Public Health
Resource Unit

Public Health Projects

NHS

HMP Bullingdon
Health Needs Assessment

SUMMARY & RECOMMENDATIONS

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1 HMP Bullingdon Health Needs Assessment: summary

1.1 Introduction

This Health Needs Assessment (HNA) was carried out between October 2007 and February 2008, with the bulk of the data collection (epidemiology, interviews, and other data) in November and December 2007.

The HNA was commissioned by Oxfordshire Primary Care Trust (PCT) and supported by the prison Governor and senior management team.

The aim of the HNA was to:

- Identify and describe all the services in Bullingdon that aim to promote and protect the health of the population.
- Describe and understand the needs of the population.
- Compare current practice with national and international guidelines and protocols.
- Compare the population, the services and the needs with similar establishments nationally.
- Take into account the views and opinions of stakeholders.
- Inform the Prison Health Delivery Plan (which is used to prioritise and plan services, as well as to allocate resources) and the health promotion strategy.
- Contribute to a three year action plan taking into account need, services, local and national priorities.

The full report is presented in three parts:

I. Introduction (Ch 1), overview of the prison (Ch 2), the health care services (Ch 3), and the prison population (Ch 4).

II. The data concerning the epidemiology of common and current health problems (Ch 5), a review of health care services and utilisation (Ch 6) and the experience and views of prisoners (Ch 7).

III. The corporate findings, (Ch 8-14) present the results in seven themes that emerged during the course of the HNA and analysis.

This brief summary presents the background and method followed by the recommendations, including the priority level that the HNA team attached to each one (excluding clinical guidelines).

1.2 Background

Bullingdon Prison opened in 1992 and operates jointly as a local and category B/C training prison for adult males. The courts area covered by Bullingdon Prison for receiving prisoners is the Crown Court at Oxford, and magistrate courts from the Thames Valley and surrounding areas. There is a health care centre providing 24-hour cover with an establishment of 23 beds. Bullingdon is located near the town of Bicester in Oxfordshire and has operational capacity for 963 prisoners, although an inspection in June 2004 reported 937 prisoners and criticised the prison for overcrowding. We found the prison to be operating at capacity throughout the assessment period.

There has been a previous HNA for Bullingdon Prison undertaken by the Public Health Resource Unit (PHRU) in 2005.

1.3 Method

We used the 'Toolkit for Health Needs Assessment in Prisons' developed by Dr Tom Marshall, Dr Sue Simpson and Professor Andrew Stevens of Birmingham University (February 2000). Whilst we recognised that many of the prevalence/incidence rates quoted will still stand, we were also concerned to include any newer estimates. For example, the increasing numbers of injecting drug users have resulted in higher rates for Hepatitis[1]. For this reason we carried out a brief literature review for each topic to identify any new sources as well as relevant findings from other work in Bullingdon or HNAs in other prisons.

We also drew on the work undertaken by Dr Tom Porter in the Huntercombe HNA (2006).

Highdown prison[2], built at the same time as Bullingdon, and to the same design, provided a comparator.

1.4 Key Findings

In total we identified in detail some 250 issues and 70 'Things to celebrate'. From these we make 276 recommendations. The 28 recommendations for good clinical practice are presented as guidelines and are not prioritised. The remaining recommendations are classified as 'high', 'medium' or 'low' priority. These priorities are based on the HNA team's assessment and the final action plan will need to take a number of other factors into account in deciding the final priorities.

This section presents an overview of the achievements since the HNA in 2005 and the key areas of concern.

1.4.1 Achievements in response to 2005 HNA recommendations

- The general practice IT system, EMIS was installed in Healthcare in 2006. The the recent employment of an IT Manager is strengthening the quality of data entry and audi.
- General Practitioner services have been fully contracted out to Wayside Network Ltd, an organisation with experience of providing GP service to other prisons. An extended GP clinic, started in October 2007, is beginning to reduce the number of prisoners needing health care appointments outside the prison.
- We found several examples of extended service achievements:
    - A psychologist in the Mental Health In-reach Team and funding to develop a day-care support service.
    - A specialist Addiction Service, in line with IDTS requirements, which includes substitute prescribing and/or detoxification.
    - The GUM service has been expanded and achieved a reduction in waiting times 6 weeks to between 1-2 weeks.

[1] Health Protection Agency: http://www.hpa.org.uk/infections/topics_az/injectingdrugusers/shooting_up.htm

[2] Sutton, Surrey. The catchment area comprises Croydon and Guildford Crown Courts and surrounding Magistrates' Courts. Currently operating as an overflow for YOs from HMYOI Feltham and HMP Chelmsford

1.4.2 Additional assets/strengths

- Oxfordshire PCT has a dedicated commissioner for HMP Bullingdon and YOI HUntercombe. This compared favourably with other prisons in the South East Region.
- There are a lot of dedicated and skilled nursing staff, who have the potential to develop their roles and be used more effectively. During the assessment several staff emphasised their willingness to develop their roles and skills:
    - Existing RMNs want to do more work with prisoners with mental illness and personality disorders, as well as helping those with anxiety and sleep disorders.
    - Pharmacy staff want to take on medicine management and more pharmacy lead clinics (such as skin clinics).
- Hep B vaccination coverage has increased from 5% in January 2007 to 93% in June 2007, resulting and a £10,000 national reward for achievement.
- Discharge planning of vulnerable prisoners from Inpatients has greatly improved, to include a pre-discharge meeting with wing staff.
- Since the implementation of the Addiction Service and substitute prescribing, the Safer Custody Officer has noted a reduction in the number of ACCTs opened in relation to prisoners detoxing.
- A consultant was recently contracted to undertake a disability audit of Healthcare facilities.
- A regular crown green bowling and gentle exercise session recently organised to meet the needs of older prisoners.
- The dental contract has been expanded to include dental health promotion inputs. However, this service is still too stretched (see below)

1.4.3 Weaknesses in Strategic Planning of Health Services

- There is not a coherent vision amongst Healthcare and prison staff of what the service needs to provide, and how. Healthcare staff consider that they have a positive contribution to make to the future shape of health service delivery, but are undervalued and rarely consulted. They also mistrust what they are being told by their senior managers.
- The ever growing demands of Offender Health and the PCT are seen by Healthcare staff to have resulted in a disjointed patchwork approach to service provision.

1.4.4 Poor management and leadership

- Staff view senior Healthcare management as inaccessible and out-of-touch with the shop-floor. We found poor delegation of planning & management responsibilities to mid-level nurse managers, who currently feel that they cannot effect any real change.
- The management style within Healthcare is reactive rather than proactive, with senior managers seen to be constantly fire fighting rather than enabling staff.
- The professional development programme is weak, with inadequate assessment, planning and training provision for nursing and Healthcare staff for both personal development and to meet service delivery requirements. This was raised in the 2005 HNA, but is still unresolved.

1.4.5 Prisoners report difficulties in accessing health care

- Prisoners report long waiting times for Doctor consultations, Dental treatment, and hospital outpatient appointments.
- A sizeable number of health applications and appointment slips appear to go missing. This is a source of frustration for prisoners, prison officers and Healthcare staff alike.
- There appears to be a lack of knowledge amongst Healthcare staff of why and how to access language interpreting, resulting in poor utilisation of this service. Both HNA interviews and 'Measuring the Quality of Prison Life' (MQPL) survey highlight a low levels of healthcare satisfaction amongst BME prisoners, particularly those with poor English. We consider it inappropriate to use other prisoners as interpreters in this context.

1.4.6 Prison staff report difficulties in communicating with Healthcare

- Prison staff experience Healthcare as isolationist and unwilling to share information that would be relevant to prisoners' care and resettlement pathways.
- Prison officers on the wings report frustration at Healthcare's poor response to health concerns. They describe '*having to fight*' on behalf of ill prisoners for Healthcare to take action.

1.4.7 Gaps in provision

Staffing

- We found the staff recruitment and retention problems reported in the 2005 HNA continue.
- The health care shift pattern is inflexible; it does not allow for alterations in the staffing mix and numbers to meet service needs. The skill mix on a shift is often innapropriate e.g. all mental health nurses, or none.
- There is greater need and thus more work at night than one nurse can safely cover. This clinical governance concern has become more prominent with the increasing numbers of prisoners arriving late into Reception- beyond 9pm. It also means that prisoners going to court who are on maintenance therapy do not receive medication before leaving the prison as their departure falls within the night shift and the nurse is unable to attend them.
- There is a high level of mental health morbidity within the prison population. We found good quality In-reach services for prisoners with secondary and more severe mental health needs, but no dedicated RMNs to meet the current or expected level of primary mental healthcare need within the prison.
- Existing RMNs are primarily employed as generic nurses: their mental health skills and knowledge are not harnessed to best effect.

Mental health screening

- Current reception and secondary health screening processes are not effectively identifying the expected number of prisoners with mild to moderate mental health problems.

Learning disability screening and care planning

- Current screening process, both by Healthcare and wing-based staff, do not effectively identify prisoners with learning disabilities. Where prisoners with learning disabilities are identified, there is no systematic multi-disciplinary care planning process.

Care for older prisoners

- There is no co-ordinated approach between Healthcare team, the residential prison staff and Offender Management Unit (OMU) to assess needs and deliver holistic person-centred care to older prisoners.
- Healthcare does not *systematically* undertake pre-release health and welfare assessments for older prisoners.

1.4.8 Teething problems with IDTS

- We found a somewhat disjointed relationship between the Addictions Team and Healthcare, particularly in relation to drug administration. This is affecting the development and success of this component of IDTS.
- There does not appear to be a clear line of accountability for the IDTS doctor service, based within Reception. It does not link into either the Addictions Service or Healthcare's clinical governance pathways. We consider this to be a potentially serious clinical governance issue.
- We found failures in joint care planning at the end of 5 days stabilisation; a lack of consultation with CARATs workers on clinical decisions made, despite their key IDTS role; a lack of commitment from the Addictions Team to co-deliver, with CARATs, the 10 week psychosocial modular group work programme.
- Members of the Addictions Team appear to be pulling in different directions. Personal views on maintenance vs detox are swaying approaches to individual prisoners. There is a risk that prisoners may exploit this team dislocation.

1.4.9 Missed opportunities for promoting a healthy prison

Exercise and physical activity

- Prisoners suggest there is not enough promotion of physical activity by gym staff on the wings. We found that just over 50% of prisoners had undertaken gym induction training (a pre-requisite for using the facility).
- Some prisoners (including a gym instructor) feel the type of exercise offered in the gym is not to be varied enough, with a lot of focus on weight training and not enough cardio vascular exercise and opportunities for outside activities, especially football.
- The numbers of referrals into the Exercise on Referral (EOR) Scheme is low, particularly from Healthcare and Chaplaincy. If referred, the up-take of EOR/Detox exercise sessions by prisoners is low, with sessions being in the morning cited as a reason for failing to use it.
- Wing-based CV rooms appear under-utilised and not fully functional. The equipment in some rooms need repair.

- The gym offers a weekly 'early birds' exercise session for prisoners on SSCU, which is meant to extend to prisoners in the In-patient unit. There seems to be a lack of awareness of this arrangement (among both gym and Healthcare staff). However, there also appears to be issues relating to escort requirements for Healthcare in that the timing of drug administration duties would make it difficult to get prisoners to this early session.

Books on Prescription

- A Books on Prescription (BOP) programme was launched jointly by the library, PCT and MH In-Reach team in March 2007. It offers a selection of approved self-help books for prisoners experiencing mental health issues. Whilst low literacy levels amongst prisoners was expected to limit the utilization of the scheme, numbers of referrals so far have been low, particularly from Healthcare.

Healthy Eating

- The Daily Food Allowance (DFA) for Bullingdon has been set at £1.52 since 2003. However, the annual average spend is currently running at £1.78 per head per day, compared with a national prison average of £2.00.
- The budget and menu design do not make it easy for prisoners to achieve their 'Five-A-Day' fruit and vegetable intake. Budgetary constraints also appear to limit whole food and whole grain options within the current menu.
- It is likely that the daily salt content in meals exceeds Government standards, because of the number of processed foods served.
- It is likely that many prisoners are exceeding the recommended daily energy intake of 2,500 calories a day for men. This is particularly an issue for older prisoners, or those with disabilities, who do not require such a high calorie intake.

1.5 Summary

This document brings together all the recommendations from the assessment and is intended to be read in conjunction with the full HNA report. This will be used to inform the Prison Health Delivery Plan and the priorities of the accompanying three year action plan.

	Area	Recommendation	Priority
	1. Service Transition		
1.1	**Service Transition**	Give Healthcare staff an opportunity to meet with the PCT's senior management (both provider and commissioning arms) to make a balanced assessment of their future employer.	High
1.2	**Service Transition**	Clarify arrangements as to how IMB is to link with the PCT to exchange information regarding health service complaints and concerns.	Low
1.3	**Service Transition**	PCT/Prison to work together to ensure the minimisation of disruption to administrative continuity within Healthcare.	High
1.4	**Service Transition**	Avoid reliance on internet/email to communicate transition information/messages to Healthcare staff, as the majority have very limited/infrequent access to email facilities.	High
	2. Strategic Direction and Leadership		
2.1	**Healthcare Strategy**	Develop an agreed vision and needs based strategy for Healthcare, shared by those commissioning, providing and receiving health services	**High**
2.2	**Healthcare Strategy**	Formalise Healthcare's strategic role in supporting the coordination of the NOMS Physical and Mental Health Pathway and the Health and Social Care in the Criminal Justice System Programme within the prison.	**High**
2.3	**Healthcare Strategy**	Develop a shared three year needs-based health care delivery plan that incorporates service equity, provision and governance; health protection; resettlement planning; and the promotion of a healthy prison.	**High**
2.4	**Healthcare Strategy**	Formalise Healthcare representation and inputs into the resettlement and planning process for prisoners returning to the community.	**High**

	2. Strategic Direction and Leadership (cont'd)		
2.5	**Leadership & management**	Review and rationalise Healthcare's management structure, with greater delegation of planning & management to band 7 and 6 nurses, and clarification of decision making powers and lines of accountability.	**High**
2.6	**Leadership & management**	The management style within Healthcare needs to be more accessible, consultative and enabling.	**High**
2.7	**Staff training & development**	Undertake a training needs assessment and produce a robust workforce development plan outlining the skills, expertise and staffing levels required to deliver the next three year needs-based health care delivery plan.	**High**
2.8	**Staff training & development**	Ensure all staff have completed mandatory training requirements within the next 6 months.	**Medium**
2.9	**Staff training & development**	More mental health training for RGNs, especially those having to manage on Reception and Inpatients who are making decisions about immediate risk and appropriate care and support.	**Medium**
2.10	**Staff training & development**	Consider the purchase of local ASIST training for all Healthcare staff, to support self-harm and suicide prevention work.	**Medium**
2.11	**Staff training & development**	Develop opportunities for staff to gain training experience within the local NHS, particularly Minor Injury Units (MIUs), Community Hospitals and/or within the acute setting.	**Medium**
2.12	**Staff training & development**	Strengthen induction programme for new and agency nursing staff so that they are able to work effectively within a prison environment (linked into PCT induction).	**Low**

	3. Access and Equity		
3.1	**Accessing Healthcare (information sharing)**	With advice from Oxfordshire PCT's Caldecott Guardian, develop a transparent and consistent health care communication strategy (and training) that clearly explains patient confidentiality, data protection, and ways of enabling information sharing relating to all the health care services provided.	**Medium**
3.2	**Accessing Healthcare (information sharing)**	CARAT to be trained to make direct referrals to Healthcare, in the same way as they do to the MH In-Reach team. They feel they could give additional useful information.	**low**
3.3	**Accessing Healthcare (information sharing)**	CARAT to be trained to refer prisoners to dental service: "We know them and can make a pretty good assessment of whether their problem is genuine or not."	**low**
3.4	**Accessing Healthcare (information sharing)**	Need protocol in place to ensure better working between Healthcare, RAPt and CARAT.	**Medium**
3.5	**Accessing Healthcare (involvement)**	Develop an inclusive PPI strategy for Bullingdon and formalise processes for involving patients and prisoners in examining service developments, and monitoring access, utilisation and quality.	**Medium**
3.6	**Accessing Healthcare (involvement)**	Ensure quality complaints system and PALS/advocacy processes are in place, specifically relating to health care services.	**Medium**
3.7	**Accessing Healthcare (involvement)**	Audit and review all DNAs in an effort to identify and limit reasons for not attending.	**Low**
3.8	**Accessing Healthcare (male professional)**	There should be a process in place whereby a prisoner can request to see a male health care professional.	**Medium**
3.9	**Healthcare Environment**	Improve the outpatient holding area by installing a water fountain and offering audio-visual health promotion information (installation of a TV and DVD would provide a valuable information medium).	**Low**
3.10	**Healthcare Environment**	To nurture a greater culture of privacy and respect within all areas of Healthcare: close doors during consultations, and avoid interrupting interviews.	**Medium**
3.11	**Healthcare Environment**	Limit waiting times in the holding area, returning prisoners to the wings as soon as their appointments are over.	**Medium**

	3. Access and Equity (cont'd)		
3.12	**Healthcare Environment**	Increase the space and number of rooms available to Healthcare in Outpatients (more consulting rooms and more rooms for senior management).	**High**
3.13	**Healthcare Environment**	Explore ways of obtaining a larger interview room and nursing station on Inpatients.	**Low**
3.14	**Healthcare Environment**	Install an intercom system to allow the GP and other practitioners to control the speed at which prisoners are sent through.	**Low**
3.15	**Wing-based Triage and Treatment**	Nominate a named link-nurse for each wing, aimed at improving communications between Healthcare and the residential areas. This can happen before the roll-out of wing-based treatment rooms.	**High**
3.16	**Wing-based Triage and Treatment**	Need to consult with all nursing staff on the development and rolling out of this initiative.	**High**
3.17	**Wing-based Triage and Treatment**	Set up a small working group to appraise and design a suitable wing-based service model, with an agreed time-bound action plan for implementation.	**High**
3.18	**Wing-based Triage and Treatment**	Ensure security cover and escort arrangements for the wing-based treatment service are agreed and in place before roll-out.	**High**
3.19	**Wing-based Triage and Treatment**	A gradual, phased roll-out of wing-based triage and treatment service, learning from the lessons of implementation on one wing, before moving on to another.	**High**
3.20	**Wing-based Triage and Treatment**	EMIS terminals and telephones (with an outside line) must be installed within each treatment room.	**Medium**
3.21	**Wing-based Triage and Treatment**	Those nurses that have undergone PGD training to be assessed and signed-up by end February 2008.	**High**
3.22	**Wing-based Triage and Treatment**	A wing-based GP appointment system to be rolled-out to each wing-based treatment room.	**Medium**
3.23	**Wing-based Triage and Treatment**	Anticipate and minimise potential isolation of wing-based nurses.	**Medium**

	3. Access and Equity (cont'd)		
3.24	**Wing-based Triage and Treatment**	Recognise that not all nursing staff will suit wing-based work, some may be frightened by prospect. Careful selection and additional training required.	**Medium**
3.25	**Wing-based Triage and Treatment**	Identification, development and/or adaptation of clear protocols, triage checklist or algorithms, and referral criteria for wing-based services.	**Medium**
3.26	**Wing-based Triage and Treatment**	Training of wing-based nurses to provide a more robust opportunity for identifying and fast tracking of prisoners with urgent dental problems.	**Medium**
3.27	**Needs of BME prisoners (Interpreting needs)**	Training for staff on when and how to access and use telephone and face-to-face interpreting.	**Medium**
3.28	**Needs of BME prisoners (Interpreting needs)**	EMIS must accurately identify those prisoners requiring interpreting inputs.	**Medium**
3.29	**Needs of BME prisoners (CDW Inputs)**	PCT to examine HMP Highdown's forthcoming Community Development Worker evaluation, whilst exploring the potential for providing a CDW in-reach service within a cluster of Oxfordshire and Buckinghamshire prisons - to achieve economies of scale.	**Low**
3.30	**Learning Disability**	Organise access routes to specialist assessment provision.	**Medium**
3.31	**Learning Disability**	Nominate a Healthcare lead to facilitate the first stage of learning disability assessment and care planning, following identification at reception or secondary assessment.	**Medium**
3.32	**Care of Elderly**	Healthcare to ensure that pre-release health and welfare assessments are systematically undertaken for *all* older prisoners.	**Medium**
3.33	**Care of Elderly**	Introduce a formalised, systematic and coordinated approach between Healthcare, residential staff and Offender Management Unit (OMU) to plan person-centred care for older prisoners, and to assess the health and service needs for older prisoners to ensure that their release and return into the community is supported and sustainable.	**Medium**

	3. Access and Equity (cont'd)		
3.34	**Care of Elderly**	For prisoners over 60 yrs, introduce routine six monthly health and welfare reviews and dental or eye check-ups, with annual medication reviews, using a tailor-made EMIS template for this purpose.	**Medium**
3.35	**Care of Elderly**	Nominated 'older persons lead' within the Health Promotion Strategy Group. Current strategy does not explicitly include issues relating to aging prisoners.	**Medium**
	4. Operational Issues		
4.1	**Staffing**	Urgent need to reprofile and recruit the number of nurses required to deliver the new service plan (including staff required to cover wing-based service).	**High**
4.2	**Staffing**	Include the nursing time required to attend SSCU 'Good Boards' within Healthcare's re-profiling, as this is a mandatory requirement.	**High**
4.3	**Staffing**	Provide dedicated administrative (personal assistant) support to the Senior Healthcare Manager/s.	**High**
4.4	**Staffing**	One WTE senior administrator Band 4/5 to co-ordinate the administrative team.	**Medium**
4.5	**Staffing**	Nurses to work a rota system that reflects an NHS model, reducing the number of staff rotas and implementing a core rota of 3-4 shift patterns.	**High**
4.6	**Staffing**	Work towards ensuring 24 hour RMN cover in the prison (probably based in the Inpatient's Unit).	**High**
4.7	**Staffing**	Discontinue the allocation of a nurse to sit in on all GP clinics, as this is an ineffective use of professional resource.	**High**
4.8	**Staffing (Night cover)**	Urgent need to ensure that two nurses cover each night shift.	**High**
4.9	**Staffing (Night cover)**	Resolve problems relating to professional isolation of the two permanent night nurses, and their lack of opportunity to get involved in service planning, continuing professional development and up-date training.	**Medium**

	4. Operational Issues (cont'd)		
4.10	**Staffing (security)**	Effectively redeploy HCOs, and ensure that there is adequate and appropriate security cover for all areas of Healthcare (see HMP Highdown's cover).	**High**
4.11	**GP Service**	Whilst GP cover is lower than in other similar establishments, an increase to the GP SLA needs to be examined in relation to the roll-out of nurse-led wing-based triage and treatment services.	**Medium**
4.12	**GP Service**	Some blurring of the line between GP and psychiatric provision. A need for clarification, particularly in relation to inpatient prescribing and medication reviews.	**Medium**
4.13	**GP Service**	Some team building required between the GP contractor and Healthcare nursing staff.	**Medium**
4.14	**GP Service**	Ensure robust monitoring and review of the Extended GP Clinic to assess its impact on reducing secondary care referrals/appointments.	**Medium**
4.15	**Dental Service**	Increase the current SLA treatment, oral health promotion and admin capacity by adding additional sessions (at least 1-2 treatment and 1-2 OHP/admin) to the contract.	**High**
4.16	**Dental Service**	Consider contracting additional external OHP inputs for cascading of training to staff and future Health Trainers.	**Medium**
4.17	**Dental Service**	There needs to be an automatic dental trigger for all prisoners seen by the GP who require analgesia or antibiotics for dental health problems.	**Medium**
4.18	**Dental Service**	Need to look at a way of linking EMIS to dental services' internal treatment database system, to enable the setting up of routine electronic dental treatment data queries and retrieval of data for planning and service improvement purposes.	**Medium**
4.19	**EMIS**	Using EMIS, Healthcare needs to improve its quality of ethnic monitoring, to examine access to health services in relation to race and language.	**Medium**
4.20	**EMIS**	PCT to facilitate a formal link between the prison and a local GP practice (may mean purchasing their input).	**Low**

	4. Operational Issues (cont'd)		
4.21	EMIS	More summarising time to be commissioned to input data from remaining 400 IMRs.	High
4.22	EMIS	The PCT contracting arm to resolve problems of EMIS data inputting by the MHIRT and the Addiction Service.	Medium
4.23	Pharmacy	The pharmacy service would benefit by expanding its role within the prison to proactively look at pharmacotherapy and adherence to NICE guidance and National Service Frameworks (NSF).	Medium
4.24	Pharmacy	Pharmacy department would like to develop a 'medicine management role, whereby they review prescriptions following a protocol and assess the possible interactions, discuss side effects and dosage with prisoners, and make suggestion to GPs to alter/improve treatment.	Medium
4.25	Pharmacy	Would be good if PCT's new prescribing lead could provide support and arbitration in the prison's Drugs and Therapeutics Committee.	Medium
4.26	Pharmacy	To have a pharmacist present at the point of drug distribution, to provide advice- in the same way as a GP surgery or chemist.	Medium
4.27	Pharmacy	Review and appraise potential for the introduction of more Pharmacy-led, special interest clinics, such as dermatology etc.	Medium
4.28	Sexual Health Services	The GUM service needs extra clinic space within Healthcare to run two simultaneous clinic sessions.	High
4.29	Sexual Health Services	A process to be established for the GUM Service to share relevant quarterly BBV testing data with IDTS and Addictions Service	Medium
4.30	Sexual Health Services	Make efforts to increase the notice period given to GUM staff to organise supplies of HIV anti-retroviral prescriptions.	Medium
4.31	Sexual Health Services	Develop and introduce a routine Chlamydia screening service within Bullingdon.	Medium

	4. Operational Issues (cont'd)		
4.32	**Immunisation**	Increase opportunistic vaccination for MMR, Meningitis and school leaver booster.	**Medium**
4.33	**Emergency preparedness**	Pandemic flu risk- CG meeting August 2007 agreed that this risk needs to be linked to the IDTS register.	**Medium**
4.34	**Service gaps**	Expedite the replacement of Healthcare's X-ray machinery, and develop/formalise radiography SLA.	**High**
4.35	**Service gaps**	The prison service would particularly benefit from physiotherapy support of 1 – 2 sessions per week to provide individual assessment and group work for pain management (e.g. back pain).	**High**
4.36	**Service gaps**	Consider the commissioning of occupational therapy support for older prisoners, and those with longer-term/chronic conditions or disabilities (i.e. beyond or combined with Day Care OT recruitment).	**Medium**
4.37	**Service gaps**	Undertake an assessment/literature review of speech therapy needs within adult male prisoner populations in England and Bullingdon.	**Low**
	5. Safety		
5.1	**Clinical Governance**	The Partnership Board to clarify overall responsibility for clinical governance following management transition to the PCT.	**High**
5.2	**Clinical Governance**	A detailed training needs assessment for nursing staff needs to be undertaken and a training plan developed to meet health care service delivery requirements.	**High**
5.3	**Clinical Governance**	There needs to be a robust clinical governance communication system that ensures all nursing staff are aware of, and have read, all existing/revised clinical policies and protocols.	**High**
5.4	**Clinical Governance**	Formalise a process of communicating feedback to nursing staff on the outcome of clinical incident investigations.	**Medium**

	5. Safety (cont'd)		
5.5	**Clinical Governance**	Make arrangements to ensure the IDTS doctor service in Reception has a clear and robust line of clinical governance accountability to the Clinical Governance Group and Partnership Board.	**High**
5.6	**Clinical Governance**	Precipitate the establishment of a Clinical Effectiveness Group.	**High**
5.7	**Clinical Governance**	Resolve inconsistencies in relation to electronic and hardcopy prescribing.	**High**
5.8	**Clinical Governance**	Ensure completion of information on all prescription charts, and avoid multiple prescription charts per prisoner.	**High**
5.9	**Clinical Governance**	Clarify arrangements for clinical investigation, accountability and reporting processes for Addiction Service incidents, and ensure they are robustly linked into the prison's Clinical Governance pathways and Partnership Board.	**High**
5.10	**Clinical Governance**	Urgent need to ensure that two nurses cover each night shift.	**High**
5.11	**Healthcare Environment**	De-cluttered consulting rooms of equipment that might pose a risk if a prisoner becomes aggressive.	**Medium**
5.12	**Prison Environment**	Improve seating on Edgecott, as communal seating is too low for older less mobile prisoners.	**Low**
5.13	**Prison Environment**	Need for an independent disability assessment of Edgecott.	**High**
5.14	**Prison Environment**	Complete the installation of disinfecting tablet dispensers on the wings, so that all prisoners have access to an effective cleaning agent.	**High**
5.15	**Prison Environment**	Establish a robust system for ensuring that the hair clippers on each wing are disinfected in between hair cuts.	**High**
5.16	**Prison Environment**	Tackle pigeon pest problem and bird faeces in communal spur rooms.	**Low**

	6. Services and Interventions		
6.1	**Healthcare screening**	There would be a benefit in reviewing current Reception and secondary screening processes to streamline inputs and increase cost effectiveness.	**Medium**
6.2	**Healthcare screening**	Ensure BBV information is delivered in a coordinated way to all prisoners within their first week of arrival. Those with a history of IVDU should be prioritised for detailed advice and referral to GUM for possible testing.	**Medium**
6.3	**Healthcare screening**	Review and strengthen initial mental health, disability, and learning difficulty/disability screening and assessment.	**High**
6.4	**Healthcare screening**	Ensure that all prisoners are seen by an RMN within the first 72 hours for a robust assessment and triage of mental health needs.	**High**
6.5	**Healthcare screening**	Reception and secondary screening misses key information as invariably prisoner detoxing or under stress. Establishing a Well-Man clinics on each wing with MOT checks would allow an additional opportunity for health screening and assessment.	**Medium**
6.6	**Healthcare screening**	There would be benefit in undertaking a review of 'poor copers' (Dorton wing) regarding health needs and demands on the service.	**Low**
6.7	**Specialist Diabetes Clinic**	Staff running diabetes clinic need a training needs assessment, and commissioned inputs from the PCT's specialist diabetes nursing service and dietician service.	**Medium**
6.8	**Specialist Asthma Clinic**	Enhance Asthma Advisory Service by including a nurse practitioners that can carry out reversibility testing.	**Medium**
6.9	**Specialist Hepatitis B Vaccination Clinic**	Reduce the overload on weekly Hepatitis B vaccination clinic by increasing secondary screening/opportunistic vaccination.	**Medium**
6.10	**Inpatients**	Ensure 24 hour RMN cover on Inpatients.	**High**
6.11	**Inpatients**	Develop a *transparent* and agreed admissions criteria for Inpatients that makes it clear what is/is not an appropriate admission.	**High**

	6. Services and Interventions (cont'd)		
6.12	Inpatients	Ensure there is a clear policy in place, agreed by the Partnership Board, that outlines the processes for clinically assessing and agreeing to receive a patient back from a secondary care hospitalization.	High
6.13	Inpatients	Develop a protocol or system to enable staff to directly link with relatives to determine pre-morbidity behaviour, and improve the care planning process (particularly in relation to prisoners with mental health problems).	Medium
6.14	Inpatients	Increase purposeful activity opportunities on Inpatients, linked to individual care planning.	High
6.15	Inpatients	Provide a dedicated budget to purchase creative/activity materials for purposeful activity.	Medium
6.16	Inpatients	Failed plans for a nursery garden in the inpatient quadrangle to be resurrected.	Medium
6.17	Inpatients	Offer exercise opportunities to inpatients: instigate weekly gentle exercise class in Healthcare; increase referral of patients to EOR.	Medium
6.18	Inpatients	Install a new TV and increase the DVD selection in Inpatients	low
6.19	Inpatients	Assess the availability of the 24hr Samaritans service in the Unit, and resolve problems of a poor telephone signal in some cells.	Medium
6.20	Inpatients	Implement recommendations of the recent external disability audit.	Medium
6.21	Inpatients	Formalise processes for working with the resettlement team (and multi-disciplinary partners) to improve care pathways for inpatients who are discharged directly into the community.	High
6.22	Inpatients	Develop a formal system for informing the Lifers Team of when a sick Lifer has been admitted to Inpatients. This could support the care planning process.	Medium
6.23	Inpatients	Ensure inpatients have easy access to the chapel, and prayer times.	Medium

	6. Services and Interventions (cont'd)		
6.24	IDTS	An IDTS Health Needs Assessment to be undertaken as soon as possible.	High
6.25	IDTS	The Head of Healthcare should be the IDTS health lead, as this post needs to take ownership of the IDTS agenda, and has authority to make quick decisions.	High
6.26	IDTS	SDP should be included within Bullingdon's IDTS's framework and partnership forum.	Low
6.27	Addictions Service	Gather data and make a more robust assessment of 'secondary treatment' needs, and resources to meet these needs.	High
6.28	Addictions Service	Partnership Board to facilitate greater teamwork between Healthcare and the Addictions service.	High
6.29	Addictions Service	Ensure that the time of higher band specialist addiction staff is being used effectively: they are currently bogged down with drug administration which is a waste of their skills.	Medium
6.30	Addictions Service	Manage the problem of some members of the Addictions team 'pulling in different directions', swayed by personal views on maintenance vs. detox.	High
6.31	Addictions Service	Expedite a robust system, and allocate resource, for the administration of maintenance and detox medication to prisoners leaving early for court.	High
6.32	Addictions Service	Ensure that Addictions Team complete appropriate sections of the Drug Interventions Record (DIR) on each prisoner under their care.	Medium
6.33	Addictions Service	DAAT/PCT to approach NTA and South Central to see if DIR- section 1-6.2- could be set up as an EMIS template for hardcopy print off.	Low
6.34	Addictions Service	Ensure that the interviewing conditions/room for the Reception-based IDTS doctor are adequate.	Medium
6.35	Addictions Service	Ensure joint care planning consistently occurs between the Addictions Service, CARATs and the prisoner at the end of 5 days stabilisation.	High

	6. Services and Interventions (cont'd)		
6.36	**Addictions Service**	Ensure that the Addictions Team co-delivers, with CARATs, the 10 week psychosocial modular group work programme.	**Medium**
6.37	**Addictions Service**	Look at more alternative therapies for substance misusers (yoga, relaxation etc).	**Low**
6.38	**Addictions Service**	The Partnership Board (and CGG) to agree a clear position and protocol for the crushing/or not of Subutex, as this is currently muddled, and not well understood by staff or prisoners.	**Medium**
6.39	**Addictions Service**	Review and agree a resolution to some current inconsistencies between the Specialist Community Addiction Service's guidelines and prison guidelines relating to the management of prisoners with substance misuse problems.	**Medium**
6.40	**Addictions Service**	Addictions Team and GP service to work together to further develop a Shared Care Approach to supporting substance misusers.	**Low**
6.41	**Addictions Service**	Review the current alcohol detox regime, and whether this function would more appropriately sit as a responsibility of the Addictions Service.	**Medium**
6.42	**Addictions Service / Mental Health**	Consider initiating more proactive work to tackle sleep problems amongst IDTS and mental health clients.	**Low**
6.43	**Addictions Service / Mental Health**	Improve coordination between Mental Health In-Reach Team, Addictions service and CARATs for care of prisoners with dual diagnosis. Consideration to be given as to whether dedicated Dual Diagnosis worker would add value.	**Medium**
6.44	**Mental Health Care**	Further development of a coherent and joined up model of holistic mental health provision and coordination, with a forum to enable multi-disciplinary partnership and collaboration, robust referral pathways and service review relating to need.	**High**

	6. Services and Interventions (cont'd)		
6.45	Mental Health Care	Set up a small working group, to appraise and design a suitable primary mental health service model, with an agreed time-bound action plan for implementation. (This report provides an Appendix on other prison's mental health service and contact, which may be worth exploring further).	High
6.46	Mental Health Care	A more robust assessment, with access to better quality data is required in order to examine whether the MHIRT is current missing secondary mental health needs in the prison.	Medium
6.47	Mental Health Care	Dedicated RMNs to be identified/recruited specifically to meet the high level of primary (tier 1 & 2) mental health needs within the prison.	High
6.48	Mental Health Care	Look at recruiting graduate workers. Will need to consider supervision needs and allocation of more trained psychologist time.	Medium
6.49	Mental Health Care	Train up RMNs and/or graduate workers to offer a programme of CBT.	Medium
6.50	Mental Health Care	Need to recruit a primary care counsellor, to link in with and provide supervisory and service monitoring support to Volunteer Counselling Service.	Medium
6.51	Mental Health Care	Consider the establishment of a drop-in mental health and well-being clinic on the wings for prisoners to access help and advice. This could operate as an assessment and triaging facility.	Medium
6.52	Mental Health Care	Set up a small working group, to appraise and design a suitable Day Care Service model, taking lessons from HMP Leeds and ensuring effective consultation with HC, prison staff and prisoners.	High
6.53	Mental Health Care	To establish a link between local (RETHINK) mental health Carers Support Service and the prison.	Low
6.54	Mental Health Care	Development of a first night assessment tool for RGNs to use with prisoners admitted to inpatients with serious mental illness.	High

	6. Services and Interventions (cont'd)		
6.55	**Mental Health Care**	Selection of wing-based prison officers, with an interest in mental health, that could become link-officers to a primary mental health team or the MHIRT- providing advice and support to wing-staff in the identification and appropriate referral of prisoners with mental health issues for further treatment and support.	**Low**
6.56	**Mental Health Care**	Mental Health Awareness and recognition training to be promoted by the prison as a mandatory requirement for all wing-based prison staff.	**High**
6.57	**Mental Health Care**	Deliver tailor-made mental health awareness training to CARATs, education and gym staff	**Medium**
6.58	**Mental Health Care**	MHIRT/Healthcare to establish formal links with the Visitors Centre, so that staff in the Centre can directly relay any visitor's concerns regarding their prisoner's mental health.	**Medium**
6.59	**Mental Health Care**	Systematically assess the mental health needs of BME prisoners in compliance with 'Delivering Race Equality in Mental Health Care' requirements, and link in with Oxfordshire's 'Delivering Race Equality in Mental Health Care' forum.	**Medium**
6.60	**Mental Health Care**	Mental health diagnosis should be entered consistently on EMIS. MHIRT data cannot be used to estimate prevalence of mental ill health in the prison due to restrictions on the type of illnesses that are referred to them.	**High**
6.61	**Mental Health Care**	Reception nurses should use screening tool devised with MHIRT input. Where previous mental health care has occurred/ or ongoing, or where a prisoner has been put in segregation, a referral to MHIRT must be initiated.	**Medium**
6.62	**Mental Health Care**	New receptions should be assessed for Drug/Alcohol misuse using standardised questionnaires. Problem scores and patients already in withdrawal should be seen by a GP to initiate maintenance or detoxification regimens according to agreed protocols.	**Medium**

	6. Services and Interventions (cont'd)		
6.63	**Mental Health Care**	Management of common mental health problems should be tackled in primary care setting via GP referral. Inappropriate referrals to MHIRT can be routed to GP care in the prison.	**Low**
6.64	**Mental Health Care**	GPs should receive training in mental health issues particularly in recognising dual diagnosis.	**Low**
6.65	**Mental Health Care**	Joint interventions involving the Addictions Service, MHIRT, CARATs, RAPt and SDP should be in place to address dual diagnosis.	**Medium**
6.66	**Mental Health Care**	Care plans should be audited for appropriateness of diagnosis, treatment, waiting times for referral, ethnicity and occupational therapy. MHIRT patients to be linked to community mental health services.	**Low**
6.67	**Health Protection / infectious disease management**	From November 2007 onwards, prison/PCT partnerships will be performance managed on the provision of Hep B vaccine as part of the new set of Key Performance Indicators (KPIs). To ensure that accurate data on both the vulnerable population and vaccine coverage, the HPA will need to receive: the number of prisoners admitted per calendar month; the number of prisoners vaccinated per calendar month; the number of prisoners who arrived in a given month and refused vaccination.	**High**
6.68	**Health Protection / infectious disease management**	GUM clinic waiting times to be reported formally in the 6 monthly reports to examine compliance with the 48 hour wait. The GP service to be approached to provide Tier 1 GU care.	**Medium**
6.69	**Health Protection / infectious disease management**	GUM clinic reports to the PCT should be standardised to show the number of appointments requested, number found inappropriate, non-attenders, number of STI screens carried out with positive test rates rates.	**Low**
6.70	**Health Protection / infectious disease management**	Chlamydia screening should be offered to all under 25year old men – possibly at second screen.	**Medium**

	6. Services and Interventions (cont'd)		
6.71	**Health Protection / infectious disease management**	New entrants are currently referred to Hepatitis B vaccine clinics at second screen – where need for vaccine is identified, the vaccine can be administered straight away. IVDUs who have not received five doses of tetanus vaccine, or who are unsure of their vaccination status, should be offered vaccination boosters as appropriate.	**Medium**
6.72	**Health Protection / infectious disease management**	New entrants/ transfers should be carefully asked at screening for current medication – this is important in view of Anti Retroviral Therapy (ART), where delays in medication or alteration of drug doses could be very serious (developing resistance).	**Medium**
6.73	**Health Protection / infectious disease management**	Suitability of Reception as a setting to provide health promotion regarding BBVs should be reassessed – Induction sessions should educate on provision of condoms, testing facilities. Over half of all IVDUs are believed to be infected with Hep C and 1 in 75 with HIV. However on identification of injecting behaviour (past or present) an opportunity exists to signpost to GUM for testing.	**Medium**
6.74	**Health Protection / infectious disease management**	The concerns of the GUM consultant regarding delayed notification of ART medication supply running low should be addressed by Healthcare.	**Medium**
6.75	**Health Protection / infectious disease management**	Provision of Emergency Post Exposure Prophylaxis (PEP) in allegations of sexual abuse/ needlestick injury (rare).	**Low**
6.76	**Health Protection / infectious disease management**	Negative test results should be communicated via letter rather than a clinic appointment (health promotion opportunity).	**Low**
6.77	**Health Protection / infectious disease management**	Health promotion sessions at induction could serve to highlight the availability of disinfectant tablets and condoms. Because most injecting activity takes place in unhygienic conditions, the risk of developing bacterial site infections is high. This can also be addressed in the above health promotion sessions.	**Low**

	7. Achieving a Healthy Prison		
7.1	**Health promotion**	Develop wing-based health promotion events, utilising Friday 'Domestic Afternoons', if possible.	**Low**
7.2	**Health promotion**	Need to initiate peer-to-peer health education/promotion, through the introduction of a Health Training Programme.	**Medium**
7.3	**Health promotion**	Set up a small working group to agree a suitable model and approach to introducing Health Trainers, and establish a time-bound action plan for implementation.	**Medium**
7.4	**Health promotion**	Consider whether to recruit a generic health promotion officer to champion PSO 3200 across the prison.	**Medium**
7.5	**Health promotion**	Consider the introduction of wing-based Well-Man clinics that could offer MOT checks.	**Medium**
7.6	**Health promotion: Induction**	Revisit previous work undertaken to increase Healthcare's involvement within the prisoner induction programme, and organise appropriate inputs.	**Medium**
7.7	**Healthy eating**	Daily Food Allowance (DFA) allocation for Bullingdon needs to be reviewed in the light of rising food and transport costs, and the Government's healthy eating guidance.	**High**
7.8	**Healthy eating**	A more detailed review of the nutritional balance of meals by a commissioned dietetic expert.	**High**
7.9	**Healthy eating**	Increase nutritional training inputs for catering staff, and commission dietetic expert inputs/support for the development of special diets.	**Medium**
7.10	**Healthy eating**	Increase opportunities for prisoners to get their 5-A-Day fruit and vegetables.	**Medium**
7.11	**Healthy eating**	Specific catering consideration to be given to the dietary requirements for sick patients and older, less mobile prisoners.	**Medium**

	7. Achieving a Healthy Prison (cont'd)		
7.12	Healthy eating	The food menu's 'Healthy Eating' (♥) classification could be strengthened and made more accurate, including traffic lighting for healthy/less healthy options (salt, saturated fat content etc).	Medium
7.13	Healthy eating	Introduce fresh fruit as an item for purchase within the canteen order form.	Medium
7.14	Healthy eating	Selected gym staff to undertake diet and nutrition training in order to increase the quality and breadth of healthy eating information within the gym induction programme and general exercise regime.	Low
7.15	Healthy eating	Examine the potential to sell summer season fresh organic vegetables, produced by the prison's Land-Based Activities (LBA) programme, through the canteen.	Medium
7.16	Healthy eating	Work with Arrowmark to review and improve dietary markings on the canteen order sheets.	Medium
7.17	Healthy eating	Increase opportunities for raising awareness amongst prisoners of the importance of healthy eating, and how to choose a balance diet and prepare healthy foods in prison and out in the community.	Medium
7.18	Physical activity	Carry out a more detailed assessment of why only half of prisoners take take-up gym activities, and what the barriers are to utilisation.	High
7.19	Physical activity	Review and improve the gym's 'link-person' scheme, so that more proactive work is undertaken by gym staff on the wings, and in Inpatients, to increase prisoner's uptake of gym facilities/activities.	High
7.20	Physical activity	Update/repair equipment in the cardio-vascular rooms and improve their utilisation.	Medium
7.21	Physical activity	Further develop and field-test an 'In Cell-Exercise' sheet for all prisoners to be able to safely use in their cells.	Medium

	7. Achieving a Healthy Prison (cont'd)		
7.22	**Physical activity**	Consider the design and implementation of a weekly gentle exercise session, run by gym staff, within the Inpatient facility.	**Medium**
7.23	**Physical activity / Mental Health promotion**	Reinvigorate the functioning, ownership, awareness and follow-up system for the Exercise on Referral scheme, particularly amongst Healthcare and Chaplaincy staff.	**Medium**
7.24	**Physical activity / Mental Health promotion**	A need for a prison specific SLA with Oxfordshire Smoking Cessation service that clearly outlines what is required of them.	**Medium**
7.25	**Physical activity / Mental Health promotion**	Consider training at least one PEO to undertake a Level 3 Certificate in Exercise Referral for Clients with Specific Controlled Conditions, to support the delivery of EOR.	**Medium**
7.26	**Mental Health promotion**	Reinvigorate functioning, ownership and awareness of the Books on Prescription scheme, particularly amongst Healthcare staff.	**Medium**
7.27	**Mental Health promotion**	Consider the development of an information leaflet about Bullingdon that could be given to prisoners before their arrival at the prison.	**Low**
7.28	**Mental Health promotion**	Develop a formal First Night Strategy for the prison.	**Medium**
7.29	**Mental Health promotion**	Consider the establishment of a First Night Unit for new arrivals (see example of HMP Birmingham).	**Medium**
7.30	**Mental Health promotion**	Use prisoners that have experienced mental health problems to educate and de-stigmatise mental illness amongst other prisoners.	**Low**
7.31	**Mental Health promotion**	Further develop the 'personal officer' programme, using lessons from Edgecott.	**Medium**
7.32	**Tackling smoking**	Consider extending the prison's smoke-free policy to encompass all shared areas within the prison complex, such as walkways, sports areas and yards.	**Low**
7.33	**Tackling smoking**	Offer more smoking cessation groups for prisoners.	**High**

	7. Achieving a Healthy Prison (cont'd)		
7.34	**Tackling smoking**	Increase the budget for incentives given out within the smoking cessation groups (usually bananas).	**Medium**
7.35	**Oral Health Promotion**	Look at alternative ways of delivering oral health promotion information, by cascading OHP training to staff such as: wing-staff, HCAs and peer-supporters and educators.	**Medium**
	8. Clinical Guidelines		
8.1	**Epilepsy**	A template on EMIS that will enable the Healthcare team to identify all prisoners who consider themselves as epileptic at Reception. After requesting previous IMR or GP case history, these patients should be offered a physician/ specialist nurse appointment to verify diagnosis (with necessary investigations if required) and management of their anti-epileptic medication on an ongoing basis.	**Not prioritised**
8.2	**Epilepsy**	A biweekly/ monthly review by a specialist nurse to identify all potential new cases of seizures occurring in prison – these should be reviewed to ascertain cause as well as medication compliance.	**Not prioritised**
8.3	**Epilepsy**	A link with secondary care to ensure training is up-to-date as well as to audit case notes/anti-epileptic medication.	**Not prioritised**
8.4	**Epilepsy**	A Pharmacy link with prisoners on anti-epileptic medication to ensure compliance.	**Not prioritised**
8.5	**Epilepsy**	Training for prison officers on dealing with acute seizures.	**Not prioritised**
8.6	**Asthma**	An electronic register – recording all diagnosed Asthma and those currently on treatment for symptoms of wheezing.	**Not prioritised**
8.7	**Asthma**	Pharmacists undertaking regular audit of prisoners receiving asthma medication and follow up with Wing-based reviews of those on asthma medication with referral to Asthma clinic if concerned about symptoms or compliance.	**Not prioritised**
8.8	**Asthma**	The register can also serve to facilitate smoking cessation and flu immunisation activity.	**Not prioritised**
8.9	**Asthma**	An annual review for prisoners with asthma.	**Not prioritised**

	8. Clinical Guidelines (cont)		
8.10	**Asthma**	A full review for new receptions who claim to be asthmatic. Where diagnosis has not been previously confirmed, arrangements for further investigations (Peak Flow Rate – PFR and a reversibility test) should be made, especially if symptoms do not match with accepted criteria for asthma.	**Not prioritised**
8.11	**Asthma**	Given the high prevalence of smoking, it is important to recognize Chronic Obstructive Pulmonary Disease COPD (irreversible) in prisoners, especially older prisoners. Clinical guidelines for management of respiratory conditions should be in place.	**Not prioritised**
8.12	**Diabetes**	Establishing a register of diabetes patients in the prison can be a single first step towards planning and managing care for this group of prisoners. This would enable flu immunisation, smoking cessation and the screening for complications like retinopathy and nephropathy.	**Not prioritised**
8.13	**Diabetes**	Review of glycaemic control by either a specialist nurse with input from secondary care if complicating factors (risk factors for CVD) present.	**Not prioritised**
8.14	**Diabetes**	Dietary regimens should be individualised to patients. Use of the Exercise on Referral Programme should be targeted towards such patients.	**Not prioritised**
8.15	**Diabetes**	Written guidelines on the management of diabetics while in prison and annual audit of care to be undertaken to improve the quality of chronic disease management.	**Not prioritised**
8.16	**Diabetes**	Given the high prevalence of smoking, it is important to recognize Chronic Obstructive Pulmonary Disease COPD (irreversible) in prisoners, especially older prisoners. Clinical guidelines for management of respiratory conditions should be in place.	**Not prioritised**
8.17	**CHD & Hypertension**	An electronic register to pick up all patients with confirmed CHD. This will enhance follow up (medication, complications check), flu immunisation and smoking cessation activity.	**Not prioritised**
8.18	**CHD & Hypertension**	Risk factors for CHD identified at second screening e.g. smoking, hypertension, Asian/ black Caribbean ethnicity, obesity, diabetes, family history and hyperlipidemia. These alert a full CHD risk assessment.	**Not prioritised**

	8. Clinical Guidelines (cont)		
8.19	**CHD & Hypertension**	A 10 year CHD risk profile to be calculated via EMIS. Prisoners flagged up via Reception screening with a history of CHD on medication should be questioned at second screen if symptoms still present and appropriate follow up arranged.	**Not prioritised**
8.20	**CHD & Hypertension**	Prisoners with elevated BP recording at Reception with no previous history of hypertension are retested at second screen. If elevated, they are referred to the GP and the weekly Hypertension (and Diabetes) Clinic.	**Not prioritised**
8.21	**Tuberculosis**	Early diagnosis - Low threshold for Sputum and X-ray testing prisoners with symptoms suggestive of Pulmonary TB (cough, night sweats and weight loss of two weeks or more duration) with isolation in Inpatients while awaiting results. Early notification to the HPU if GP suspects TB or results confirm the diagnosis.	**Not prioritised**
8.23	**Tuberculosis**	Management – Guidelines for dealing with a case of TB (infection control, treatment and contact tracing) should be in place. Key to the effective management of incidents is ensuring continuity of treatment, which involves avoidance of prison transfers and compliance with treatment.	**Not prioritised**
8.24	**Substance misuse**	Level of dependency on alcohol and illicit drugs assessed at Reception by the IDTS doctor.	**Not prioritised**
8.25	**Substance misuse**	Mandatory urine test prior to any programme of management.	**Not prioritised**
8.26	**Substance misuse**	Referral to Addictions Service and CARATs.	**Not prioritised**
8.27	**Substance misuse**	Ideally, prisoners arrive with a DIR record that is issued by the DIP or Smart worker in the police station or court.	**Not prioritised**
8.28	**Substance misuse**	Protocols for managing 'maintenance' and 'detoxification' particularly those who may already be in withdrawal due to preceding stays in police cells/ court appearances.	**Not prioritised**
8.29	**Substance misuse**	Prisoner views to be taken into consideration in deciding duration and plan of treatment.	**Not prioritised**