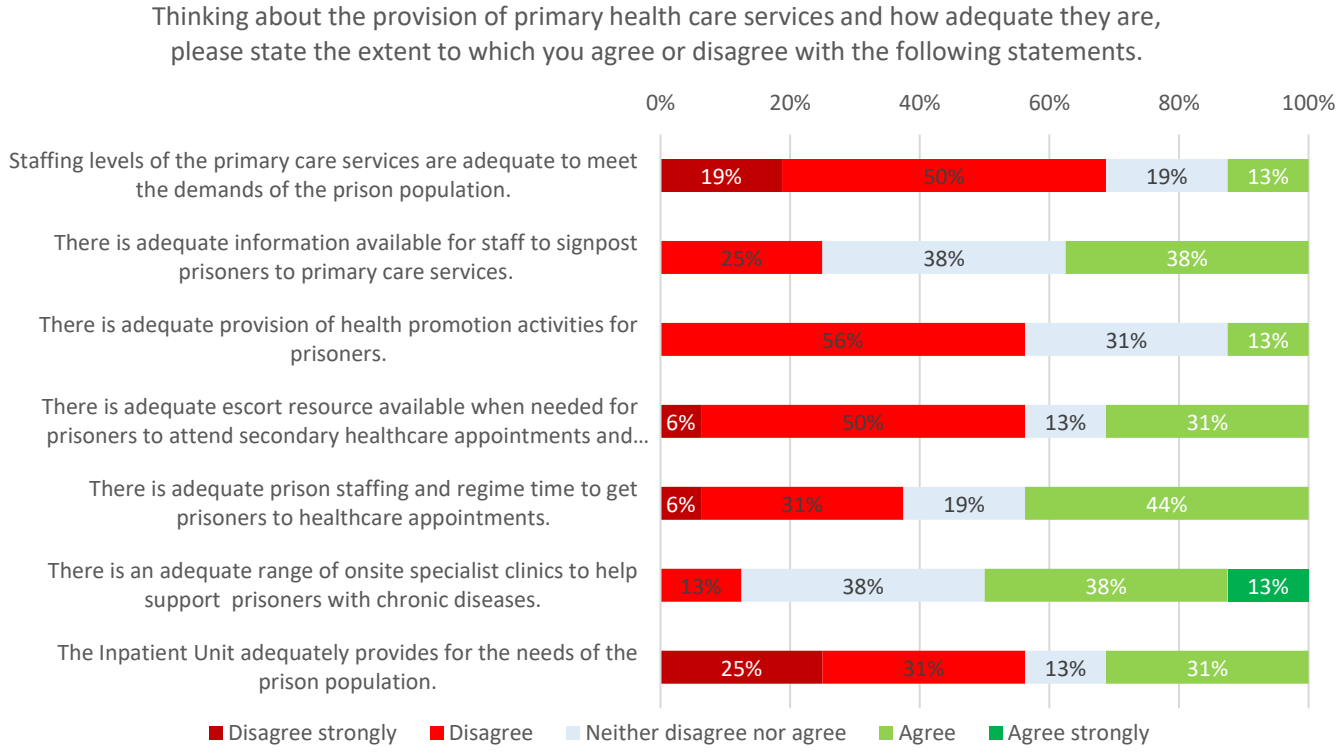
- 68% disagreed that Staffing levels of the primary care services were adequate to meet the demands of the prison population.
- 56% disagreed that there is adequate provision of health promotion activities for prisoners.
- 56% disagreed that there is adequate escort resource available when needed for prisoners to attend secondary health care appointments and offsite emergency care.
- 56% disagreed the Inpatient Unit adequately provides for the needs of the prison population.

12.8 Correspondingly:

- 50% agreed that there is adequate prison staffing and regime time to get prisoners to health care appointments.
- 44% agreed that there is adequate prison staffing and regime time to get prisoners to health care appointments.
- 37% agreed that there is adequate information available for staff to signpost prisoners to primary care services.

12.9 This is set out in the chart below:

Chart 57: Stakeholder perceptions of Primary Health care services (Stakeholder survey 2019)



12.10 There were three respondents that took the opportunity to explain their views and these were expressed as:

- I do not know this area well however I once had a patient there who was being observed as they were disorientated, basics such as a fluid balance chart were not immediately instigated etc.
- My impression is there is not enough primary health staff, and very rarely is there enough capacity to cover for staff being ill
- The Primary Care Mental Health Team is totally understaffed for what they are expected to do in the prison. The whole prison is chronically understaffed to be honest, which has a detrimental impact on the prisoners.
- The Inpatient unit is also inadequate for our prisoner's needs, in that there are little to no activities in place for prisoners located there. The

nursing staff there are not always particularly knowledgeable about the prisoners in their care, and often show bias towards those with physical health issues over those with mental health issues, which comes down to their lack of understanding and confidence when dealing with these issues. It's also not helped that many of them do not read the notes on SystmOne, so of course would not be aware of the person's issues. The handover process is getting a little better, in that they are now involving the officers stationed there for the shift, however it still needs work.

12.11 The survey then moved onto substance misuse. This set of questions sought to identify perceptions about the provision of substance misuse services in the prison. A series of statements were offered, and respondents were asked if they agreed, disagreed or were not sure about the responses. In summary:

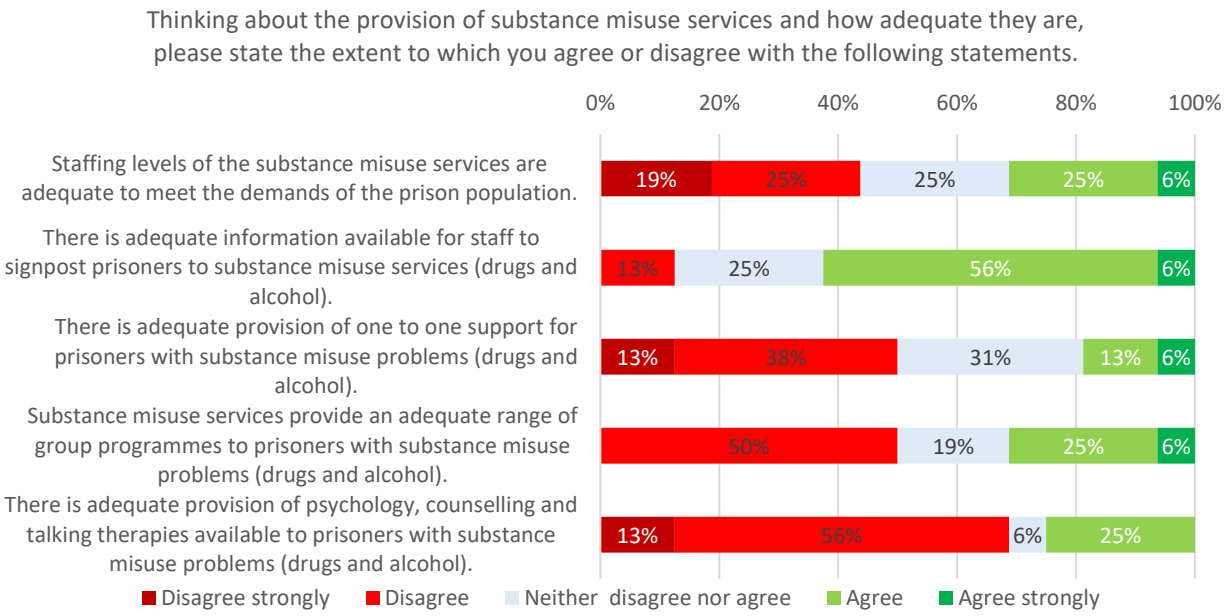
- 69% disagreed that there is adequate provision of psychology, counselling and talking therapies available to prisoners with substance misuse problems (drugs and alcohol).
- 50% disagreed that substance misuse services provide an adequate range of group programmes to prisoners with substance misuse problems (drugs and alcohol).
- 50% disagreed that there is adequate provision of one to one support for prisoners with substance misuse problems (drugs and alcohol).
- 44% disagreed that staffing levels of the substance misuse services are adequate to meet the demands of the prison population.

12.12 In contrast:

- 62% agreed that there is adequate information available for staff to signpost prisoners to substance misuse services (drugs and alcohol).

12.13 The full findings are set out in the chart below:

Chart 58: Stakeholder perceptions of Substance misuse services (Stakeholder survey 2019)



12.14 Five respondents took the opportunity to explain why they had answered in the way they did.

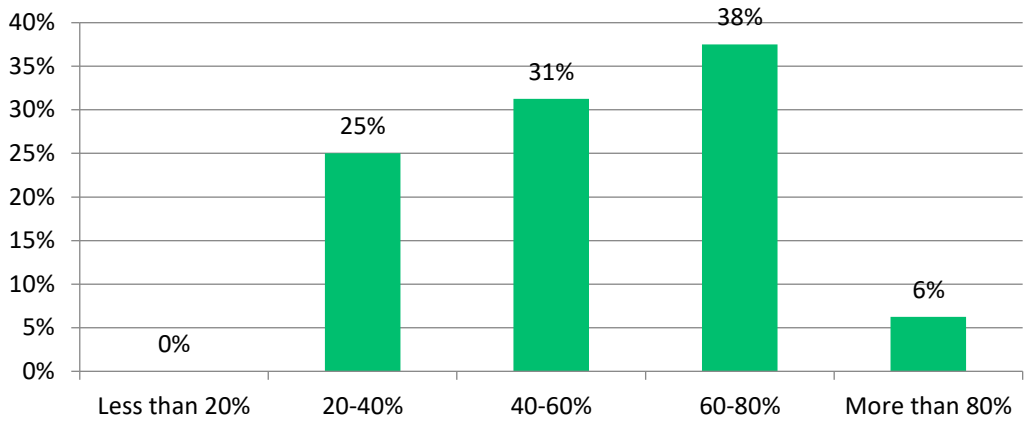
- 'In my opinion substance misuse services work to be fair and equitable and address peoples most pressing needs around dependence, keep them sable and re integrate in the community. The clinical team do this and psychosocial work to see people in a one to one and group sessions. There is generally a waiting list for 1-1 and groups. Also, the range of groups reflects the number of staff. Substance misuse service works to reflect the current orange guidelines, people are not forced to stop medication, we work to stabilize and titrate people safely then to re integrate them in the community'.
- 'I would say less than 20% and I say this as I have seen the figures around NPS response in a month this is less than 10%. So, I suspect it may be up to 40% but accept it may be higher'.
- 'Staffing levels need increasing to provide adequate services (in respect mainly of question 5 here)'.
- 'In the clinical section there are enough staff to provide a just in time service. People are seen on arrival for assessment and then seen up to 5 days depending on need, then at 5, 28, 8 weeks and 13 weeks people are seen by NMP on day 2 and subsequent approx. day ten then at reviews. Also, we have one full time admin person whose time is taken by arranging community appointments, this will, as we move forward, become a greater part of her work. There is no spare time and the amount of prescribing has increased by over 25% in the last 8-12 months

with no subsequent increase in NMP time and no time or space for regular MDT'.

- 'SMS aims to assess people and by using OST establish, re-establish or continue appropriate prescribing to allow people to be stable and more on control of their decisions, management of time in prison and ability to reengage with community services, acknowledging that dependency can be a chronic relapsing condition for some years before people manage recovery conditioning'.
- 'To psychosocial colleagues who provide groups and one to one often struggle with providing one to one assessments, and psychosocial often have a waiting list, their aim is to maximize the staff they have, with more resources and more integration it could be more thorough'.
- 'SMS works with mental health and primary care and aims to be responsive and not leave people waiting unrealistic amount of time. As we move forward all of these challenges will be more challenging. My opinion is that areas which are of concerns could be improved by more staff and better integration and communication across services some'.
- 'There is an adequate range of group programmes however not enough staff to deliver them'.
- 'I'm never sure exactly what is the status of the counsellors in the prison, as this is run via the Chaplaincy, and it's always unclear as to who exactly meets their criteria, as well as their availability'.
- 'I'm unsure on whether the staffing for the drug and alcohol teams are adequate, however the Psychosocial team certainly offer a wide range of courses and work for our prisoners'.
- 'There is certainly a lack of talking therapies available, as we do not have an IAPT service. We have a psychologist as part of our team (secondary mental health care), however they can only see so many people at one time, hence why there is a long waiting list. I have been trying to get on courses and training in CBT and DBT in order offer this to some of our prisoners where I can, however I also can only see so many people at one time'.

12.15 Respondents were asked what percentage of prisoners, in their opinion, were using illicit substances. The chart below shows that 44% of respondents felt that this figure was over 60% of the population. Indeed, none of the respondents felt it was less than 20%. Clearly there is a real perception that substance misuse in the prison is normalised and that there are high proportions of the population who are using substances.

Chart 59: Perceptions of the percentage of illicit substance misuse in the prison (Stakeholder survey 2019)

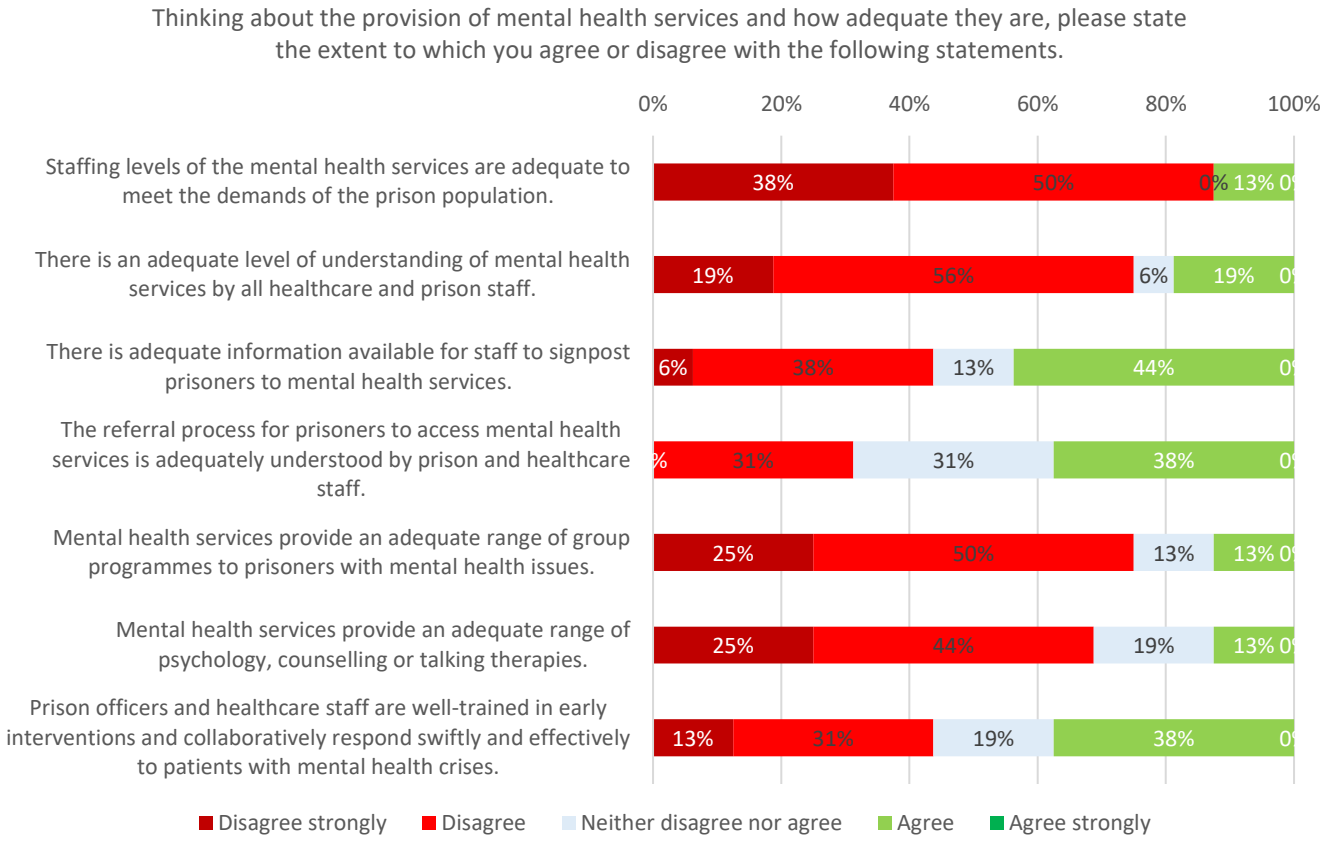


12.16 The survey then moved onto mental health needs. This set of questions sought to identify perceptions about the provision of mental health services in the prison. A series of statements were offered, and respondents were asked if they agreed, disagreed or were not sure about the responses. In summary:

- 87% disagreed that staffing levels of the mental health services are adequate to meet the demands of the prison population.
- 75% disagreed that there is an adequate level of understanding of mental health services by all health care and prison staff.
- 75% disagreed that mental health services provide an adequate range of group programmes to prisoners with mental health issues.
- 69% disagreed that mental health services provide an adequate range of psychology, counselling or talking therapies.
- 44% disagreed that prison officers and health care staff are well-trained in early interventions and collaboratively respond swiftly and effectively to patients with mental health crises
- 44% disagreed and 44% agreed that there is adequate information available for staff to signpost prisoners to mental health services.
- 37% agreed that prison and health care staff adequately understand the referral process for prisoners to access mental health services.

12.17 The full findings are set out in the chart below:

Chart 60: Stakeholder perceptions of Mental Health services (Stakeholder survey 2019)



12.18 Five respondents took the opportunity to explain why they had answered in the way they did.

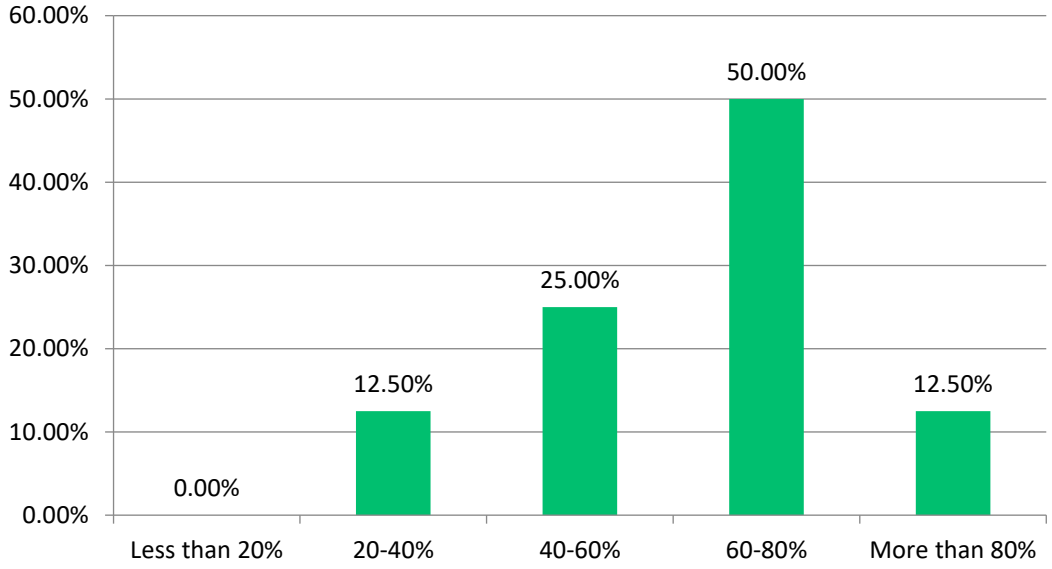
- 'There are insufficient mental health staff many people do not understand the difference between the separate strands of mental health'.
- 'The prison has no pathway for personality disorder and or learning disability 2 big areas of need'.
- 'We need a lot more mental health service provision - for learning difficulties, autism, personality disorder. That said, the current team do very well with the resources that we have but they need more'.
- 'My observation is that - primary mental health staff are under continual demand to assess and monitor people - I think that the understanding of how and when to refer could be improved'.
- 'There is no personality disorder pathway commissioned in a prison of 1100 plus.'
- 'There is no commissioned pathway for people with learning disability in a prison for 1100 people'.
- 'My experience is that all referral can be made to PMHT and will be seen however the process of accessing secondary mental health care appears to be tightly gated and I sometimes wonder if this being a less restrictive

gate keeping would be helpful as there are people who will be marginal for both primary mental health and secondary mental health'.

- 'Lastly re the question below I see many good and professional officers and many good and professional health staff and I understand the purpose of prison. Bullingdon like many is seriously overcrowded and there a large periods of time due to the regime where many have nothing to do. However progressive the prison management is these are large hurdles to promoting any improvement in mental health'.
- 'The mental health teams, both primary and secondary, are both very much understaffed, meaning that we cannot provide the level of support and interventions for our prisoners that we would want to. We do try to offer what we can with the limited resources that we have, including trying to get onto training with regards to talking therapies, and also setting up group work for some of the prisoners (most recently a trauma focused group)'.
- 'With regards to the understanding of prison officers and health care staff of the various mental health issues, this is relatively poor. This comes down to lack of training and education in this area, which we have been trying to offer/provide, however we have been unable to make any progress in this area'.
- 'Main need is in regards personality disorder, so for example, DBT therapy, no such therapy, no PD pathway, no specialist psychologists for this, primary care mental health team try to reduce risk but often "fire-fighting" secondary care mental health services are separate, different commissioning agent, they do not fully accept pd so massive gap.'
- 'Teams should not be split, leads to splitting both psychological and therapeutic/clinical services, should be one whole team of mental health nurses should have a mixture of caseload both enduring and pd so lower risk of compassion burnout'.

12.19 Respondents were asked what percentage of prisoners, in their opinion, were using illicit substances. The chart below shows that 63% of respondents felt that this figure was over 60% of the population. Indeed, none of the respondents felt it was less than 20%. Clearly there is a real perception that mental health needs in the prison are widespread and that there are high proportions of the population who need support and provision.

Chart 61: Perceptions of the percentage of prisoners with mental health needs in the prison (Stakeholder survey 2019)

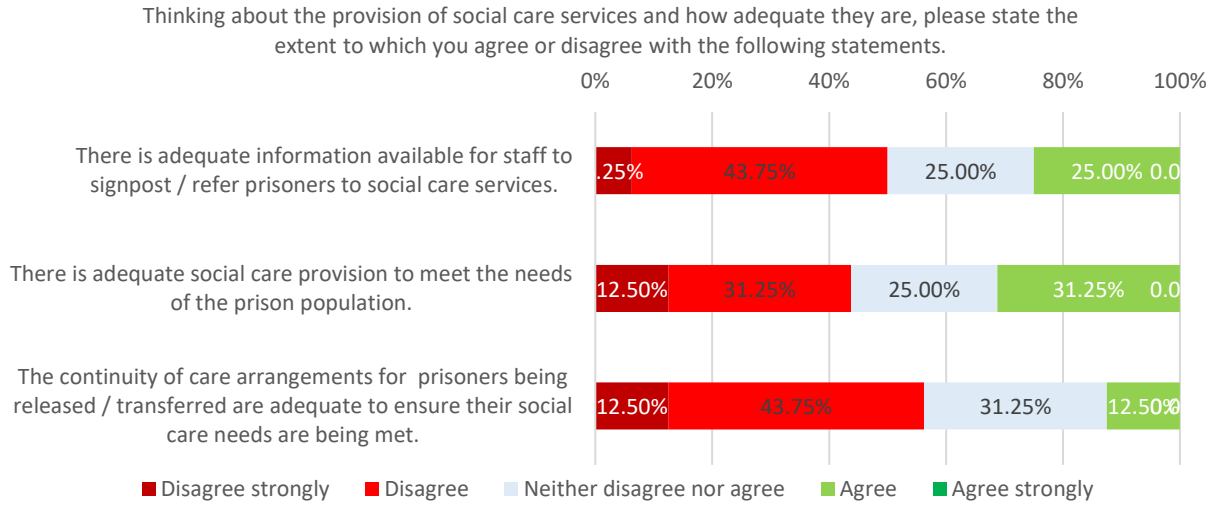


12.20 The survey then moved onto social care needs. This set of questions sought to identify perceptions about the provision of mental health services in the prison. A series of statements were offered, and respondents were asked if they agreed, disagreed or were not sure about the responses. In summary:

- 56% disagreed that the continuity of care arrangements for prisoners being released / transferred are adequate to ensure their social care needs are being met.
- 50% disagreed that there is adequate information available for staff to signpost / refer prisoners to social care services.
- 44% disagreed that there is adequate social care provision to meet the needs of the prison population.

12.21 The full findings are set out in the chart below:

Chart 62: Stakeholder perceptions of Social care services (Stakeholder survey 2019)



12.22 A respondent took the opportunity to explain why they had answered in the way they did.

- 'My impression is that there is insufficient allowance and insufficient available, many come in and out homeless'.
- 'An example would be a man who left here having finished his sentence so not on license but following major surgery which left him with an impaired gait and on high doses of pain relief. Luckily, he was taken to the MPCC and a lot of work and pushing was done to get him accommodation for when he left, but many are not so lucky'.

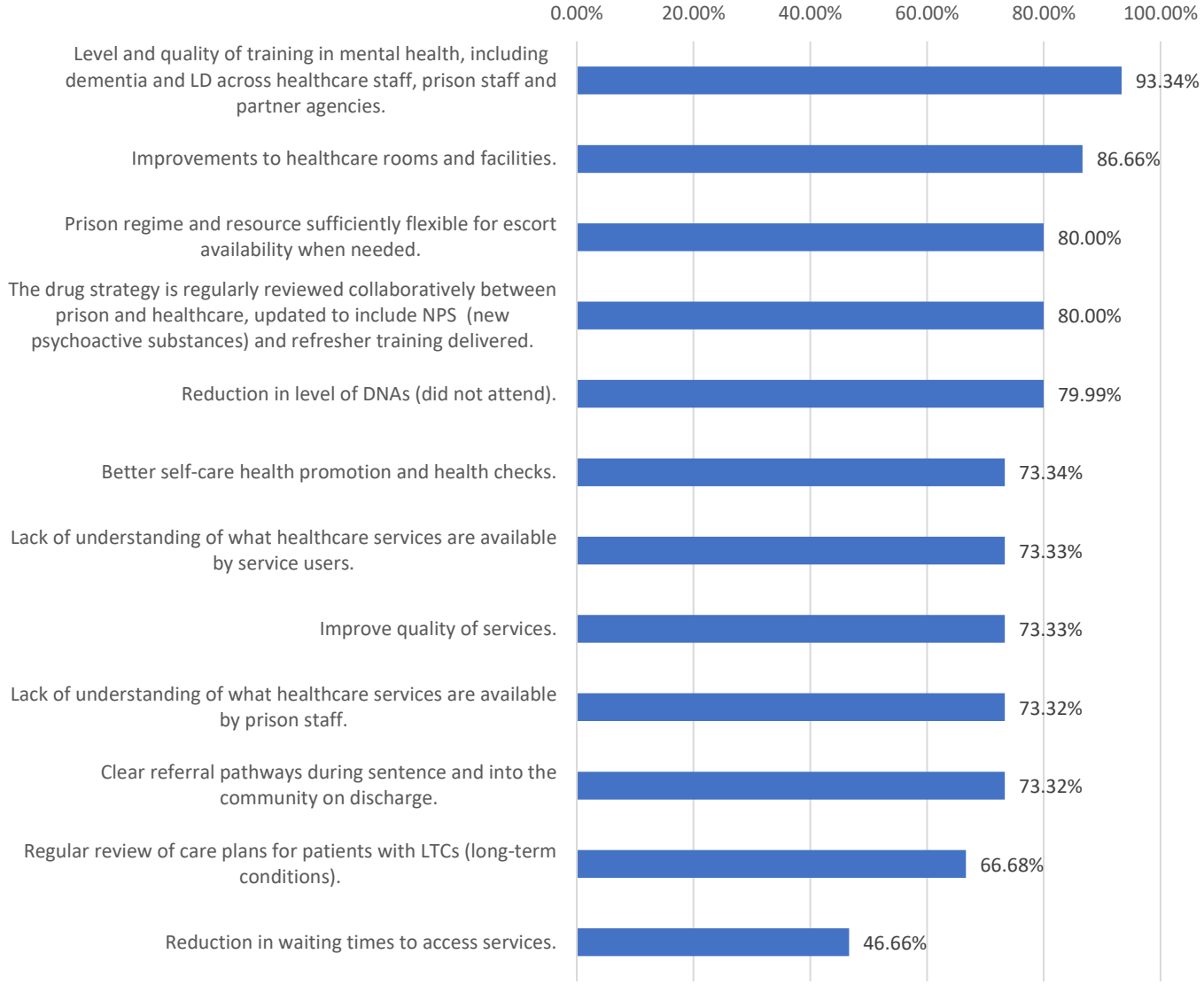
12.23 The next question sought to access people's perceptions about the working relationships between different parts of the prison to support prisoner's health and wellbeing. As before a series of statements were offered, and respondents were asked if they agreed, disagreed or were not sure about the responses. In summary:

- 69% agreed that there is a good working relationship between primary health care, mental health, substance misuse services and other parts of the prison.
- 50% agreed that multi-agency interventions and case reviews are standard practice in my prison.
- 31% agreed that there is a strong ethos of partnership working in my prison. (NB 56% stated they neither agreed nor disagree).

12.24 The final question of the survey sought to identify what respondents felt were the most important areas for improvement to the prison's healthcare services. The survey gave people the options to score the following areas of activity out of 10 with 10 being the highest. For the purposes of this chart the areas scoring 6 to 10 have been consolidated thus describing those priority areas for improvement in the

prison. It is clear that from these responses: mental health training, healthcare rooms and facilities, more escort availability, regularly reviewed drug strategy and reduction in DNA were the most pressing areas highlighted. The full table is listed below.

Chart 63: HMP Bullingdon Perceptions of priority areas for improvement 6-10 scores (Stakeholder survey 2019)



The findings in summary

12.25 It is clear from the respondents engaged that:

- The health needs that are a priority in the prison are Mental Health, Substance misuse and smoking cessation.
- There is a perceived inadequacy of staffing levels of primary care, substance misuse and mental health services.
- From a primary care perspective there is a strong sense of the inadequacy of health promotion, escorting and the inpatients unit.

- From a substance misuse perspective there is a deemed adequacy of psychology, counselling and talking therapies, one to one and group work.
- From a mental health perspective there were concerns with the lack of training and awareness of mental health, group work and psychology, counselling or talking therapies.
- From a social care perspective there were concerns with respect to the adequacy of staffing, and social care provision generally and also the continuity of care arrangements on release back to the community.
- 44% of respondents felt that more than 60% of the prison population was illicitly using substances in the prison.
- 62% of respondents felt more than 60% of the prison's population had mental health needs.
- The key areas respondents felt were important for improvement were: mental health training, improvements to healthcare rooms and facilities, more escort availability, regularly reviewed drug strategy and reduction in DNAs.

Service user survey

12.26 Three service user surveys were sent out to HMP Bullingdon, relating to primary healthcare, mental health and substance misuse services. Responses to the mental health and substance misuse service user surveys were low and therefore have not been analysed. Instead key themes emerging from the responses have been highlighted below.

HMP Bullingdon – Primary Healthcare Service User Survey Findings

12.27 Primary healthcare service users were invited to participate in this survey. The survey was designed and agreed with the input of the HNA Steering Group. Surveys were printed, and healthcare disseminated them amongst prisoners, collecting responses and forwarding them back for analysis. Surveys were completed between 27 May and 25 June 2019. In total, 11 service users took the time to complete these surveys.

12.28 Respondents to the survey were aged between 21 and over 80. Respondents were mostly from white ethnic groups (82%) or Asian ethnic groups (18%) and all were British nationals.

Table 37: Age, ethnicity and Nationality profile of respondents (Service User Survey 2019)

Age	Responses (%)	Responses (no.)	Ethnicity	Responses (%)	Responses (no.)	Nationality	Responses (%)	Responses (no.)
Under 21	0%	0	White	82%	9	British	100%	9
21-29	20%	2	Mixed	0%	0	Non-British	0%	0
30-39	30%	3	Asian	18%	2			
40-49	10%	1	Black	0%	0			
50-59	10%	1	Other	0%	0			
60-69	10%	1	Unknown	0%	0			
70-79	10%	1						
80+	10%	1						
Total responses		10	Total responses		11	Total responses		9

12.29 Respondents were asked how being in prison had impacted on their health. Fifty percent of respondents felt their health had got better, 10% felt it had got worse and 40% felt it had remained the same.

Table 38: Impact of being in prison on health (Service User Survey 2019)

Impact of being in prison on health	Responses (%)	Responses (no.)
My health feels better	50%	5
My health feels worse	10%	1
My health feels the same	40%	4
Total responses		10

12.30 Reasons offered by those who felt that being in prison had made their health better:

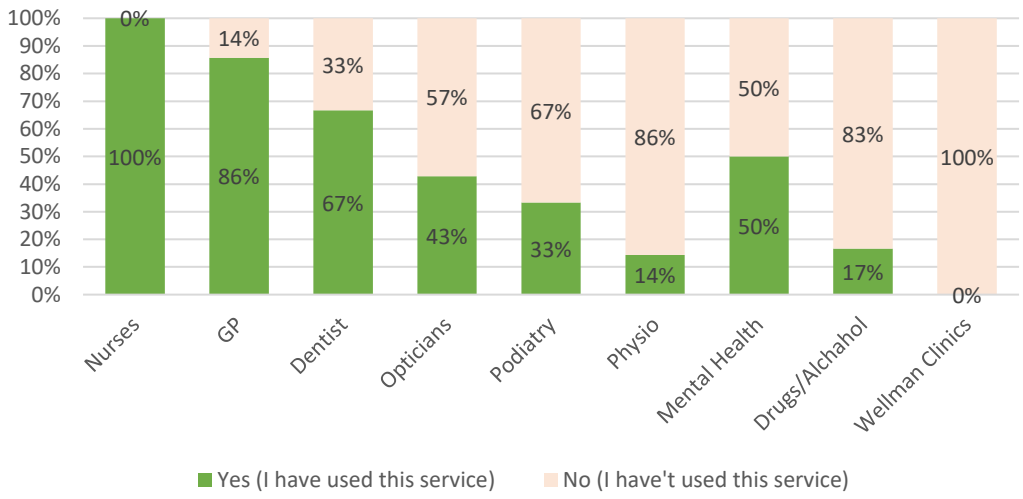
- 'Pharmacy really helped me with my meds'
- 'Nurses always helpful and know what steps to take'

12.31 Reasons offered by those who felt that being in prison there was no change in their health:

- 'Because of the treatment I have been given whilst here'
- 'Because there is only one way to get anything done is to go via "Sam" to get your medication'

12.32 Most respondents knew generally how to get help from the all health services. However, accessing help from some services was seen as more of a challenge. Such services included well-man clinics (57%), podiatry (22%) and optician (22%). The proportion of responded that have used or not used health services are set out below:

Chart 64: Accessing services (Service User Survey 2019)



12.33 Overall, respondents rated the health services well, 73% felt the health services were excellent or good, 18% felt the health services were average and 9% felt they were poor.

Table 39: Rating health services (Service User Survey 2019)

Rating health services	Responses (%)	Responses (no.)
Very Poor	9%	1
Poor	0%	0
Average	18%	2
Good	27%	3
Excellent	45%	5

Total responses		11

12.34 Reasons for rating the health services excellent or good include:

- 'Because of the care and consideration i have been given for the health problems I have had'
- 'Because I have been called in and been helped with back injury and toothache'
- '3 times my dental appointment was cancelled on the day and i was left to re-book'
- 'When you collect your medication there only so much Sam can do, but she tries her best to get things sorted if she finds a problem with medication'
- 'They are helpful'

12.35 Reasons offered for average rating:

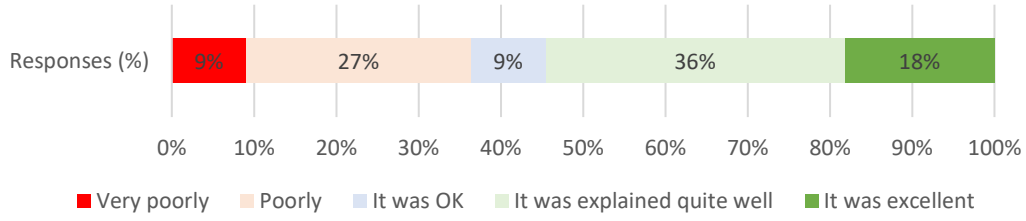
- 'Can be improved with a more frequent visit from the GP'

12.36 Reasons offered for poor rating:

- 'Attitude of doctors and nurses and all healthcare staff'

12.37 Seventy-three percent of respondents felt they received an excellent explanation about health services when they first came to HMP Bullingdon or that the service was explained quite well. Nine percent felt the explanation about health services was okay. 36% felt the information they received about health services was poor.

Chart 65: How well were services explained on arrival (Service User Survey 2019)



12.38 Most respondents accessed health services through an application process.

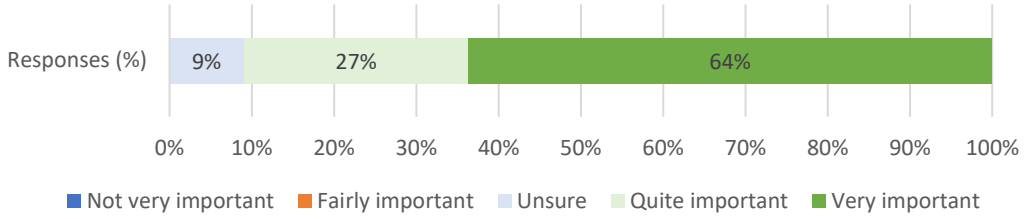
12.39 Ninety percent of the respondents felt that waiting times were reasonable.

12.40 Fifty percent said that health reps were trained and supported. Ninety-one percent stated that health reps were important to them and 9% said they were unsure. Views expressed by the respondents about healthcare included:

- 'E wing rep is excellent'
- 'The healthcare reps do the best they can with what they are given, can't fault them'

- 'Our healthcare nurses are very confident, helpful and friendly in nature. easily accessible as well'

Chart 66: How important health reps are (Service User Survey 2019)



12.41 Most respondents felt it was okay or easy to get the right medications (82%) and the remaining felt it was quite difficult (18%).

Table 40: Getting the right medication (Service User Survey 2019)

Getting the right medication	Responses (%)	Responses (no.)
It's very difficult	0%	0
It's quite difficult	18%	2
It's OK	36%	4
It's quite easy	18%	2
It's very easy	27%	3
Total responses		11

12.42 Almost all respondents felt the on-going support for health needs when leaving prison was important, with 55% stating it was quite important or very important.

12.43 Most statements about the positive aspects of the healthcare service related to the staff that respondents were in contact with for example they were police, friendly and supportive.

12.44 Statements about what improvements could be made to healthcare services were about quicker access to certain services including GP, optician and access to medications. Cancellations and access to hospital appointments was also raised as areas for improvement.

Table 1: Positive statement and suggested improvements to services (Service User Survey 2019)

Positive statements about health services	Improvements to health services
'Great optician'	'Access to dentist'
'GP is superb'	'Uninterested nurses'
'GP was excellent'	'More seating in meds bays'
'Good staff'	'Nurses could be more thorough'
'Good dietician'	'Faster response for appointment apps'
'Doctors are thorough and supportive'	'General lack of help from some (not all) nurses'
'They are really polite and friendly'	'Waiting time to see GP'
'Very helpful pharmacy'	'Nurses speaking to prisoners like rubbish'
'Pharmacy is excellent'	'Stop cancellations for going to hospital'
'The nurses and doctors explain things really well'	'Time it takes to get your meds from outside'
'Dentist very efficient'	'Continuity of pharmacy dispenser'

Positive statements about health services	Improvements to health services
'Never had any problems with healthcare always been very good'	'The time you wait from filling in an app to seeing the doctor'
'They really help with your medical issues'	'More time outside the cells compared to being banged up'

The findings in summary

12.45 It is clear from the respondents engaged that:

- Fifty percent felt their health had got better since being in prison and a further 40% felt it stayed the same and 10% felt it had got worse. For those who felt their health had got better this was down to the help they received from the pharmacy and nurses.
- Most respondents knew generally how to get help from the all health services. However, getting help from some services was seen as more challenging - this included well-man clinics (57%), podiatry (22%) and optician (22%).
- Overall, respondents rated the health services well, 73% felt the health services were excellent or good, 18% felt the health services were average and 9% felt they were poor.
- Seventy-three percent of respondents felt they received an excellent explanation about health services when they first came to HMP Bullingdon or that the service was explained quite well.
- Ninety percent of the respondents felt that waiting times were reasonable.
- Ninety-one percent stated that health reps were important to them and 9% said they were unsure. Those that had experience of health reps said they were excellent.
- Most respondents felt it was okay or easy to get the right medications (82%) and the remaining felt it was quite difficult (18%).
- Almost all respondents felt the on-going support for health needs when leaving prison was important, with 55% stating it was quite important or very important.
- Most statements about the positive aspects of the healthcare service related to the staff that respondents were in contact with in that they were police, friendly and supportive.
- Statements about what improvements could be made to healthcare services were about quicker access to certain services including GP, optician and access to medications. Cancellations and access to hospital appointments was also raised as areas for improvement.

HMP Bullingdon – Mental Health and Substance Misuse Service User Survey Findings

12.46 The response rate for the service user survey relating to the mental health and substance misuse service was low making it statistically unreliable for analysis. As such, the key themes coming out the responses have been highlighted below:

- The mental health services and substance misuse services were considered good and it was felt the service was explained well on arrival to HMP Bullingdon and both services had reasonable waiting times.
- For mental health services, mental health reps were considered important, providing support to other prisoners.
- All service users felt ongoing care when leaving the prison was important.
- Positive statements about the mental health services were about the staff, which included comments such as 'polite staff' that are 'easy to talk to.' The service was also described as good.
- Areas suggested by service users where mental health services could improve included, a faster process of seeing mental health services when arriving to the prison and more signposting to services.

Service user focus groups

12.47 Set out below are reports of the three focus groups completed at HMP Bullingdon on the 13th June.

HMP Bullingdon – Primary Health Care Services

Patient Perspectives

"There are some good staff, but overall health care needs to shape up. Processes are poor and services are either inconsistent or non-existent"

Engagement

A focus group was undertaken with 5 residents from HMP Bullingdon regarding their perceptions of primary health are, their experiences and what they consider important when accessing these services. Residents from across the prison, with a variety of experiences participated to discuss themes related to the current service provision.

We asked residents to determine what was important to them when engaging with services, why this was important, what currently works at HMP Bullingdon, and finally, suggestions to enable service development, supporting improvement to patients' outcomes.

100% of the participants were current service users or had accessed the service during their sentence. Before the start of the focus group, the residents were informed of what a Health Needs Analysis (HNA) is and how their contributions would be utilised within it. Residents were asked how being in this prison impacts on their physical health. 100% of participants felt their physical health had declined.

Every participant provided a personal account where they surmised they had not received a reasonable standard of care since their stay in this prison and offered further accounts of wider residents' experiences. The most prominent themes raised by the group included inconsistencies to care, too few nurses, cancellation of outside appointments and delayed (internal) treatment that exacerbated health issues. Additionally, participants felt poor processes created problematic access to services and increased waiting times, which were deemed by the group as 'too long and unnecessary'.

"Nothing is consistent here, agency nurses don't help the situation, the lack of staff, the triage system doesn't work. As an example, two out of thirteen people were seen today, overall care is poor.".

Participants added that the dispensing of medication was, at times, managed by inexperienced staff and this impacted negatively on the community. The group explained morning medications were dispensed between unlock and 10am. Participants gave examples of when new or agency staff had stopped dispensing before seeing all patients thus causing some patients to go without medication. Additionally, participants felt the process for triage was inefficient, with too few patients being triaged. The group noted nurses were often 'doing nothing' due to the high levels of DNAs – but attributing the DNAs to inadequate processes, that did not account for regime.

Participants saw this as a poor use of time and resources and felt a more efficient triage service was required to meet the demand for services and support better outcomes for patients.

The participants were able to list the following services/support available to them in the prison.

Nurses	**GP**	**Opticians**	**Dentist**
Physio	**Phlebotomy**	**Podiatry**	**Diabetic Nurse**

"Some of them (health care staff) are brilliant, but their good work is overshadowed by bigger, systemic issues with health care".

Residents were asked to rate the primary healthcare at HMP Bullingdon. Collectively, the group rated the services as poor or very poor. When discussing the care delivered to patients, the entire group acknowledged there were 'some key staff that cared and tried', but there remained an overall perception of wider inadequate processes and services. Additionally, the group highlighted a 'significant lack of (social) care' for older adults. This included a lack of support with personal care, adaptations for cells and the wider prison environment; and assessments for patients showing signs of dementia and residents that experienced other neurodiverse conditions.

Access

Participants highlighted two ways to access help on site, these included:

Via app process	**Via health care rep (one wing only)**

The group felt app processes were inconsistent and further work needed to create a more efficient and effective system. Participants agreed it was possible to access nurses 'if you were proactive', but attributed the most successful way to access healthcare was via the healthcare rep. The group felt the triage list could be better managed to make the best use of patient and nurse time. Participants suggested the patient list for morning triage services were generated too late to maximise engagement and was the primary reason for missed appointments.

It was explained a daily triage list was issued each morning, but this was often too late; and subsequently those who had requested to see healthcare had already gone

to work or education, without knowledge of an appointment. The group felt a more efficient way of managing this would be to generate a list the previous afternoon to alert patients of their appointment the following day; or to offer an afternoon triage service enabling patients to be alerted in the morning, providing adequate notice to attend in the afternoon. Additionally, the group felt urgent requests to see health care were rejected based on full triage lists, despite unreasonable numbers of DNAs. When considering patient access across all the primary healthcare services, collectively the group felt general waiting times were too long and this negatively impacted on patient outcomes.

Nurses

The group reported there was a distinct difference in the level of care provided by Care UK nurses and agency staff; and this created inconsistency in the care they received. Participants felt the nurses employed by Care UK were 'caring and tried' but agency staff were, at times 'disrespectful', with 'little care or understanding' of patients in prison. Participants that suggested more directly employed nurses were required to better support the health needs of the community.

GP

Participants overwhelming felt the GP offered a 'good service' and felt 'well cared for' when accessing the service. However, the group highlighted the wait for GP services was unreasonable, stating it could be a number of weeks after submitting an application before they would receive an appointment, by which time health issues had declined further.

"The GPs are good. There is one that will go above and beyond for patients, the problem is it can be too late, things get worse. The wait time is far too long sometimes, and by the time you see him, you can be in agony".

Dentist

Participants felt routine dental check-ups were well managed but felt accessing emergency treatment could be problematic. Collectively participants reported the quality of the dentist was good, but accessing urgent appointments was difficult and lengthy waiting times for x-rays delayed treatment.

Opticians

Again, waiting times and long waiting lists were highlighted as the priority concern for patients when discussing the service provided by opticians. The group felt access issues impacted negatively on their views of overall quality of service, describing it as poor.

"Once you're in, it's ok, the battle is getting an appointment, other than that I have no complaints".

Physio

Physio was highlighted as another service in which waiting times were viewed as unreasonable. One patient highlighted he had been waiting for 4-5 months to see a physio and other group members corroborated this by noting it 'was not unusual'. Outside of the perceived unreasonable waiting times, participants felt the service was satisfactory once accessed.

Social Care

Participants reported a distinct lack of social care on site for, predominantly, older adults, though did highlight a lack of assessment and care for those with wider neurodiverse conditions. The group felt dedicated social care was needed for those who struggled. Participants reported the only provision for older adults was a buddy system. Buddies helped others with personal care, assisted with dressing, getting medication and meals, but felt strongly this should not be the sole resource available for those who needed social care support. The group felt care for older adults was inadequate and care standards needed to be clear and met by services. The group agreed in addition to specialist care, adaptations to the environment were required to support health equalities for older adults.

"It's not fair, old boys are forgotten here. They need so much more, but it's like no one cares, they are just left to slowly rot. It's a disgrace. The boys (buddies) do what they can, but that isn't nearly enough, and they are not trained professionals, just doing what they can".

Podiatry

Residents agreed podiatry offered a good level of care but noted extended waiting times could exacerbate health concerns. One resident explained long waiting times had caused a condition to worsen and it was no longer treatable in prison, requiring a referral to hospital thus resulting in further waits and increasing pain. The group noted early intervention could have resolved the issue without the need for treatment outside of the prison.

"It's just a verruca, you think it would be simple to treat. Delays in being seen means they (Podiatry) can no longer treat it here, it's too big and too deep. Because it is so painful, I raised it with DHL, they have said I can no longer work there, so it's impacted on my job and I have to wait for god knows how long to get an outside appointment".

Patient Recommendations

- Reduce waiting times
- More staff and consistent care
- Improved access to all services through efficient and effective app processes
- Improved triage processes that works with regime and not against it.
- Additional services to reduce clear waiting lists
- Early intervention for simple conditions
- Increased social care for older adults/adaptations for environment
- Reduced cancellations for outside appointments and transparency as to why cancellations had taken place
- Health care reps on every wing
- Assessments for those with neurodiversity.

HMP Bullingdon – Mental Health

Patient Perspectives

"All prisoners have issues (mental health), even if it's just stress or worry, services should assume everyone needs their help and work from that basis…self-secluders are slipping through the net. People are suffering in silence with nowhere to go".

Engagement

A focus group was undertaken with 2 residents from HMP Bullingdon regarding their perceptions of mental health services, their experiences and what they consider important when accessing these services on site. We asked residents to determine what was important to them when engaging with services, why this was important, what currently works at HMP Bullingdon, and finally, suggestions to enable service development, supporting improvement to patients' outcomes.

Both participants were current service users or had accessed the service during their sentence. Before the start of the focus group, the residents were informed of what a Health Needs Analysis (HNA) is and how their contributions would be utilised within it. Residents were asked how being in this prison impacts on their mental health and there was a mixed response. One resident felt he was beginning to manage his mental health through the ongoing support of a worker, though '*feared for others*'.

"*My worker is great, she listens and has helped me through the worst, I'm not sure where I would be without her. It's still hard but with support I know someone is there*".

The other participant stated the support he received in the first six weeks of his sentence had helped, but since being discharged from service felt a decline in his mental health. He reported he had tried to access mental health services a number of times for further support, but to date he had not received a response.

Participants suggested the wider prison environment contributed to residents mental health issues. Stating there were too few officers, a lack of understanding of mental health conditions, increased in-cell time, access to spice was easy, alongside limited access to services to support improved mental health and reduce substance misuse.

Both participants agreed that some residents resorted to self-medicating through the trading of medication and use of illicit substances rather than reaching out for help and felt there was '*lots of hidden mental health*' within the prison.

The participants were able to list the following specific services/support available to them;

121 Worker	Psychiatrist	Psychologist

Residents were asked to rate the mental health services at HMP Bullingdon, and the responses, again, were mixed. One resident stated support from a mental health worker had solely contributed to the improved management of his mental health. The second participant agreed 121 support had helped him but felt support had been time limited and he experienced difficulties when trying to access further help. Both felt residents would benefit from more workers and a wider variety of interventions to help them manage their mental health.

Access

Participants reported there were two ways to access mental health services, via the application process and during induction when first entering prison.
The major concern highlighted by residents reagrding the app process was that it was ineffective for those who required immediate mental health support or fell into crisis. Participants noted the average wait time for a worker to be approximately three weeks, in which time participants believed '*anything could happen*'.

Both residents reflected on their induction process as a positive way of accessing services, agreeing they had been assessed quickly and the mental health service had repsonded promptly to their needs, including support to access medications. Residents felt there were not enough mental health workers to confidently manage the number of patients who required support. Both residents agreed the mental health workers were kind, caring and responsive but sessions could '*feel rushed*' due to large caseloads.

> "*My worker listens to me and helps me work though the things that make worry. I was in a very poor way when I came into jail, but this has slowly improved".*

Barriers to Access

The group felt the service could offer a wider range of access points and this would encourage more residents who needed help, to ask for it.

One participant felt that mutliple apps had not secured him the help he needs and offered further examples of this from the wider community, leaving patients feeling the app process was frustrating and problematic.

Raising awareness within the prison to whole communities was suggested as a way to challenge the stigma of mental health, which was seen as a barrier for some. They suggested further health promotion and mental health awareness days could help overcome this. Both participants who mentioned this would encourage referrals from residents and improve relationships and understanding across the prison communities – including with officers.

Residents felt the perceived lack of understanding from officers prevented residents from seeking help. The group suggested officers responded to disruption caused by ill mental health, with punishment and without fully understanding the root causes for poor discipline.

> "*There's lots of ways access to services could be improved, teams need to think creatively to reach out to everyone. Lots of people need help".*

Quality of Service

"My worker knew where I was at and I was having some personal problems. The GP wanted to change my medication, but my worker explained it wasn't the right time".

When discussing the quality of the service participants agreed the support provided by mental health workers was '*good*' and promoted improved mental health in patients.

An example provided by a participant of a quality service included a mental health worker challenging a GP decision to reduce medication at a time the resident felt unstable. "*I was listened to and I appreciate that, I trust them*".

However, unamimously, both participants felt the number of mental health interventions were limited and more could be done to improve overall quality.

Both residents agreed information on induction could be improved, suggesting a more comprehensive information pack could be issued to new receptions that included techniques to help cope with life in prison.

Additionally, residents felt wing-based groups that addressed stress, anxiety and depression would improve the quality of service and day to day life for residents and act as an early intervention.

"Having groups on the wing would help a lot of people, I think it would help people deal with prison before their problems get too big".

Peer led Initiatives.

Residents reported the mental health service did use reps/mentors in the prison, but felt they would be beneficial for the community. Residents suggested reps could provide an alternative way to access services and offer support to those with low level mental health concerns. Residents suggested trained mental health reps could help reduce the number of patients requiring support, enabling workers to prioritise those with significant issues. Participants suggested reps on induction would strengthen the service and provide new receptions with a trusted person to go to if they needed help.

Continuation of Care

Both participants were unsure of the support provided to residents when planning for release. One resident was being released within a week after serving five months in prison and was experiencing ill mental health. He expressed he was very concerned about how to access support in the community as he was being released homeless.

He aknowledged support in prison had helped his mental health, but felt it would be helpful for services to work with him to secure support in the community.

Both particpants felt it would be useful to leave prison with contact details for local community mental health services but understood the limitation to this for those released with no fixed abode.

"It's a very worrying time for me thinking about release. Part of me wants to stay here because I have been helped, my mental health is better. My worker would help if she could, but what can she do when I have no home. I lost my home coming to prison and right now, I have nowhere to go when I am released".

Both residents agreed it would be useful for mental health services to raise awarness in the community of how they could help people when planning for release namely to manage the expectations of patients, reduce stress and improve outcomes.

Additional Discussions
Bereavement counselling/support was raised as a priority for residents. They highighted the service provided from the Chapliancy was limited and specialised counselling such as Cruse Bereavement support would benefit those who had experienced a loss.

The partipants also discussed the current processes for medications. Both reisdents reported the queue for controlled medications regularly took up to an hour and queues were poorly managed by healthcare and officers. Both participants highlighted slow processes when nurses administered medications, resulting in patients becoming frustrated and being abusive to nurses, supervising officers and other residents.

ACCT was raised as a primary theme requiring improvement. Residents agreed existing practises seemed like '*more of an observation process'* rather than a meaningful way of managing risk and enabling improved mental health. Participants felt there was *'very little confidentiality'* for those on ACCT and this could increase risk rather than reduce it. '*Everyone knows you're on it, everyone knows you're vulnerable'*.

Participants felt strengthing family ties was important to them and helped them in managing their mental health. One resident felt there was an inadequate number of phones working on his wing and this limited residents in accessing thier families for support. He reported feeling intimidated using the working phones but highlighted the phone as *'a lifeline'* for some residents.

Patient Recommendations
- Increased service provision including counselling, groups and/or courses for stress, depression, anxiety and coping mechanisms
- Structured mental health and emotional wellbeing mentor/rep programme
- Increased health promotion including; mental health days and officer training
- Increased staffing levels
- Mental health wing drop-ins

HMP Bullingdon – Recovery Services

Patient Perspectives

"Staff with lived experience get it, know the struggles, it's the best thing about the services here, there should be more of them, people who've been through it, get us."

Engagement

Table 2:

A focus group was undertaken with 3 residents from HMP Bullingdon regarding their perceptions of recovery services, their experiences and what they consider important when accessing these services.

Residents from across the prison, with a variety of experiences participated to discuss themes related to the current service provision. We asked residents to determine what was important to them when engaging with services, why this was important, what currently works at HMP Bullingdon, and finally, suggestions to enable service development, supporting improvement to patients' outcomes.

100% of the participants were current service users or had accessed the service during their sentence and two of the three participants were or had received clinical treatment alongside psychosocial support during their sentence. Before the start of the focus group, the residents were informed of what a Health Needs Analysis (HNA) is and how their contributions would be utilised within it.

Residents were asked how being in this prison impacts on their substance use. Two thirds felt their substance use had improved, with the remaining one third of the group stating his substance use had been varied since coming to prison.

When asked to discuss their responses, residents who felt their substance use had improved attributed to this to a successful detox and a greater awareness of substances through drug awareness courses they had completed. For the participant who felt his substance use had changed, stated his drug use, at times in HMP Bullingdon had increased and changed based on the availability of substances in the prison. He had recently been approved for Espranor, to help manage his dependency and saw this as a positive step in managing his substance use, reporting previous relapses when detoxing on Subutex and Methadone.

The participants were able to list the following specific services/support available to them;

Psychosocial support – 121	Detox	Awareness Courses	Acupuncture

Table 3:

Residents were asked to rate the current recovery care services at HMP Bullingdon, and the responses were mixed. Collectively the entire group felt services needed to be developed to ensure they were a good fit for patients in prison, and reported the positive work undertaken by recovery workers was often undermined by the availability and trading of illicit substances. The group noted prison staff lacked understanding of substance use and dependency and this supported disengagement from the service.

Two thirds of the group felt recovery services had somewhat met their needs, with access to informative courses and successful detoxes. However, this cohort felt a reduction or withdrawal of psychosocial support directly following completion of detox and the courses negatively impacted their recovery going forward.

'Detox isn't enough, you need ongoing support, the relapse prevention course is ok, but regular support from workers help the most. Someone to talk to when you struggle…. or NA that would be good, would help a lot of people".

The final resident felt that much more was needed to strengthen services, reporting that despite failing MDTs he was not referred to recovery services and the only response to positive drug tests was to be punished by prison staff. Before reaching out for help, he explained how he resorted to extreme actions to obtain illicit drugs, including violence against others. He suggested recovery services needed to work in partnership with the prison to provide supportive responses to positive MDTs, rather than the current punitive approach, which favoured punishment over support.

There was a consensus 121-support provided by recovery workers was good and those with lived experience were valued highly by participants, offering an authentic understanding and sense of integrity to the service.

Access

Participants reported only one known access route to services; via the app process. The group felt despite, on occasion, taking '*a long time*', most requests for support would be acknowledged. Participants highlighted experiences where multiple apps had been submitted before support was provided and raised concerns over this feeding into increased use and trading of illicit substances.

The group discussed their experiences when coming to the prison for the first time and participants agreed induction/reception processes could be improved; two thirds reporting unreasonable gaps in treatment causing them increased stress and unmanageable physical withdrawal symptoms. The group suggested there was a '*disconnect between services from the point of induction that ran all the way through prison*'.

""*If someone is reaching out for help, they need it today. People will just self-medicate, that's how people acquire drug habits in prison*".

The remaining participant felt a referral to services had occurred within reasonable timeframes following induction and that they'd been able to see a worker promptly. Collectively the group saw a distinct difference in their needs and suggested access to services was more problematic for those requiring clinical treatment, rather than those solely accessing psychosocial services.

Barriers to Access
The main barriers reported by residents when considering engagement was the responsiveness of the service, the limited number of interventions available, the limited ways to access the service and the reported widespread availability of drugs in the prison. The group unanimously agreed more workers with lived experience would offer people in prison a more authentic approach to recovery and would encourage those who use substances, but are not accessing services, to engage.

Participants suggested the introduction of wing-based recovery reps/mentors would support '*visibility*' of the service and could offer an alternative to the app process for those who required support.

Quality of Service

> *"They could do more, more relevant courses, NA, drop-ins, reps, provide support that didn't drop off after you've done your course, choice in how you manage detox, all of those things would improve the quality of the service".*

Participants highlighted the recovery workers as the most positive part of the service and felt increased staffing levels would enhance the quality of support. Additionally, they agreed a wider range of interventions would maximise reach to those who use substances. Suggestions included group interventions, awareness days, and courses that addressed a wider range of substances. One resident stated that whilst he had found drug awareness courses informative, he was disappointed that benzodiazepines were not addressed within any course content, and this was his substance of choice in the community.

One resident explained how the introduction of Espranor improved the quality of service, both to patients and wider prison. He based this on how quick the medication could be dispensed and taken, its inability to be traded in the community, and most importantly to him, '*acted as a blocker to other drugs'.*

Peer led Initiatives*.*
Participants reported that recovery reps/mentors did not operate within the prison. When discussing barriers to access - all participants agreed further pathways to support would be helpful, suggesting that embedding '*lived experience'* throughout the recovery services, including reps would enhance opportunities for residents to engage. Suggestions included the training and recruitment of a team of wing-based peer mentors who worked alongside staff to support others and facilitate groups.

Continuation of Care
When discussing continuation of care participants believed no support was in place to help residents plan for release. Collectively, the group agreed recovery workers would '*try to help as best they could'*. Support accessing community services was highlighted as a priority theme for people planning release, alongside having copies of recovery plans as evidence of the work they had done in prison towards a substance free life. Alongside this participants noted naloxone training would be beneficial.

Additional Discussions

The group reported the ease of obtaining and using of illicit substances across the prison remains a barrier for some people in terms of recovery. Particpants spoke openly about the availibility of illiict subtances in their community. Self medication was noted as a reason to use illicit substances. The group felt a variery of healthcare needs went unmet in the prison and this attributed to some substance use. Viewing residents usage as a means to better manage physical pain, better cope with mental health issues and reduce substance dependency cravings.

"It's rife, everyone sells everything…heroin, spice, steroids, Valium, cannabis…you name it, it's being sold. Drug debts are collected in one way – violence".

"Get unlocked late, get banged up early, what else is there to do? Doing whatever takes you away, releases the boredom and monotony of prison".

Participants felt that a lack of purposeful and meaningful activity compounded the issue of substance use, with boredom playing a significant role in illicit use. There was a feeling that recovery services should be more proactive in responding to this. All participants agreed physical activity not only served as a deterrent to use substances, but aided in *'killing boredom'* and achieving a sense of overall wellness.

Residents felt more work could be done to train or educate prison staff in substance dependency and in how to manage and respond to requests for support. Prison wide awareness days were offered as a suggestion to build understanding and community cohesion.

Patient Recommendations

- Increased staffing levels, particularly those with lived experience
- Supportive responses to positive MDTs in preference to punitive ones
- Structured mentor/rep programme
- Introduction of AA/NA
- Wider course content
- Group interventions or wing-based drop ins
- Recovery awareness days
- Additional Gym – more meaningful and purposeful activities
- Improved partnership working between prescribers and GPs.

13 Methodology

Key Methodologies

13.1 A range of the key methodologies used to complete this HNA is set out below.

Measuring throughput

13.2 'Turnover' is defined by the MOJ as 'A measure of how fast a population turns over. Prison level turnover may be defined as (first receptions + transfers in)/ (average population) or (first receptions + transfers in + change in status)/ (average population).' Using NOMS/HJIP data, there were 2514 new receptions in the year to March 2019, plus 1426 transfers/recalls; totalling. = 3940 arrivals.

13.3 Based on an Op Cap of 1114; this is a turnover of 3.54 to 1.

Prevalence of Health Conditions

13.4 Disease prevalence in the prison has been calculated based on counts of disease seen as a proportion of the prison population at that time. Moreover, where possible, general population prevalence data has been researched and used to enable comparisons to be drawn.

13.5 In addition, the overall prevalence (%) and expected number of prisoners with a condition has been calculated using age-specific data, where possible. This considers that certain diseases are more common in different age groups, i.e. long-term conditions are more prevalent in older populations, asthma is more prevalent amongst younger populations and some conditions occur across the whole population regardless of age. Where appropriate, information for specific conditions is set out in detail in the appendices.

13.6 Local data has been extracted from the SystmOne database. SystmOne is used for health surveillance amongst prisoners and records Quality Outcomes Framework (QOF) prevalence and benchmarking against national rates. However, for the purposes of this needs assessment SystmOne has been analysed to establish the numbers of patients on the major conditions registers at different points in time to assess the profile and hence prevalence of these presentations in the prison.

13.7 Some caution should be applied in interpreting the local data, as it is reliant on the use of correct and consistent 'read codes' of diseases by healthcare professionals, which has the potential to be incomplete and is more likely to underestimate prevalence.

Prevalence explained

13.8 Prevalence provides a measure of the population burden of a disease, and therefore assists with service planning. There are two measures of prevalence:

point prevalence and period prevalence. Point prevalence is the number of persons with a disease *at a single point in time*, whereas period prevalence relates to the number of persons with a disease *at any time over a specified period*. In this section point prevalence has been used.

13.9 QOF prevalence is the number of patients on a prisons clinical register, which can be used to calculate measures of disease prevalence. It expresses the number of patients on each register as a percentage of the number of patients on the prison list.

Key Data Sources:

13.10 The specific prison HNA Data requested and its analytical rational are set out below:

Prison population from prison data system (setting context for the H&SCNA)

Prison Description:
Prison category – Capacity - Resident units (capacity and description)
Prison Population (snapshot - as of xx date):
Number of prisoners
Breakdown by sentence (number on remand/convicted or un-sentenced/sentenced/recalled/other)
Length of sentence (i.e. <6 months/6 months - <1 year/1 year - <2 years etc.
Age profile (single years or age groups)
Ethnic profile - Nationality – Disability - Sexuality
LA of residence
Transfers from CYP secure estate (to adult prisons)
Prison Population capacity and turnover (past 12 months/latest 12-month period):
Number of people entering prison each year (receptions) (annual)
Number of prisoners released to community (annual) - Transfers (annual)

NB *Additional Descriptions*: Prison accommodation and Layout (Capacity and description)

13.11 HealthCare Data (Drilling down into the Health Needs of the Establishment) Analysis:

- Prevalence (count, x% of population with presenting need)
- Profile of Conditions by Age (count, x% of population with presenting need)
- Profile of Conditions by Ethnicity {standardised categories} (count, x% of population with presenting need)

SystmOne Data Report:

Condition	Condition
AST001 – Asthma Register	AF001 – Atrial fibrillation register

Condition
BP – BP Register
COPD001 – COPD Register
CAN001 – Cancer register
CVD-PP – CVD Register
CKD001 - Chronic Kidney Disease Register
DEM001 - Dementia Register
DEP - Depression Register
DM017 - Diabetes Register
EP001 - Epilepsy register
HF001 - Heart Failure Register
HYP001 - Hypertension Register

Condition
LD003 - Learning Disabilities Register
MH001 - Mental Health Register
OB001 - Obesity register
OST004 - Osteoporosis Register
PC001 - Palliative Care Register
PAD001 - Peripheral Arterial Disease Register
RA001 - Rheumatoid Arthritis Register
CHD001 - Coronary heart disease register
STIA001 - Stroke and Transient Ischaemic Attacks Register

- We have taken a SystmOne report for April 2018, July 2018, September 2018, December 2018 and March 2019.
- To address prevalence, we have data for the whole prison population, the whole prison age profile (in bands) and the whole prison ethnicity profile by standardised ethnic categories.
- We have data also for the prevalence of the whole prisoner population in England and the whole general population in England.

13.12 Screening for health needs operational data

- First Night screening: copies of the tool/questionnaire
- Last 12 months (month by month) counts of levels of screening eligibility, consents and actual screening undertaken for:
- AAA – Diabetes - Health Checks - Bowel Cancer - And any other Screening activity you undertake.

13.13 Escorting and Bedwatch

- 12 Month period by Month
- Count of Escort to external outpatients (Hospitals and A&E) (Counts and time/if available and reasons for the offsite visit)
- Escort/Bedwatch for External Operations (Counts and time/if available and reasons for the offsite visit)

13.14 Death in Prison

- Count in last year, previous years if appropriate/available from 2010 to date
- Breakdown of reasons for death

13.15 Sexual Health

- Core data – STIs by type
- Prevalence of need against the prison population

13.16 Mental Health

- Mental Health Register
- Breakdown of MH conditions presented
- Profile of presentations by age and ethnicity

13.17 Drugs and Alcohol

- Drug use by choice of Drug/Alcohol
- Opiate and non-opiate - Opiate substitute treatment

- Those in treatment - Treatment outcomes - Successful completion
- Clinic times - Key working - Care plan and service user support
- Range and take up of therapeutic provision

13.18 Additional Operational data (not all of which is statistical)

Level of prescribed drug use
Controlled drugs
Non-controlled drugs
Preventing ill-health and promoting wellbeing:
Mental health promotions and well-being
Smoking cessation/reduction
Healthy eating
Oral health promotion
Sex and relationship education and parenting classes
Healthcare Provision (clinics/times etc.) (Programme timetable
Staffing
Healthcare staffing levels (structure chart, whole time equivalent posts, vacancies)

14 Learning from HMP Durham and HMP Wandsworth

14.1 HMP Bullingdon is due to complete a reconfiguration process from a Cat B Local to a Reception and Resettlement Prison in the Autumn of 2019. This paper seeks to highlight the findings and experiences of HMP Durham and HMP Wandsworth, which have both undergone the reconfigurement process in 2017.

HMP Durham

14.2 Overview of the Commissioners.

- Feedback from healthcare staff has been that they felt unsafe in the reception area due to the volume of prisoners, availability and visibility of discipline staff.
- The reception area needs to be carefully planned out (for health and discipline processes) and any remedial work to make it fit for purpose completed prior to the role change (including IT and S1 access).
- There is insufficient time to complete the secondary health screening; mental health assessments and psychosocial DART assessments – this means that care plans are not always fully complete.
- When healthcare needs are identified, that require a secondary care referral, this is made but when the men are then transferred the whole process has to start again.
- There is the additional risk created by license recalls, short stays and the potential of people coming in packed with drugs.
- There was a significant increase in men suffering from mental health and substance misuse needs.

Table 4: HMP Durham SM Caseload v Reception intake Example

Operations change

Year	Number of new receptions	Number of new receptions beginning a substance misuse treatment episode	Proportion	Receptions	SM Cases
Q1 2016/17	916	492	54%	0	0
Q1 2017/18	1123	589	52%	207	97
Q1 2018/19	1378	720	52%	462	720

Table 5: Number of Mental Health referrals HMP Durham from Jan 2016 - December 2018

All information has been provided either by Systm1 or HJIP returns.	2016	2017	2018
JANUARY	124	143	329
FEBRUARY	122	150	289
MARCH	113	171	337
APRIL	121	160	307
MAY	119	206	370
JUNE	100	277 **R**	353
JULY	115	284	368
AUGUST	137	271	347
SEPTEMBER	135	270	335
OCTOBER	143	289	342
NOVEMBER	160	325	341
DECEMBER	146	299	255
TOTAL	**1535**	**2845**	**3603**
MONTHLY MEAN	**128**	**237**	**300**

R = The month that HMP Durham officially became a remand prison, however an increasing number of remand prisoners were accepted into HMP Durham several months leading up to June 2017.

- The men transferring from HMP Durham are not always stabilised on opiate substitute therapy and/or mental health medication.
- The nature of care has had to change, with the mental health team reporting that the majority, if not all, of their time is spent undertaking crisis care due to the complex nature of new presentations/receptions.
- This has been a very challenging process to manage for both NHS England (commissioners and providers) and HMPPS. An unintended consequence of the reconfiguration process has been the significant stress and pressure that it has brought upon individuals and the system itself.
- The reality is that they have had to be reactive not proactive, managing risks and crisis daily.
- There have been significant risks to patient safety introduced into the system that have occurred since the re-role. This in turn has an impact on healthcare's ability to recruit and retain staff, putting further pressure on an already strained system.
- It impacts upon receiving establishments and their workforce given the churn rate from HMP Durham.

- The data that was provided pre-reconfiguration did not match what happened. Resources have not been able to be realigned due to the significant churn and there is increased pressure on the workforce and the system.

Table 6: Summary of predicted and actuals in HMP Durham HNA refresh Dec 2018[76]

Predicted	Actual
• Previously new receptions into prison from the community were 2,784 P.A. into Durham and 1,608 into Holme House. • Therefore, combining these, we projected receptions in HMP Durham would increase by 58% from some 2,784 P.A. to 4,392. • The MOJ briefings did not describe significant numbers transferring into HMP Durham.	• Using the same data source as the projection, MOJ describe 3,871 for the year to March 2018.46 This is a partial picture and less than projected. • Note there is an enormous discrepancy between the numbers given by MOJ and the numbers from the prison. • The prison described 3,224 first receptions, plus 416 transfers in, combining to mean 3,640 for the first half of 2018/19. This equates to 7,280 per annum, which is 65% greater than projected. • This is in part because no one foresaw transfers in from other prisons continuing. This will account for some 800 receptions this year. The local description stated the number of transfers has increased. The prison-supplied data does not support this claim. • The prison data indicates that from the north east, the volume of receptions from the community has increased; this is at a time when MOJ state that first receptions across the whole estate are decreasing.47 • Data is contradictory, but generally described an increase far greater than projected.
• Data about the proportion of the population who were remands was confused. Our best estimate was that the remand population would increase to 530 men.	• As projected, the OMU return dated 4.10.2018 described 556 prisoners on remand, convicted unsentenced, or sentenced uncategorised.
• The previous SLA described 20 long-term prisoners (2%). We predicted this would be unchanged (subsequently the prison supplied contradictory data describing 20% of the population as having been in the establishment for over a year).	• Our only data point is the local HMP supplied data. Currently 3.6% (34 men) have been in the establishment for over a year.
• We were told that in the future all short-term recalls would go to HMP Durham. That would have meant that up to a quarter of the	• We did not obtain data for current recalls.

[76] HMP DURHAM HEALTH AND SOCIAL CARE NEEDS ASSESSMENT November 2018 Tamlyn Cairns Partnership

Predicted	Actual
population could have been recalls (increased from 14%).	
• We projected drug treatment starts would increase from 1,420 P.A. to 2,240 P.A.	• The number of new starts during 2017/18 was 2,837 (2,524 for drug treatment and 762 for alcohol, including an overlap of 449 non-opiate and alcohol users who are in both groups). • The proportion of all new receptions commencing either drug or alcohol treatment is far higher than in any comparator prison. There is no explanation for this. • We projected a 58% increase in new treatment entrants to drug treatment. The demand increased by 78%.
• We predicted a doubling of mental health presentations	• As predicted, a greater proportion of prisoners presented to MH services (up from 60% of all prisoners to 71%). • It is not easy to determine numbers. A consistent measure is the number of patients with a read code for a mental health condition, excluding addictions. This will double count where a patient has more than one condition. The count was 1449 in 2016/17. It was 2768 in 2017/18. • As projected, the number doubled.
• We predicted a greater proportion of primary care conditions would be unmanaged. We were not able to make numerical predictions.	• Primary care described their new role as assessment and urgent care. As such, the management of long-term conditions has been largely eclipsed.

14.3 Despite the best endeavors of all concerned, in many ways this has been a reactive process, as planning assumptions have not matched with the reality. There remain significant challenges, particularly regarding patient safety, recruitment and retention of staff.

HMP Wandsworth

14.4 HMP Wandsworth did not take part in a pilot reconfiguration prison. Healthcare in particular was going through a recommissioning process at the time. Many in the establishment, as well as NHS England commissioners, felt that HMP Wandsworth was not suitable for the first phase of the reconfiguration process.

14.5 As such there is a lack of direct learning to be gleaned from their experiences as they are at the same position as HMP Bullingdon.

Headline findings:

14.6 From HMP Durham's experience it is evident that the health needs of prisoners have not substantively changed, certainly not in terms of prevalence of specific conditions and general health needs. However, what has changed has simply been the volumes of receptions and transfers and the increased throughput in the prison and thus the time it has taken to process clients has increased. This has created a huge strain on the healthcare services on site. Substance misuse and mental health patients have increased in volume. The proportionality of need, however, has remained constant.

15 Equality Impact Assessment

15.1 This equality impact assessment (EqIA) of the health and social care provision in HMP Bullingdon has been done in conjunction with this Health Needs Assessment. The normal focus an EqIA is to ensure that services meet NHS England's responsibilities under the Equality Act 2010, and its subsequent amendments.

15.2 Indeed, NHS England like all other public bodies has a duty through the Equality Act 2010 to:

(a) have regard to the need to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

15.3 The nine protected characteristics set out in the Equality Act are set out below. These are going to be the base line elements of any equality impact assessments:

15.4 The HNA has identified the profiles of various protected characteristics within HMP Bullingdon and this includes; age, gender, disability, ethnicity, sexual orientation, religion and faith. Data is not available with respect to the protected characteristics of pregnancy and maternity, gender reassignment and marriage and civil partnership.

What does the current equality data show?

15.5 The **age** distribution of the current prison population ranges between 18 and 70 years, which illustrates there is a broad representation across all ages. Overall, the prison population is younger in comparison to the age profile of the male prison population and the general male population of England and Wales. Most of the prison population of HMP Bullingdon are in their thirties (33%) and twenties (30%). Nationally, 16% of the

prison population are aged 50 and over, and this age has risen faster than any other age group over the last decade.[77] In HMP Bullingdon, a lower proportion of the prison population are aged 50 and over (11%)

15.6 The **gender** profile of the prison is male.

15.7 The **disability** profile of HMP Bullingdon was not available at the time of this HNA, however the last HMIP inspection self completion questionnaire stated that 31% of prisoners felt they had a disability.

15.8 There is more **ethnic** diversity in the population of HMP Bullingdon with prisoners from BME groups representing 30%, compared to 28% across male prisons in England Wales.

15.9 11% of the prison population was made up of foreign national prisoners. This is consistent with the proportion of foreign national prisoners that make up the male prison population of England and Wales (11%).[78]

15.10 The profile of **religion** shows 48% identify with Christianity and 18% Islam and 28% stated they had no religion.

15.11 In HMP Bullingdon from a **sexual orientation** perspective, 83% reported they were heterosexual, 0.6% reported they were gay, 0.3% bisexual and the remaining 16%, sexuality was unknown.

15.12 There is no data available on the number of **transgender** prisoners in the population of HMP Bullingdon.

15.13 There is no data available on **marriage/ civil partnership** and or **maternity/paternity or pregnancy.**

15.14 The table below seeks to highlight where there may be instances of negative impact on specific protected characteristics and also to identify potential actions to mitigate this negative impact.

Table 7: Equality Impact Assessment outline grid

Protected Characteristic	Possible Negative impact	Potential mitigating action
Age	• There are clear differentials in the health needs of older patients however health care are responsive to the needs of all age groups • LTC and obesity have higher prevalence in older prisoners • There is an increasing number of patients that are likely to be	• Implement the social care MOU and build a social care environment within the prison through training and awareness raising particularly of the roles of different parties and referral pathways

[77] UK Prison Population Statistics, House of Commons Library Briefing Paper, 23 July 2018

[78] Offender Management Statistics, Table 1.7, Jun 2017

Protected Characteristic	Possible Negative impact	Potential mitigating action
	presenting with forms of dementia, there is equally a need for a dementia pathway in the prison • Older prisoners in the focus groups have stated that their needs are simply not catered for	• Formalisation and training for the current buddy system of supportive care in the prison to bolster provision • Establish dementia pathway • Establish geriatric care pathways where appropriate
Gender	• The prison is a male prison and hence there are no inequalities on the basis of gender	• None required
Disability	• Physical disabilities are presented to the prison • There is a limitation of appropriate disability specific cell space, with approximately adapted cells • LD are not picked up and there is a need to develop a LD pathway • The social care contract is in place and there are some opportunities to have resources provided that address the needs of people with specific impairments. (this may take time and is likely to be a longer-term solution which may not fit into the reconfiguration of the prison	• Identification of accessible cell space to ensure that appropriate modifications/adaptions are in place • Review existing provision for people with learning disabilities and Establish an LD pathway within the prison
Ethnicity	• There is a disparity in the presentation of health needs by different ethnic groups with a disproportionately low level of presentation from BAME residents on the obesity, epilepsy, hypertension registers	• Seek to identify if there are any 'cultural' barriers to presentation within the prison • Review BAME patients on specific under-represented registers to seek to identify if there are any other reasons

Protected Characteristic	Possible Negative impact	Potential mitigating action
	and a disproportionately high profile on the diabetes register • There is a disproportionately low presentation of BAME residents on the depression register • There is a disproportionately low presentation of BAME residents in substance misuse treatment • Data is currently insufficient in that not all patient ethnicities are picked up on SystmOne	why there is this disparity in presentation • Ensure the ethnicity recording of patients is up to date and or corrected on SystmOne, this includes the minimisation of 'not stated' which will likely remain with men that are new to the prison system.
Faith	• There is no evidence that there are nay faith or religious based issues which negatively impact on the health profile of need in the prison	• None required • Maintain a constant review to identify if access to health services are being impaired by a prisoner's faith or if a prisoner's faith limits the equal opportunity to access services
Sexual Orientation	• From a sexual orientation perspective there is no evidence of any health inequalities based on this protected characteristic • Whilst not specifically a sexual orientation issue, maintain the screening for STI and HIV and BBV to minimisation the escalation disease that is a reflection of unprotected sex • Sexual assault is a reality in the prison system and vigilance and active working with the regions SARC is critical	• Work in partnership with the prison's equality team to understand the potential needs of prisoner who have a declared themselves to be gay or bi-sexual to ensure that they have equal access to all healthcare • Maintain an emphasise screening provision for STI particularly for men who have sex with men
Trans Gender	• There is no data held on any prisoner that is in transition	• None required currently • It is nonetheless important to maintain a review and to

Protected Characteristic	Possible Negative impact	Potential mitigating action
		have appropriate operational policies in place to ensure that health care opportunities are not denied to any prisoner because they are undergoing a transition
Marriage/civil partnership	• There is no data held on the marital status of prisoners within the health services available in the prison	• None required
Pregnancy/maternity	• Being a male prison there are no cases of pregnancy or maternity. • Paternity is potentially an issue that can cause stress and anxiety particularly for fathers who are excluded from their children particularly those that are excluded because of their prison sentence. • Paternity, however, is not recorded on SystmOne.	• Record parental status on SystmOne.

15.15 The identified possible negative impacts and the potential mitigation actions could be reviewed in conjunction with the healthcare risk register. This way the needs of different protected characteristics can be maintained and reviewed on a regular basis

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