

HEALTH NEEDS ASSESSMENT

DOVER IMMIGRATION REMOVAL CENTRE

MARCH 2008

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This Dover Immigration Removal Centre Health Needs
Assessment
was considered and adopted by the Dover Immigration
Removal Centre Health Partnership Board at its meeting
on Friday 9th May 2008

Signed

Signed

Date

Date

**Governor
Dover IRC**

**Deputy Director of Public Health
Eastern & Coastal Kent PCT**

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1 Executive Summary

Introduction

This Health Needs Assessment focuses on identifying the health needs of male detainees in an Immigration Removal Centre in Dover in Kent. The report was commissioned by the Dover Immigration Removal Centre Health Partnership Board and is the first integrated health needs assessment undertaken in this format and therefore serves as a starting point for future service development.

Methods

The study was carried out using the three main methods of epidemiological, corporate and comparative health needs assessment.

The epidemiological needs assessment consisted of an analysis of detainee medical records, a review of clinical activity and services and a literature review for evidence of effectiveness.

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The corporate needs assessment consisted of comments from detainees and consultation with key stakeholders within the Centre both from management, healthcare and the Independent Monitoring Board.

The comparative needs assessment compared existing services against current healthcare standards and targets as well as HMPs Canterbury & Bullwood. No data was available from Haslar Immigration Removal Centre.

Results

Healthcare services within the Centre are long standing and operate under challenging circumstances.

There is enthusiasm and a will to improve services among the staff within the Centre.

There is a continuing need for better management of information systems so that future assessment of need is based upon reliable and robust data that has clear audit features and linked to quality outcomes.

There is now greatly improved joint working with the Primary Care Trust and this needs to be widened to include other partners within the NHS family and other agencies.

Gaps have been identified between baseline services and the needs identified through the health needs assessment. These form the basis of the recommendations.

Recommendations

The recommendations have not been prioritised or costed as this will form part of the action planning process led by the Health Partnership Board.

Primary Care

- The most appropriate model for primary care delivery needs to be honed and developed including the recruitment and retention of healthcare staff including GPs.
- Investigations should be made to implement the community based Out of Hours service for the detainees.
- The computerised clinical system for recording detainee medical records should be developed in line with national requirements and used by all staff as well as agreement on uniform procedures for record keeping. Investment should be made to ensure that all levels of staff are trained to their appropriate level of competence with the system(s).
- Ensure that treatment guidelines, management protocols and performance frameworks are in line with national guidelines
- Ensure the continuing development of nurse led services supported by investment in their training to meet this development.
- Ensure the provision of nurse led Chronic Disease Management Clinics and associated registers. Clinics should be delivered to the standards outlined in the National Service Frameworks or equivalent where available and audited against the Quality and Outcome Frameworks for General Practice.
- Implement a skills mix review.

Specialist Services including Communicable Disease

- Develop the current reception and secondary healthcare screening to provide nurse led blood borne virus clinics. Full implementation of guidelines for prevention (including immunization where appropriate), screening and treatment of tuberculosis, blood borne viruses and other communicable diseases needs to be ensured.
- Commission a review of the current Mental Health Service Level Agreement to ensure that the identified mental health needs of the centre's population, including primary mental health are addressed. (The outcome of foreign nationals Mental Health Needs Assessment may well influence the development of primary & secondary MH services at the Centre).
- Commission through the relevant organisation (HMPS/KDAAT) a focused needs assessment for alcohol interventions particularly for those prisoners whose drinking is not associated with substance misuse.

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Other Services

- The Centre should adopt the Health-Promoting Centre strategy, supported by investment to ensure that health promotion and health education are done in a proactive rather than reactive manner and that a whole establishment approach to health promotion is adopted.
- Consider developing a Centre Smoking Cessation Strategy for both detainees and staff, in association with the PCT.
- Commission through Medway PCT a review of the current Pharmacy Service Level Agreement to ensure that the identified needs of the Centre's population and their healthcare staff are addressed.
- Commission appropriate training for relevant healthcare staff in BBV, sexual health, chronic disease management, and health needs assessment.
- Commission a detailed audit into secondary care access including escorts and bed watchers.
- Commission an options report for the provision of dental services at the Centre
- Formalise arrangements for consultation with key stakeholders through the PCT's "Public, Patient Engagement" process.

2 Introduction

This report focuses on identifying the health needs of detainees in Dover Immigration Removal Centre. No health needs assessment (HNA) has previously been undertaken for the current prison population under the current health care arrangements. This health needs assessment therefore serves as a starting point for future service developments.

Context

Although not prisoners historically, providing health care for detainees has been the responsibility of British Immigration Agency and by a service level agreement discharged through the prison service and prison governors. The required standard for the healthcare of detainees has been linked to levels of service to that received by prisoners. In 1996, Her Majesty's Chief Inspector of Prisons, Sir David Ramsbotham, stated that:

"Prisoners should be entitled to the same level of health care as that provided in society at large. Those who are sick, addicted, mentally ill or disabled should be treated, counselled and nursed to the same standards demanded within the National Health Service." (1)

In response to this, in 1999 a Joint Prison Service and NHS Working Group outlined a way forward in their report 'The Future Organisation of Prison Health Care' (2). Further guidance, 'The Prison Health Handbook' (3) was published a year later, which outlined the approach to assessing the health needs of prisoners and improving their health services.

Since then there has been further guidance on the organisation and standards for prison health care, including the requirement for primary care trusts (PCTs) and prisons to build on health needs assessments and prioritise the development and implementation of Prison Health Delivery Plans (4).

Health Needs Assessment

The aims of a health care needs assessment are to (5):

- Provide information in order to plan, negotiate and change services for the better and to improve health in other ways
- To build a picture of current services- the baseline

There are five objectives of a health care needs assessment:

- **Planning:** This is the central objective used to help decide services required; for how many people; the effectiveness of these services; the expected benefits and at what cost
- **Intelligence:** Information gathering to determine the existing baseline; the population it serves and the population's health needs

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- **Equity:** Improving the allocation of resources between and within different groups
- **Target efficiency:** Having assessed needs, measuring whether or not resources have been appropriately directed
- **Involvement of stakeholders:** Carrying out a HNA can stimulate the involvement and ownership of the various players in the process

A health needs assessment will determine the population's (the detainees') ability to benefit from healthcare. The systematic process used in HNA provides ideal opportunities for engaging with detainees and staff, gathering evidence from and about them, and utilising an evidence-based approach to effect service changes and improvements with their full involvement.

It is important to distinguish health needs from both the supply and demand for health. It is known that "in custody" populations consult for primary health care more frequently than the general population. A health needs assessment will examine whether this demand represents genuine health care needs. In addition, detainee populations have a higher risk for blood borne viruses than the general population and a HNA will also seek to determine whether appropriate access to services for preventing and managing these conditions are available.

Health needs can be:

- Perceptions and expectations of the profiled population (felt and expressed needs)
- Perceptions of professionals providing the services
- Perceptions of managers of commissioner/provider organisations, based on available data about the size and severity of health issues for a population, and inequalities compared with other populations (normative needs)
- Priorities of the organisations commissioning and managing services for the profiled population, linked to national, regional or local priorities (corporate needs).

An HNA should involve comparing and balancing these different needs when selecting priorities (6).

The Centre.

Dover Immigration Removal Centre

Dover Immigration Removal Centre is an Immigration Detention Centre that is run by the Prison Service for foreign nationals awaiting deportation. Dover Immigration Removal Centre can hold 316 male detainees from the age of 18 upwards.

At Dover they do have an education department which covers English as a second language to level 2, CLAIT PLUS, Graphics and Web design plus a workshop which helps any detainees that are studying through the Open University. There is also the opportunity to learn to play musical

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instruments. The Centre also holds a relaxation class for any detainees that may want to attend. They also have a very well equipped Gym which is very popular with the detainees as is the astro-turf facility.

There are a variety of employment activities from cleaning, kitchen work, gym orderly, and cycle repair shop and soon there will be a workshop that repairs furniture for which detainees can apply.

Because it is an Immigration Removal Centre that only holds foreign nationals there is sometimes a language problem as some of the detainees do not speak, understand or read English. The Centre has the health screening questionnaire translated into 21 different languages and they do use The Big Word telephone interpreter service when necessary.

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There were 195 new receptions in December 2007 and 284 discharges in December 2007, the discharges include detainees going out to court, hospital appointments, bail, temporary admissions and others so a significant number come back into the centre.

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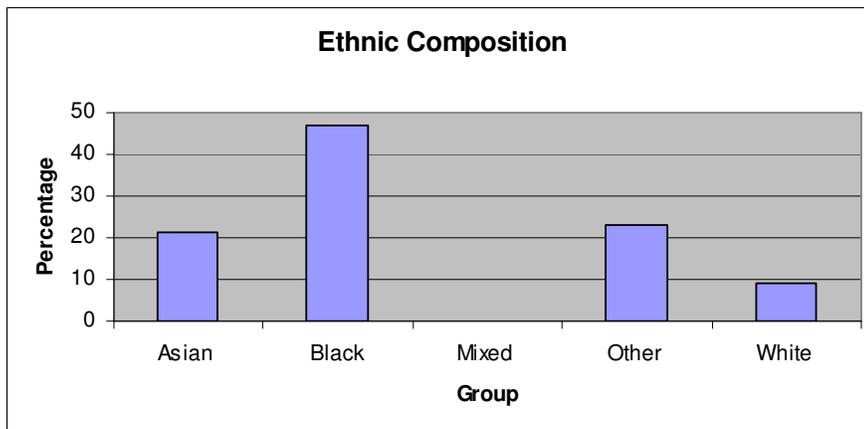
- 2147 new receptions from January 2007 – Dec 2007
- Detainees that are going to be transferred or released on prescribed medication are supplied with a 7 days medication and a discharge letter if necessary.

2.4 Ethnic composition:

Dover as at 30 th December 2007	Number of population	Percentage of population
Ethnic Group		
Asian	66	21.3
Black	145	46.7
Mixed	0	0
Other	71	23.0
White	28	9.0
TOTAL	310	100%

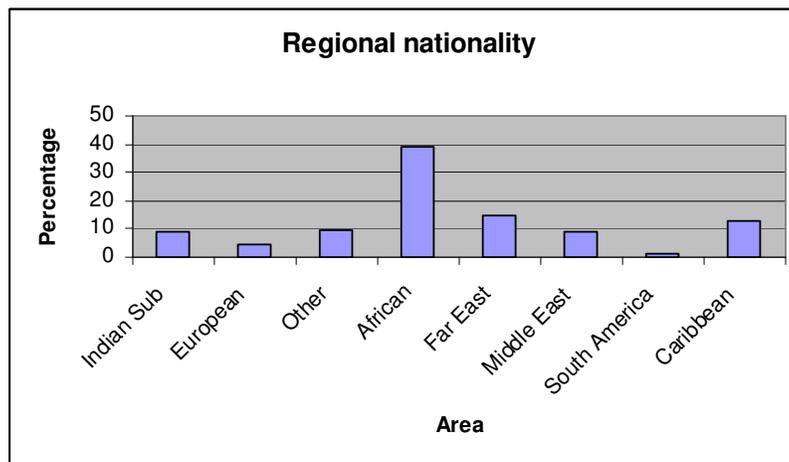
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2.5



Dover as at 30th December 2007	Total	Percentage
Nationality		
Somalia	14	4.6
Jamaican	37	12.0
Nigerian	24	7.8
Angola	3	1
Iraq	12	3.9
Iran	10	3.2
India	9	2.9
Sri Lanka	8	2.6
Algeria	18	5.8
China	33	11
Ghana	5	1.6
Congo	12	4
South Africa	3	1
Turkey	4	1.3
Italy	1	0.3
Yugoslavia	2	0.6
Switzerland	1	0.3
Russia	3	1
Brazil	2	0.6
Bangladesh	2	0.6
Dahomey	1	0.3
Canadian	1	0.3
Ivory Coast	2	0.6
Cameroon	5	1.6
Germany West	1	0.3
Dominican Republic	1	0.3
Ecuador	1	0.3
Egypt	2	0.6
Ethiopa	6	2
France	2	0.6
Georgia	1	0.3
Gambia	3	1
Hong Kong	1	0.3
Kenya	2	0.6
Kuwait	1	0.3
Lebanon	2	0.6
St Lucia	1	0.3
Liberia	3	1
Libya	1	0.3
Morocco	1	0.3
Moldavia	1	0.3
Mauritius	1	0.3
Panama	1	0.3
Pakistan	9	2.9
Poland	1	0.3
Portugal	1	0.3

Sudan	5	1.6
Sierra Leone	3	1
Swaziland	1	0.3
Togo	1	0.3
Trinidad and Tobago	1	0.3
Vietnam	11	3.6
Zimbabwe	7	2.3
Not Known	26	8.4
Total	310	100%



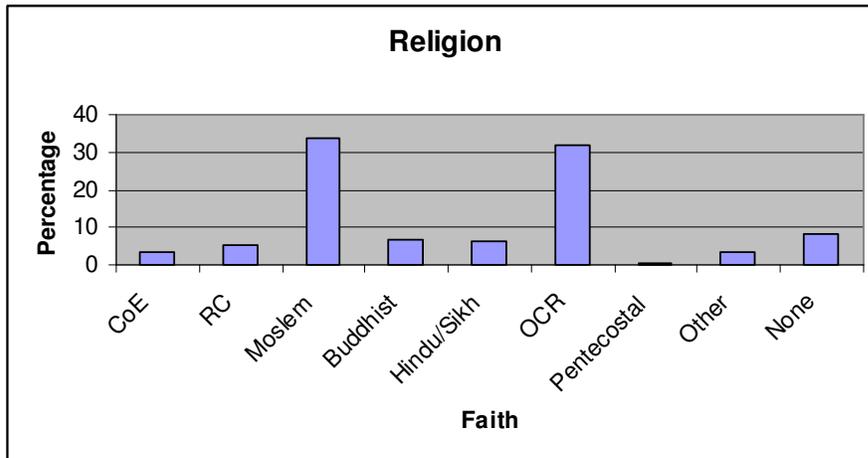
The position regarding nationality can be fairly fluid and the nationality mix change quite suddenly, for example in the latter months of 2007 the top five nationalities were Jamaican, Vietnamese, Chinese, Nigerian and Algerian. (Source: Border & Immigration Agency monthly Report November 2007)

2.6 Breakdown of Religion:

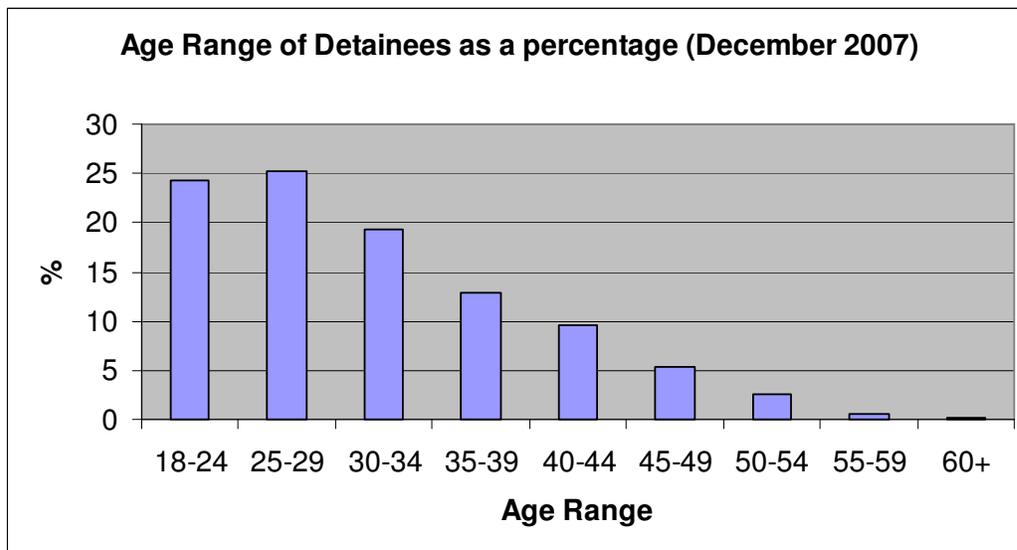
Dover as at 30th December 2007	Total	Percentage
Religion		
Church of England	11	3.5
Atheist	1	0.3
Muslim	105	33.9
Buddhist	21	6.8
Hindu/ Jain	8	2.6
Sikh	12	3.9
Roman Catholic	16	5.2
Non Conformist	1	0.3
Other Christian Religions	98	31.6
Jehovah Witness	1	0.3
Orthodox Greek/Russian	2	0.6
Christian Scientist	1	0.3

Rastafarian	4	1.3
Taoist	1	0.3
Pentecostal	2	0.6
Baptist	1	0.3
No Religion	25	8.1

Comment [IS3]: Formatting so table on 1 page



2.7 Age of Prisoners



This indicates that at the time of the audit just fewer than 24% were under 25 years of age and approximately 82% were under 40. Approximately 3% of prisoners were over 50 years of age.

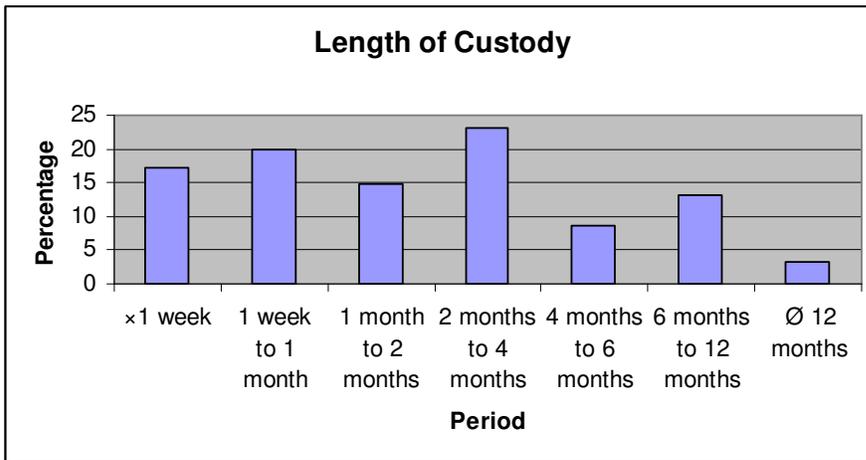
2.8 Length of Custody

The average length of custody since the Removal Centre opened is 34 days. The average length of custody for the current population (Nov 2007) was 92 days compared with 89 days in October 2007. Ex Foreign National Prisoners (FNPs) length of custody was 107 days with non FNPs average custody being 40 days.

16.5% had been in custody for over 6 months and 3.3% over 12 months.

Almost 37% were in custody for less than 1 month.

Comment [IS4]: This makes it sound like British national prisoners rather than those FN who aren't prisoners



3 Methodology

The health needs assessment was conducted using the “Toolkit for health care needs assessment in prisons” developed by the University of Birmingham (5).

Three main methods were used – corporate, comparative and epidemiological approaches.

Corporate approach – Stakeholders or others with a special knowledge were canvassed to determine their views.

The views of detainees was obtained through the questionnaire . The questionnaire was only available in English as it was impractical to translate into so many different languages.

The views of other staff were obtained through a questionnaire.
Comparative approach – An attempt was made to compare services to those of other similar Immigration Removal Centres and prisons with a foreign national’s population and that had completed a HNA. The profile of detainees at Dover IRC was compared to foreign national prisoners in HMP Bullwood Hall in South East Essex and at HMP Canterbury. Haslar IRC in Hampshire had not completed a HNA at the time of this assessment. Also some comparisons were made to prisoners in the general prison population.

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Epidemiological approach – Health care needs were assessed by estimating the incidence and prevalence of health conditions, reviewing the effectiveness and cost effectiveness of services and describing the existing services available for the conditions that were prevalent at the prison.

Foreign national detainees awaiting deportation are not an homogenous group. Originating from numerous countries, detainees are a mixture of offenders, failed asylum seekers and those who have out-stayed their visas, who will have spent varying amounts of time not only within the detention system but also the UK. Therefore their health needs may not completely reflect those of the generic UK prison population or those of asylum seekers or refugees within the community, whilst still having commonality with these populations.

The prevalence of chronic conditions, risk behaviours and health seeking behaviours will be a reflection of genetics, ethnicity, life experiences, prevalence of the condition in the country of origin, individual risk behaviours and experiences of health care. These will of course vary from individual to individual, however it is important to gauge the major health needs for this unique population in order that health care delivery is reflective of these needs.

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Utilising country specific data published by WHO was considered as a source of prevalence information, however with over 60 different countries of origin this was considered neither practical nor relevant.

A few surveys and health needs assessments have been undertaken for refugees and asylum seeker populations within the community as well as the UK prison population, however rigid application of these findings to the population in DIRC should be treated with caution.

Peter Le Feuvre (7) proposed a model of health needs for refugees and asylum seekers, the 'Sequence of Need' from arrival through settling, establishing, integrating and departure. This model aids in determining what areas of health need may be prevalent within this subgroup, and perhaps serves as a useful tool for clinical practitioners, however different detainees may present at different parts of the sequence, and without having an understanding of the proportion of detainees at each level it is difficult to assess the priority for different interventions.

The health needs of DIRC in its current format have not previously been assessed, and there are no pre existing datasets from which to draw reliable estimations. It was therefore necessary to estimate the health needs of this diverse population using primary data collection methods.

Epidemiological data was collected in two formats, firstly a survey of a sample of 150 (50%) inmate medical records was undertaken to establish the prevalence of chronic disease and health behaviours. The audit tool can be found in Appendix 2. Secondly a survey of consultations was undertaken to determine the reasons for health centre clinic attendance, to give a further estimation of the demand for health care services.

All detainees undergo a health screen on arrival. A full screen comprising a questionnaire regarding current health problems and health behaviours, and baseline measurements (height, weight, BP) is undertaken on arrival at Dover Immigration Removal Centre. If they have come from another centre and had a full screen recently then the healthcare staff at Dover can choose to do a shortened screening if they have no concerns or do a full one. These are undertaken by a nurse however each detainee is offered an appointment with a doctor on arrival.

At the time of the healthcare needs assessment, detainee medical records (DMRs) at Dover Immigration Removal Centre (DIRC) were maintained in paper form in the absence of a primary health care health information system (PHCIS). DMRs were kept in the medical centre for the duration of the detainees stay at DIRC. Once moved from DIRC, an individuals' DMR would either accompany them to another detention centre or in the case of those deported or released into the community, the DMRs are archived, some locally and the deported ones centrally .

There are chronic disease registers in place at DIRC, however it was felt that the completeness of the data could not be relied upon to give a robust picture of chronic disease prevalence within the centres' population.

There are of course limitations to both of these methodologies, the main caveat being that the data collected only reflects the self declared health problems of detainees. It therefore does not reveal their undeclared needs. The population at DIRC is constantly changing therefore the prevalence estimates may not remain relevant if there is a dramatic shift in the demography of the detainee population.

Comment [IS5]: Is the table regarding the audit supposed to be here? Or perhaps the overall summary should be in the appendices

4 Baseline Assessment

4.1 Staff:

Staff	Hours
Healthcare Manager Non-Operational G	1 WTE
RGN CNM (Band 6)	1 WTE
RGN Primary Care Nurse (Band 5)	7 WTE
RGN Primary Care Nurse (Band 5)	1 P/T 28 HRS
RMN Nurse (Band 5)	3 WTE
Administration Officer	1 WTE

4.1 Funding

For 2007/8 the budget for PCT funding of £215,000 is topped up by UKBA funding to give an overall budget of £730,334. The funding for the Agenda for Change pay rise has been agreed, & has been calculated to be £31,654. This has now been included in the budget to give an overall budget figure of £761,988.

This figure is made up from the new UKBA allocation of £515,334 and the PCT figure of £218,000 that it was agreed would be honoured for this financial year.

4.2 Primary Care Access

The Healthcare Department at Dover IRC is a 24/7 service with two nurses on night duty to deal with receptions and any house calls.

There is a GP present every day apart from Christmas Day for two hours each day. One Doctor is employed by the Prison Service and practices 5 days out of 7, another Doctor on a regular fee provides one session and the Centre has to use an agency GP for another session. The Doctor who is employed by the Prison Service deals with all callouts and provides out of hours cover. This situation is not sustainable.

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Any detainee requiring In Patient facilities will be transferred to a Detention Centre that has this facility.

New reception detainees are seen on the day of arrival in the reception healthcare screening room by a nurse who screens the detainee and offers them the opportunity to see the GP within 24 hours of their arrival at Dover IRC. All detainees are given a booklet which informs them of the services available and how to apply for an appointment to see a nurse. The nurse will then triage the detainee and refer where necessary if they cannot treat the

detainee themselves. This system has been in place from 02/01/2008, prior to this the detainees attended on a drop in basis between 9 – 11 and 14.00 – 16.00 every day. The new system has reduced the number of detainees seeing the nurses dramatically. Under the drop in clinic arrangements the nurses saw 11526 detainees in 2007 which equates on average to 31.5 detainees a day. With the new appointment system they generally see between 12 – 20 detainees a day

Nurses Drop In Clinic.

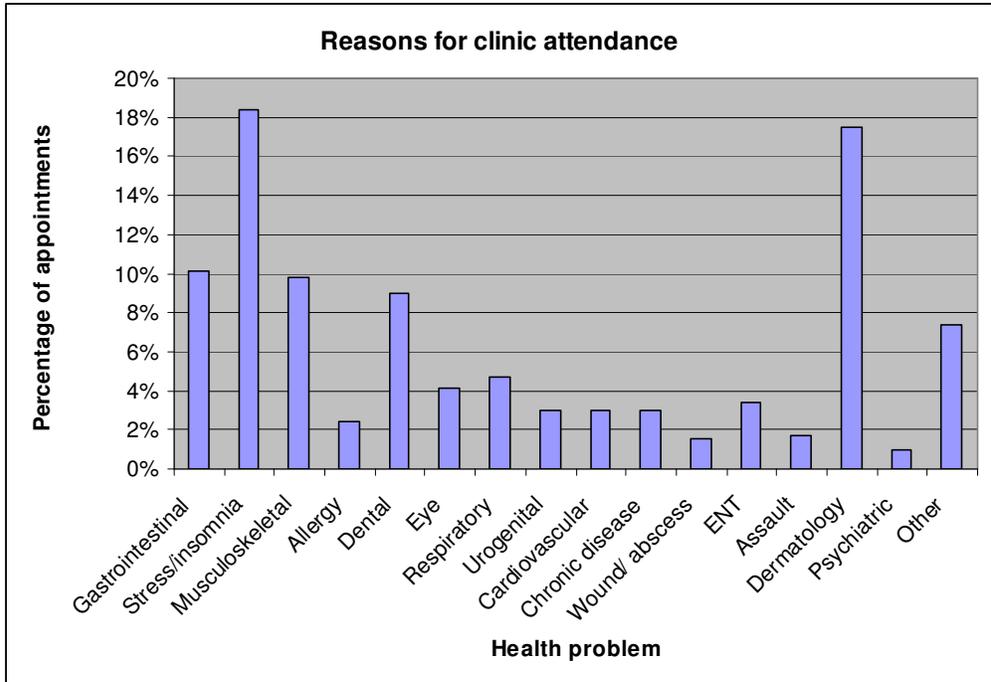
Nurse drop in clinics were run every day in 2007, this has changed to an appointment based system every day from 02/01/2008. This does not include receptions, returns and house call outs.

	12 Months	Monthly Average	December 2007
No. Attended nurse drop in clinic	11526	960	951
No. Referred to Doctor including receptions that wanted to see the Dr	4440	370	371
DNA Doctor Appointment	932	77.6	81
% DNA Doctor Appointments	26.5%		

Clinic attendance survey

Comment [IS6]: Should this be in the epidemiological section?

A further study was undertaken which looked at the reasons for attendance at the medical centre. Each consultation was categorised by the attending practitioner into categories, previously defined in the Canterbury dataset, for the period 1st to 29th February 2008. This enabled an analysis of activity data in the medical centre, as well as identifying the main reasons for seeking primary care services.



As can be seen from the above chart the commonest reasons for seeking medical help are stress, anxiety or insomnia, and skin problems. Dental problems account for 9% of clinic attendances, which then require referral to an external provider.

In a study of the health needs of asylum seekers and the rest of the UK population Petrie (2005) (8) described the following indicators:

	General UK Population	Asylum seekers
Depression/anxiety	17%(in age group 20-39)	33%-50%
PTSD	1%-7.3%	7%-37%
Primary Care (% of consultations)	Respiratory 31% Musculoskeletal 17% Nervous system inc ears 17% Skin 15%	Respiratory 18% Musculoskeletal 30% Gastro-intestinal 29% Skin 26%

As can be seen from the above figures asylum seekers have significantly higher rates of mental health problems as well as attending more frequently for musculoskeletal, gastrointestinal and dermatological conditions than the general UK population. These findings are borne out in the DIRC clinic attendance survey.

4.4 Mental Health

Primary and Secondary Mental healthcare needs

The GP deals with all detainees with mental health problems and refers them on to the CPN and Psychiatrist as necessary. The CPN visit twice a week and

generally sees between 2 and 4 detainees each time depending on their problems. Collecting data on this has been historically difficult due to no computerised records and the movement of detainees along with their medical records.

However the survey of the sample of detainee's medical records shows that 24% had a history of mental health problems, with 14% having self harmed. Mental health problems ranged from anxiety and depression to psychosis, with stress related episodes being the most common.

14% of detainees had a history of substance misuse. The implications of this include need for detoxification programmes, the potential mental health problems arising from substance misuse and potential exposure to blood borne viruses in those who inject illicit drugs.

The Dover IRC Health Partnership Board are aware of the current mental health services position and are awaiting the outcomes from the HMP Canterbury Mental Health Needs Assessment due for completion in June 2008. This Needs Assessment relates to a cohort of some 284 foreign national prisoners. This it is hoped will further clarify the status of detainee mental health within Dover IRC and thereby guide the commissioning of their mental health services.

Substance misuse:

Dover Immigration Removal Centre has not previously had a problem with substance misuse but since the Centre has been receiving more ex foreign national prisoners there appears to be more of a drugs & alcohol problem. The scale and extent of this problem needs to be quantified.

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Smoking:

Of note in just under half of the records analysed there was no indication of smoking status. In those where smoking status was known, 76% were smokers. The health screening questionnaire used by the Centre does not include a question relating to smoking habits.

The Healthcare Centre has a trained nurse to run smoking cessation clinics at Dover Immigration Removal Centre but none were offered in December 2007. Smoking cessation courses will continue to be offered by this nurse as & when approached by clients who wish to stop.

Smoking status	Smoker	63 (42%)
	Non smoker	20 (13.3%)
	Unknown	67 (44.7%)

4.5 Other Primary Care Services

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Pharmacy Services

Patients are allowed to have in their possession medication on a daily, weekly or monthly basis, based on clinical judgement, and risk assessment. Prescribed medication is issued to patients the same day in some instances but in general it is issued the following day. The original prescription is faxed to Rochester pharmacy on a daily basis and is delivered from them on a Monday, Wednesday and Friday. Emergency prescriptions are obtained from Tesco Pharmacy in Whitfield.

Cost of medicines:

Charges for medicines and related costs for 2007/08 is £44,400

Dental Services

The overall prevalence of dental decay within the adult male prison population is 87% with a mean Decayed, Missing or Filled Teeth (DMFT) score of 15.4. (reference)

As noted in para 4.2 above under reasons for clinical attendance some 9% of detainees request dental services, however this only reflects those presenting with symptoms.

There is currently no on site dentist which means that detainees have to be escorted to a local dentist by the security company G4S. This service is vulnerable due to potential shortage of escorts and its provision needs to be reviewed to ensure cost effectiveness and effective delivery.

Optician

There is no on site optician, detainees have to be escorted to a local optician by G4S.

Secondary Care

Number requiring transfer to NHS Hospitals for an in-patient stay:

Period	Number of patients	Bed-watch Nights	Where Treated
12 Months	1	3	William Harvey Hospital
	1	2	William Harvey Hospital
	1	0	William Harvey Hospital
	1	2	William Harvey Hospital
	1	6	William Harvey Hospital

December (2007)	0	0	
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Comment [IS7]: Why is December included in this table?

Number of Accident & Emergency visits to NHS Hospitals

Period	Number of patients	Number Admitted	Nature of treatment needs	Where Treated
12 Months	7	5	VARIOUS	William Harvey Hospital
December 2007	0	0		

Comment [IS8]: As above

Non urgent NHS hospital treatments required in December 2007 were as follows:

Period	Total Number Referred to Specialist consultant	Number of Appointments attended
12 Months	157	113
December 2007	12	7

Details of All Hospital Visits for the period 1st January 2007 to 31st December 2007:-

Type of Visit	TOTAL
Maxillo Facial	1
Ultrasound	14
X-Ray/Radiology	37
Cardio	9
Specialist	18
Fracture	7
Orthopaedics	3
A&E	7
Chest Clinic	1
HIV	10
Pre Op Assess	5
Day Surgery	8
Surgery	0
Vascular Clinic	0
CT	2
Barium swallow	3
General Surgery	0

Comment [IS9]: Does this mean unknown specialist? As opposed to those already defined

Urology	3
Rheumatology	3
Endoscopy	3
MRI	2
Dermatology	0
Chemo/Cathedra	0
Echocardio	0
ENT	0
Gastroenterology	0
Ophthalmology	2
Sub Total	157

Comment [IS10]: ?This doesn't make sens?. Also should you include those with a 0 as they may form part of the 'specialist' category

Continuity of primary care on release:

Detainees with a medical condition on release from the Centre, are given a letter to be taken to their GP along with a weeks supply of their current prescribed medication. If the detainee is receiving care from the CPN and the Healthcare Centre are informed of his release, then the CPN is informed which enables them to provide continuity of care if they are released into the UK. This does not happen if the detainee was being deported. If detainees are transferred to other detention centres (see para 2.3), their medical files are sent with them.

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	12 Months	Monthly Average	December 2007
Number of detainees released on bail, temporary admission and others. These figures do not include hospital in patient, court or transfers.	1224	102	121

4.6 Effectiveness and Cost –Effectiveness of Services

The prison population is recognised as a vulnerable group known to have higher rates of mental illness, substance abuse and some communicable diseases such as Hepatitis C and HIV compared to the general population.

The prison health service is operated under the principle that the prisoner population should have access to health care that meets the same standards as the general population. In keeping with this evidenced-based policies and guidelines are produced by the Department of Health and the Prison Service that conform to relevant National Service Frameworks and NICE guidance.

Specific guidance includes:

- Reception screening (Prison Service Order 3050, February 2006) (9). This is designed to detect any health issues in newly received prisoners before their first night in prison so that appropriate actions and referrals can be made.
- *Developing and Modernising Primary Care in Prisons* (June 2002) (10). The vision is that “Primary Care within a prison should develop needs based health services in partnership with their local NHS providers that deliver effective evidence based care to both individual prisoners and the prison population as a whole.”
- *Changing the Outlook: A Strategy for Developing and Modernising Mental Health Services in Prisons* (December 2001) (11). The joint strategy between the Department of Health and the Prison Service addresses implementation of the 1999 NSF for Mental Health in the prison setting. Mental health promotion is central to the vision outlined in the strategy. It is noted that “Imprisonment is stressful, especially for first time prisoners or those on remand who have the added uncertainty of not knowing what will happen next.” While prisoners may not have specific health problems the strategy recognises that they may need help at times to cope with stress in order to maintain their mental health wellbeing.
- National Institute for Health and Clinical Excellence (NICE) has received and published comments from the consultation on their guidance on drug misuse – opiate detoxification in July 2007. The management of alcohol use disorders will be considered by NICE in their next work programme wave.
- *Recommended Standards for Sexual Health Services* (March 2005) (12) was commissioned by the Department of Health and produced by the Medical Foundation for AIDS and Sexual Health (MedFASH).
- *Getting Ahead of the Curve: a Strategy for infectious diseases* (January 2002) (13) identified tuberculosis, hepatitis B, hepatitis C and HIV as priority infections. Immunisation against hepatitis B should be offered to

all new inmates. An action plan for hepatitis C (Hepatitis C: Action plan for England - July 2004) (14) outlines actions to identify and manage prisoners who are infected and also activities to prevent spread especially through infected needles among injecting drug users.

- *A Pharmacy Service for Prisoners* (June 2003) (15) outlines the principles for developing these services. Among the points highlighted were:
 - Pharmacy services to prisoners should be patient focused, be based on identified patient needs, and support and promote self-care.
 - Developments in medicines management in the NHS, including repeat dispensing and medication review, should be reflected in pharmacy services provided to prisoners.
 - All prisoners should have appropriate access to a pharmacist or pharmacy staff.
 - Medicines in use should normally be held in the possession of prisoners unless there are clearly indicated individual factors why this should not be the case.
 - All prisons should have, or be covered by, a Drug and Therapeutics Committee responsible for the development of evidence-based local formularies, disease management guidelines and medicine-related policies and procedures.
 - Pharmacy leadership roles should be established on a regional basis to help drive forward the required programme of change locally.
 - An IT system delivering the same level of information and support for the prescription and supply of medicines that is widely available in the NHS should be introduced.

- Prison Service Order 3200 which was a commitment in the strategy '*Health Promoting Prisons: a shared approach*' (April 2002) (16), sets out straight forward means for integrating action to address health promotion by encouraging and detailing how to create a **whole prison approach**. This approach is built upon evidence of what works best in prison based health promotion. The Order mandates:

“Governors and Directors of contracted out prisons, working in partnership with Primary Care Trusts (or Health Boards in Wales) must ensure that by end of December 2003 they have included health promotion considerations adequately and explicitly within their local planning mechanisms, drawn up in partnership with their PCT. The Health Promotion Section in the local plan must specifically address, as a minimum, needs in the five major areas:

 - Mental health promotion and well being
 - Smoking
 - Healthy eating and nutrition
 - Healthy lifestyles, including sex and relationships and active living

- Drug and other substance misuse”

Research commissioned by the Department of Health Tobacco Programme Team and Prison Health “Stop Smoking Support in HM Prisons: The Impact of Nicotine Replacement Therapy” (January 2007) (17) found that “Substantial quit rates can be achieved in prison settings with considerable prisoner interest in participation.”

- The *Strategy for Modernising Dental Services for Prisoners in England* was published in April 2003 (18). The strategy set out recommendations about the standards of dentistry in prisons. A top priority for investment in these services was the reduction of long waiting lists. A further recommendation in the strategy was that prisons should aim to provide at least 1 dental session per week for every 250 prisoners according to the local situation. *Reforming Prison Dental Health Services in England: A Guide to Good Practice* (July 2005) (19) and *Choosing Better Oral Health: An Oral Health Plan for England* (November 2005) (20) build on the strategy and emphasise prevention and health promotion as well as treatment.

5 Epidemiological Needs Assessment

5.1 Protocol

The protocol for completing the epidemiological needs assessment was adapted from the “Toolkit for health care needs assessment in prisons” developed by the University of Birmingham (5). It is well established that primary care consultation rates in custody are higher compared to demographically similar community populations. Whilst prisoners are also known to have poorer levels of physical and mental health, including significantly higher levels of substance misuse, communicable disease and sexual health problems the available data on detainees is sparse but believed to also exhibit high levels of morbidity.

Physical Health

5.2 Chronic Disease

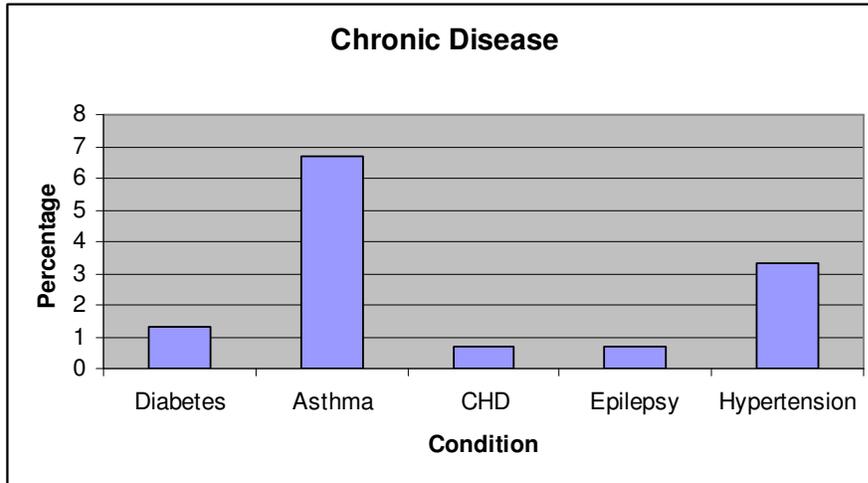
The prevalence of chronic disease present within the detainee population is shown below

Type of illness	HMP Bullwood	%	HMP Canterbury	%	Dover IRC	%
Heart Disease	None	0	None	0	1	0.70
Diabetes	4	2.60	8	2.80	3	1.30
Asthma	10	6.45	3	1.06	10	6.70
COPD	0	0	None	0	None	0
Epilepsy	2	1.30	None	0	1	0.70
Hypothyroidism	None	0	None	0	None	0
Cancer	None	0	None	0	None	0
Stroke (& TIA)	None	0	None	0	None	0
Hypertension	9	5.80	5	1.76	5	3.30

Whilst the rates for diabetes at HMP Canterbury are in line with expected rates of the general prison population namely 2.6% for Type 2 diabetes the level at Dover IRC is lower. The rate for asthma is low when compared with rates of the general prison population (13% of males have doctor diagnosed asthma). Others are below the expected rates not only in terms of expected rates within the general prison population but also when compared with those from HMP Bullwood except for asthma (see above).

As can be seen from the above data, the prevalence of significant chronic diseases at Dover IRC was low, with less than 7% of records showing evidence of asthma, diabetes, coronary heart disease or epilepsy. Asthma

had the highest prevalence, which is perhaps unsurprising in a young population.



5.3 Communicable Disease.

The 1997 Survey carried out by the Public Health Laboratory Service and the Prison Service to find out the prevalence of blood borne virus infections and risk factors found that one in four adult male prisoners engaged in activities that put them at risk of infection with HIV/AIDs, Hepatitis B or Hepatitis C. High proportions of prisoners also engage in risky sexual behaviour. Rates for HIV/AIDs range from 0.26 – 2%; Hepatitis B 8 – 31%; Hepatitis C 9 -39%. Hepatitis C virus infection is a global health problem that leads to significant morbidity and mortality from complications of end stage liver disease. As Hepatitis C virus infection is usually sub clinical there are no reliable predictive factors for chronic infection, screening is recommended for a number of high risk groups including:

- History of injecting drug use
- HIV infection
- Current sexual partners if people infected with Hepatitis C
- Conditions with high seroprevalence of Hepatitis C virus infection

Further to a positive test for Hepatitis C virus infection, detainees should be referred to specialist services for further investigations and treatment.

The data below shows the reported prevalence in the Centre population. The numbers & rates of those infections recorded appear to show within the expected range for HIV/AIDs but significantly below for both Hepatitis B & C. However there is no systematic screening of individuals therefore the actual prevalence may be higher.

Deleted: .

Sexually Transmitted Infection data is not shared with Centre Healthcare.

Communicable diseases – known cases (from register):

December 2007	
HIV/Aids	2
Hepatitis B	1
Hepatitis C	2
Sexually Transmitted Diseases	1
Immunosuppressed	0

There is no systematic screening of individuals for blood borne viruses (BBVs), or systematic offer of Hepatitis B vaccination. Of the 150 IMRs examined, 2 detainees were known to have Hep B and 2 HIV, however only 20 underwent testing for BBVs.

It is believed that detainees should receive Hepatitis B vaccination. Although not a prison in the conventional sense the Centre is a residential facility where individuals are detained, and therefore it could be argued that Hepatitis B vaccination should be routinely offered to detainees. 12% of detainees whose records were examined were at least partially vaccinated for Hepatitis B.

TB screening in the prison setting should comprise a health questionnaire on entry and in those with symptoms and signs suggestive of TB a chest x-ray and sputum samples. More involved screening is not felt to be cost effective; however the population within the Centre is made up of foreign nationals, some of whom will be from high incidence countries. The question of whether there should be a more involved TB screening process at Dover IRC in line with the NICE recommendations for new entrants is not clear. There were no detainees with active TB in the cohort identified, however only 14% had documented evidence of BCG vaccination.

Meningitis C Vaccinations:

At present Dover IRC do not offer Meningitis C vaccinations to the under 25's.

Under 25's Chlamydia Screening

In December 2007 Dover IRC did not offer this screening but it is hoped to this in the near future.

Condom Scheme:

Dover Immigration Removal Centre has a Policy in place where condoms and lubricants are available free of charge from healthcare at any time.

Learning difficulties:

During December 2007 there were two detainees with dyslexia.

Physical and sensory disability:

DIRC has limited resources for disabled detainees who would normally live at home if they were in the community.

Impairment	Cases in December 2007
Visual	1
Hearing	None
Wheelchair Users	None
Mobility (reduced)	1
Senile dementia	None
Stroke	None

6. Corporate Needs Assessment

The corporate needs assessment consisted of comments and observations from consultation with key stakeholders within the Detention Centre from senior management team, healthcare staff, and detainees.

There is also analysis of relevant contemporary HMCIP Reports and the IMB Annual report relating to Healthcare at the Detention Centre.

Relevant questionnaires were made available to the various groups

A combined corporate response was received from the senior management team (SMT), one from the Independent Monitoring Board (IMB), three from healthcare staff and some 33 from detainees although 4 of these appeared to have been completed by one individual citing the same comments on each of the 4 forms.

In terms of what healthcare does particularly well both the SMT and IMB cited the screening/monitoring role that healthcare exercise. This is also echoed by healthcare staff who also alluded to specialist clinics and quick and easy access. In broad terms the detainees recognise that the healthcare service is good at reception screening, the offer of healthcare appointments and the general provision of care and attention. Some detainees commented that Dover IRC healthcare is better than other healthcare services at unnamed IRCs.

Whilst commenting upon the provision of healthcare services HM Chief Inspector of Prisons (HMCIP) note that healthcare is provided at least to the standards of the NHS and cite as good practice clinical supervision sessions for nursing staff being used appropriately and documented, as well as the provision of "easy reader" spectacles by healthcare staff to minimise optician appointments. (Announced inspection March 2007).

Comment [IS11]: ?what is a clinical supervision session

Concerns about the health of detainees at Dover IRC were raised by the SMT & IMB as the lack of provision of dental, counselling and mental health services. This latter point echoes the fact that mental health services issues were highlighted in HM Inspectorate of Prisons' Thematic Report on Foreign Nationals (2006). These concerns were repeated by healthcare staff along with concerns regarding lack of screening for blood borne viruses, provision of health promotion and a need for more gainful employment and exercise.

SMT saw a role for improved health promotion in improving healthcare whilst the IMB called for improved mental health & dental services. The better use of RMNs was an issue raised by healthcare staff along with counselling, dental & podiatry service provision. Additional clinics focusing upon dental hygiene and healthy eating were also highlighted as important improvements.

Detainees raised various improvements such as improved dental service provision, health promotion, better screening and more flexible access to healthcare. Improved food and more exercise were also mentioned.

All relevant stakeholders believe that detainees have good access to healthcare but language/communication was a problem. Again this latter issue has previously been highlighted in HM Inspectorate of Prisons' Thematic Report on Foreign Nationals (ibid), but within the constraints that this brings most believed that healthcare listened to detainee concerns about their health.

Whilst the Health Needs Assessment process is a driver in the assessment of healthcare staffing numbers, stakeholders believed that there were sufficient healthcare staffs. The Healthcare team were aware of staffing numbers and some aware of the budget size at Dover IRC and believed that the IRC delivered more services with less staff and a smaller budget than other establishments. There was recognition that a skill mix review was necessary and that more training was required across all grades.

In terms of particular problems bullying, mental health, sexual health and drug abuse were seen by some stakeholders as problematic with language difficulties being highlighted by detainees. There were however expressed opinions about counselling, education, torture and abuse and finally alcohol.

Improved contact with family and friends would be beneficial and more exercise and better food plus more fruit were highlighted by detainees with other stakeholders mentioning education, family and food.

In terms of counselling services including anger management there was universal support for this to be developed. The IMB also alluded to the increasing number of released foreign national ex prisoners within the IRC and the resultant impact.

Finally senior management, the Independent Monitoring Board and HMCIP had all commented upon the need for an up to date health needs assessment.

7 Recommendations

The recommendations have not been prioritised or costed as this will form part of the action planning process led by the Health Partnership Board.

Primary Care

The most appropriate model for primary care delivery needs to be honed and developed including the recruitment and retention of healthcare staff including GPs.

Investigations should be made to implement the community based Out of Hours service for the detainees.

The computerised clinical system for recording detainee medical records should be developed in line with national requirements and used by all staff as well as agreement on uniform procedures for record keeping. Investment should be made to ensure that all levels of staff are trained to their appropriate level of competence with the system(s).

Ensure that treatment guidelines, management protocols and performance frameworks are in line with national guidelines

Ensure the continuing development of nurse led services supported by investment in their training to meet this development.

Ensure the provision of nurse led Chronic Disease Management Clinics and associated registers. Clinics should be delivered to the standards outlined in the National Service Frameworks or equivalent where available and audited against the Quality and Outcome Frameworks for General Practice.

Implement a skills mix review.

Specialist Services including Communicable Disease

Develop the current reception and secondary healthcare screening to provide nurse led blood borne virus clinics. Full implementation of guidelines for identification, screening and treatment of tuberculosis, blood borne viruses and other communicable diseases needs to be ensured.

Commission a review of the current Mental Health Service Level Agreement to ensure that the identified mental health needs of the centre's population, including primary mental health are addressed. (The outcome of foreign nationals Mental Health Needs Assessment may well influence the development of primary & secondary MH services at the Centre).

Commission through the relevant organisation (HMPS/KDAAT) a focused needs assessment for alcohol interventions particularly for those prisoners whose drinking is not associated with substance misuse.

Other Services

The Centre should adopt the Health-Promoting Centre strategy, supported by investment to ensure that health promotion and health education are done in a proactive rather than reactive manner and that a whole establishment approach to health promotion is adopted.

Consider developing a Centre Smoking Cessation Strategy for both detainees and staff, in association with the PCT.

Commission through Medway PCT a review of the current Pharmacy Service Level Agreement to ensure that the identified needs of the Centre's population and their healthcare staff are addressed.

Commission appropriate training for relevant healthcare staff in BBV, sexual health, chronic disease management, and health needs assessment.

Commission a detailed audit into secondary care access including escorts and bed watchers.

Commission an options report for the provision of dental services at the Centre

Formalise arrangements for consultation with key stakeholders through the PCT's "Public, Patient Engagement" process.

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Acknowledgements

The PCT would like to thank everyone who gave up their time to support and / or provide information for this Health Needs Assessment. We would particularly like to thank Heather Mcadam, Head of Healthcare & her team from Dover IRC Healthcare for their support, comments and patience and Sheila O' Sullivan for her developmental work on the corporate stakeholder element.

APPENDIX 1

Eastern & Coastal Kent Prison Cluster

(Dover)

Health Care Needs Assessment Analysis for 2008- 2009 conducted January 2008

Centre Manager	James Carmichael
Healthcare Manager	Heather McAdam
Clinical Nurse Manager	Letitia Charge
Health Needs Assessment Nurse Lead	Anita Harding
Public Health Specialist (PCT)	Stephen Cochrane

Address	Dover Immigration Removal Centre
Tel No:	01304 246400
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1. Category, logistics and detection function:

Dover Immigration Removal Centre is an Immigration Detention Centre that is run by the Prison Service for foreign nationals awaiting deportation. Dover Immigration Removal Centre can hold 316 male detainees from the age of 18 upwards.

At Dover we do have an education department which covers English as a second language to level 2, CLAIT PLUS, Graphics and Web design plus a workshop which helps any detainees that are studying through the Open University. There is also the opportunity to learn to play musical instruments. We also hold a relaxation class for any detainees that may want to attend. We also have a very well equipped Gym which is very popular with the detainees as is the astro-turf.

There are a variety of employment activities from cleaning, kitchen work, gym orderly, cycle repair shop and soon there will be a workshop that repairs furniture that detainees can apply for.

Because we are an Immigration Removal Centre that only hold foreign nationals we do sometimes have a language problem as some of the detainees do not speak, understand or read English. We do have the health screening questionnaire translated into 21 different languages and we do use The Big Word telephone interpreter service when necessary.

There were 195 new receptions in December 2007 and 284 discharges in December 2007, the discharges includes detainees going out to court, hospital appointments, bail, temporary admissions and others so a lot of them come back into the centre.

- 2147 new receptions from January 2007 – Dec 2007
- Detainees that are going to be transferred or released on prescribed medication are supplied with a 7 days medication and a discharge letter if necessary.

Ethnic composition:

Dover as at 30th December 2007	Number of population	Percentage of population
Ethnic Group		
Asian	66	21.3
Black	145	46.8
Mixed	0	0
Other	71	23.0
White	28	9.0
TOTAL	310	100%

Breakdown of Nationality:

Dover as at 30th December 2007	Total	Percentage
Nationality		
Somalia	14	4.6
Jamaican	37	12.0
Nigerian	24	7.8

Angola	3	1
Iraq	12	3.9
Iran	10	3.2
India	9	2.9
Sri Lanka	8	2.6
Algeria	18	5.8
China	33	11
Ghana	5	1.6
Congo	12	4
South Africa	3	1
Turkey	4	1.3
Italy	1	0.3
Yugoslavia	2	0.6
Switzerland	1	0.3
Russia	3	1
Brazil	2	0.6
Bangladesh	2	0.6
Dahomey	1	0.3
Canadian	1	0.3
Ivory Coast	2	0.6
Cameroon	5	1.6
Germany West	1	0.3
Dominican Republic	1	0.3
Ecuador	1	0.3
Egypt	2	0.6
Ethiopa	6	2
France	2	0.6
Georgia	1	0.3
Gambia	3	1

Hong Kong	1	0.3
Kenya	2	0.6
Kuwait	1	0.3
Lebanon	2	0.6
St Lucia	1	0.3
Liberia	3	1
Libya	1	0.3
Morocco	1	0.3
Moldavia	1	0.3
Mauritius	1	0.3
Panama	1	0.3
Pakistan	9	2.9
Poland	1	0.3
Portugal	1	0.3
Sudan	5	1.6
Sierra Leone	3	1
Swaziland	1	0.3
Togo	1	0.3
Trinidad and Tobago	1	0.3
Vietnam	11	3.6
Zimbabwe	7	2.3
Not Known	26	8.4
Total	310	100%

Breakdown of Religion:

Dover as at 30th December 2007	Total	Percentage
Religion		
Church of England	11	3.5

Atheist	1	0.3
Muslim	105	33.9
Buddhist	21	6.8
Hindu/ Jain	8	2.6
Sikh	12	3.9
Roman Catholic	16	5.2
Non Conformist	1	0.3
Other Christian Religions	98	31.6
Jehovah Witness	1	0.3
Orthodox Greek/Russian	2	0.6
Christian Scientist	1	0.3
Rastafarian	4	1.3
Taoist	1	0.3
Pentecostal	2	0.6
Baptist	1	0.3
No Religion	25	8.1

2. Learning deficits:

During December 2007 there were two detainees with dyslexia.

2.1 Physical and sensory disability:

DIRC has limited resources for disabled detainees who would normally live at home if they were in the community.

Impairment	Cases in December 2007
Visual	1

Hearing	None
Wheelchair Users	None
Mobility (reduced)	1
Senile dementia	None
Stroke	None

3. Health status:

At Dover we don't have that many serious health problems but that could be due to the age of the majority of our detainees.

4. Substance misuse:

Dover Immigration Removal Centre has not up till now had a problem with substance misuse but since we have been receiving more ex foreign national prisoners there is more of a drugs problem. We are looking at training for the nurses to be able to deal with de-tox if it is required.

4.2 Smoking:

We have now trained a nurse to run a smoking cessation clinic at Dover Immigration Removal Centre but in December 2007 we did not. Smoking cessation courses will be delivered by this nurse once she has some clients that wish to stop.

4.3 Communicable diseases – known cases:

December 2007	
HIV/Aids	2
Hepatitis B	1
Hepatitis C	2
Sexually Transmitted Diseases	1
Immunosuppressed	0

Hepatitis B Vaccinations:

Each new reception to the establishment is seen by Healthcare staff and a health screen is carried out. During that interview hepatitis vaccination status is requested. At present we do not routinely offer vaccination as previously our detainees would not be here long enough for us to complete a course. If a detainee has been started on a course elsewhere then we will complete it or if the MO decides that it is necessary. An induction booklet will be issued to all detainees on arrival at Dover from January 2008 explaining the services available and how to access healthcare. This has been translated into 21 different languages.

Meningitis C Vaccinations:

At present we do not offer meningitis C vaccinations to the under 25's. The PCT may wish us to do this once they take over the commissioning of the healthcare services. The nurse will need to be trained in vaccination because at the moment it is only the MO that does any vaccinations that are required.

Under 25's Chlamydia Screening

In December 2007 we did not offer this screening but I have been in discussion with the relevant people and we are looking at offering this in the near future.

Condom Scheme:

Dover Immigration Removal Centre has a Policy in place where condoms and lubricants are available free of charge from healthcare at any time.

5. Mental Health

Primary and Secondary Mental healthcare needs

The GP deals with all detainees with mental health problems and refers on to the CPN and Psychiatrist as necessary. The CPN visit twice a week and generally sees between 2 and 4 detainees each time depending on their problems. We cannot give you figures for this as our detainees move on and their medical file goes with them and we do not hold computerised records yet.

5.1 Chronic illness: (data from chronic disease registers)

Type of illness	December 2007
Heart Disease	0
Diabetes	4
Asthma	9
COPD	0
Epilepsy	0
Hypothyroidism	0
Cancer	0
Stroke (& TIA)	0
Hypertension	5

5.2 Number requiring transfer to NHS Hospitals for an in-patient stay:

Period	Number of patients	Bed-watch Nights	Where Treated
--------	--------------------	------------------	---------------

12 Months	1	3	WHH
	1	2	WHH
	1	0	WHH
	1	2	WHH
	1	6	WHH
December (2007)	0	0	

5.3 Number of Accident & Emergency visits to NHS Hospitals

Period	Number of patients	Number Admitted	Nature of treatment needs	Where Treated
12 Months	7	5	VARIOUS	WHH
December 2007	0	0		

5.4 Non urgent NHS hospital treatments required in December 2007 were as follows:

Period	Total Number Referred to Specialist consultant	Number of Appointments attended
12 Months	157	113
December 2007	12	7

Details of All Hospital Visits for the period 1st January 2007 to 31st December 2007:-

Type of Visit	Jan 07	Feb 07	Mar 07	April 07	May 07	June 07	July 07	Aug 07	Sept 07	Oct 07	Nov 07	Dec 07	TOTAL
Maxillo Facial									1				1
Ultrasound				1	4	1	3		1	1		3	14
X-Ray/Radiology	3	1	5	4	2		9	3	3	3	2	2	37
Cardio			1	2	1			1		3		1	9
Specialist	2	3	1	4	2	2	5	6	8	3	4	3	43
Fracture	2	1	1	1	1	1							7
Orthopaedics						1						2	3
A&E	2	2	2		1								7
Chest Clinic								1					1
HIV		1				2	4	2			1		10
Pre Op Assess	1							1		1	1	1	5
Day Surgery		1						2	2	2	1		8
Surgery													0
Vascular Clinic													0
CT					1				1				2
Barium swallow					1	1					1		3
General Surgery													0
Urology						1		1		1			3
Rheumatology													3
Endoscopy													3
MRI									2				2
Dermatology													0
Chemo/Cathedral													0

Echocardio														0
ENT														0
Gastroenterology														0
Ophthalmology				1						1				2
Sub Total	10	9	10	13	13	9	21	17	18	15	10	12		157

6. Continuity of primary care on release:

Detainees released from DIRC if Immigration inform us, and have a medical condition are given a letter to be taken to their GP along with a weeks supply of medication if they are in receipt of any. If the detainee is receiving care from the CPN and we are informed of his release then the CPN is informed which enables him to provide continuity of care if they are released in this country. Obviously this would not happen if the detainee was being deported. A lot of detainees are transferred to other detention centres and their medical file goes with them.

	12 Months	Monthly Average	December 2007
Number of detainees released on bail, temporary admission and others. These figures do not include hospital in patient, court or transfers.	1224	102	121

6. Healthcare staff and services:

6.1 Staff:

Staff	Hours
Healthcare Manager Non-Operational G	1 WTE
RGN CNM (Band 6)	1 WTE
RGN Primary Care Nurse (Band 5)	7 WTE
RGN Primary Care Nurse (Band 5)	1 P/T 28 HRS
RMN Nurse (Band 5)	3 WTE
Administration Officer	1 WTE

6.2 Primary care access:

The Healthcare Department at DIRC is a 24/7 service with two nurses on night duty to deal with receptions and any house calls.

We have a GP every day apart from Christmas Day for two hours each day. One Dr is employed by the Prison Service and does 5 days out of 7, another Dr on a regular fee provides one session and we have to use an agency GP for another session. The Dr who is employed by the Prison Service deals with all callouts.

Any detainee requiring In Patient facilities will be transferred to a detention centre that has this facility.

New reception detainees are seen on the day of arrival in the reception healthcare screening room by a nurse who screens the detainee and offers them the opportunity to see the GP within 24 hours of their arrival at DIRC. All detainees are given a

booklet which informs them of the services available and how to apply for an appointment to see a nurse. The nurse will then triage the detainee and refer where necessary if they cannot treat the detainee themselves. This system has been in place from 02/01/2008, prior to this the detainees attended on a drop in basis between 9 – 11 and 14.00 – 16.00 every day. The new system has reduced the number of detainees seeing the nurses dramatically. With the drop in clinic the nurses saw 11526 detainees in 2007 which equates on average to 31.5 detainees a day. With the new appointment system they generally see between 12 – 20 detainees a day so far.

6.3 Nurses Drop In Clinic.

Nurse drop in clinics were run every day in 2007, this has changed to an appointment based system every day from 02/01/2008. This does not include receptions, returns and house call outs.

	12 Months	Monthly Average	December 2007
No. Attended nurse drop in clinic	11526	960	951
No. Referred to Doctor including receptions that wanted to see the Dr	4440	370	371
DNA Doctor Appointment	932	77.6	81
% DNA Doctor Appointments	26.5%		

6.4 Chronic disease management clinics:

A Chronic Disease Register is held in Healthcare and updated as and when new detainees arrive and when they leave.

The registers contain details of those who suffer with Asthma, Diabetes, HIV, Hypertension, Hepatitis and TB.

6.5 Other primary care services:

Pharmacy services

Patients are allowed to have in possession medication on a daily, weekly or monthly basis based on clinical judgement, and risk assessment. Prescribed medication is issued to patients the same day in some instances but in general it is issued the following day. The original prescription is faxed to Rochester pharmacy on a daily basis and is delivered from them on a Monday, Wednesday and Friday. Emergency prescriptions are obtained from Tesco Pharmacy in Whitfield.

Cost of medicines:

Charges for medicines and related costs in December 2007:

Dental services: No on site dentist, detainees have to be escorted to a local dentist by G4S.

Optician No on site optician, detainees have to be escorted to a local optician by G4S.

6.6 Health promotion: Smoking Cessation and Well Man Clinic.

7. Deaths in custody January 2007 – December 2007 - None

New procedures for investigation of death in custody by the healthcare commission and prison health ombudsman enable lessons to be learned from examination of health care provided prior to death.

8. Corporate approach to needs assessment:

9. Staff input:

Healthcare staff, senior management team, detainee groups and the Independent Monitoring Board have provided the evidence for this Health Needs Assessment. The emerging picture highlights that more nurse-led clinics are required in order to meet the detainees health care needs as is an on site dentist, optician and podiatrist when necessary.

10 Data Collection:

Health Needs Assessments will be repeated next year to support the refresh of the Prison Health Delivery Development Plan. The next Health Needs Assessment review is planned for February 2009 and will be facilitated by improved data collection.

Signed Governor: _____

PCT Prison Lead: _____

Date: _____ Date to be reviewed:

References:

- Bridgewood & Malbon (1994) *Survey of the Physical Health of Prisoners* London: Office of National Statistics
- Hudson, T. and Gray, S. (2006) *MPQL Research carried out at HMP Maidstone between 20-23 November 2006*. London: HM Prison Service
- Kent & Medway Prison Mental Health In reach Team (2006). *Study to undertake a Mental Health Needs Assessment across Kent and Medway Prison Estate*. West Malling: West Kent NHS and Social Care Trust.

APPENDIX 2

DETAINEE MEDICAL RECORDS ANALYSIS

1. General Information

Unique identifier	Age	Length of stay (mths)	
Smoking status	Smoker/ Non smoker/ Not recorded	BMI recorded	Yes/ No
Medication (regular)			

2. Health Care Utilisation at DIRC

Consultations with Dr or nurse (excluding reception)	
Reason (and number)	
Substance misuse	
Physical	
Mental health	
Sexual health	
Referrals to secondary care (number)	Medical Surgical Mental health
Referrals to other HC professionals	Dentist Optometrist Podiatrist Other

3. Physical Health

Asthma	Diabetes	CHD	Epilepsy
Other:			

4. Substance Misuse

Recorded history of any of the following:			
Benzodiazepines	Crack/ cocaine	Heroin	Methadone
Amphetamines	Alcohol	IV drug user Y/N	Other

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5. Mental Health

History of MH issues	
History of self harm	
ACDT completed	
History of torture	
Immigration informed	
Treatment	

6. Sexual Health and Communicable Disease

	Screened Y/N	Treatment/ Vaccinated
TB		
HIV		
Hep A		
Hep B		
Hep C		
Chlamydia		
Genital warts		
Genital Herpes		
Gonorrhoea		
Other		

Date completed:.....

APPENDIX 3

Mental Health Needs Assessment

To be inserted

APPENDIX 4 Corporate consultation literature

Governing Governor,
Dover IRC,
Dover

Dear Governor,

Dover IRC Health Needs Assessment Stakeholder Consultation

As you may know Eastern & Coastal Kent Primary Care Trust (PCT) is carrying out, along with the Centre's Healthcare staff a Health Needs Assessment of the foreign national detainees in Dover IRC.

As part of this process an essential element is consultation with important and key stakeholders. You and your senior management team are recognised as a significant element within this group and I would like to take this opportunity to invite you and your team to participate in this exercise. Other consultees include healthcare staff, the Centre GP, the IMB, Centre staff, detainees etc.

I have enclosed two documents, one general one relating to the Health Needs Assessment process and a second document which frames a series of questions relating to healthcare and associated activities at Dover IRC.

If you wish to participate in the consultation exercise I would be grateful if you could complete the form and return it to me as soon as possible. However if you would prefer a "one to one" interview structured upon these questions then please do not hesitate to contact me and I will arrange to meet with you.

Yours sincerely,

Stephen D Cochrane
Public Health Specialist

**Healthcare staff questionnaire
Dover IRC
Health Needs Assessment**

CONFIDENTIAL

**If found, please return to Stephen D Cochrane, Public Health Dept,
Eastern & Coastal Kent PCT, Protea House, New Bridge, Dover, CT17 9HQ**

Healthcare Staff Semi-Structured Questionnaire

Date

Interviewee

Position

What do you think Dover IRC does particularly well from the health care point of view?

Do you have any concerns over the health of the detainees at Dover IRC? What are these?

Do you have any suggestions for ways the health of detainees could be improved?

Do detainees get the same care at Dover IRC as if they were at home or went to their GP?

Is there sufficient money available to run a reasonable health service at Dover IRC?

Are staffing levels sufficient to run a reasonable health service at Dover IRC?

Do you feel adequately trained for your job? Are you content in your job?

Are the buildings adequate to run a reasonable health service at Dover IRC?

Do you feel supported by the Prison Service?

Are any of these a particular problem:

Bullying?

Accidents?

Drug abuse?

Mental health?

STIs/sexual health?

Alcohol?

Literacy and/or speech difficulties?

Discharge planning?

Any particular medical problems?

Do you think any of the following would be useful at Dover IRC?

More contact with family/friends?

More exercise for detainees?

Better food?

Anything else?

Do you think the detainees would benefit from better availability of counselling services (specifically, sexual/physical abuse/fatherhood/dealing with anger)?

Any other comments? Any other key contacts?

Thanks.

Would you like to see an anonymous summary of everyone's views for comment before the HNA is completed?

Yes/No

If yes, email address:

**General staff questionnaire
Dover IRC
Health Needs Assessment**

CONFIDENTIAL

**If found, please return to Stephen D Cochrane, Public Health Dept,
Eastern & Coastal Kent PCT, Protea House, New Bridge, Dover, CT17 9HQ**

General Staff Semi-Structured Questionnaire

Date

Interviewee

Position

What do you think Dover IRC does particularly well from the health care point of view?

Do you have any concerns over the health of the detainees at Dover IRC? What are these?

Do you have any suggestions for ways the health of detainees could be improved?

Do the detainees have a clear idea of how to access health services? Is there a good awareness amongst staff and detainees of what Healthcare can offer?

Do detainees feel they can talk to any staff about personal issues in confidence?

Are there enough healthcare staff at Dover IRC?

Are any of these a particular problem:

Bullying?

Accidents?

Drug abuse?

Mental health?

STIs/sexual health?

Alcohol?

Literacy and/or speech difficulties?

Do you think any of the following would be useful at Dover IRC?

More contact with family/friends?

More exercise for detainees?

Better food?

Anything else?

Do you think the detainees would benefit from better availability of counselling services (specifically, sexual/physical abuse/fatherhood/dealing with anger)?

Any other comments? Any other key contacts?

Thanks.

Would you like to see an anonymous summary of everyone's views for comment before the HNA is completed?

Yes/No

If yes, email address:

Making life better
at Dover IRC

Your views count!

CONFIDENTIAL

**If found, please return to Stephen D Cochrane, Public Health Dept,
Eastern & Coastal Kent PCT, Protea House, New Bridge, Dover, CT17 9HQ**

This questionnaire is anonymous

It is not a test – there are no ‘right’ or ‘wrong’ answers

All information provided is confidential

Exceptions may be made if a child protection, security or self-harm issue is raised

You can refuse to answer any questions you wish

You can ask me any questions you wish

We are looking at how we can make detainees at Dover IRC healthier

If there is anything, big or small, you think we should know about, tell us!

We need your views!

This questionnaire won't take long

This survey is being carried out by Stephen D Cochrane, Public Health Dept, Eastern & Coastal Kent PCT.

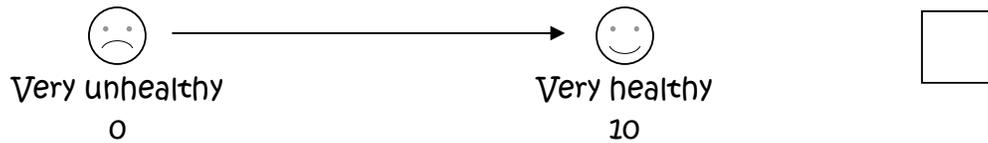
Do you agree to take part?

YES			NO	
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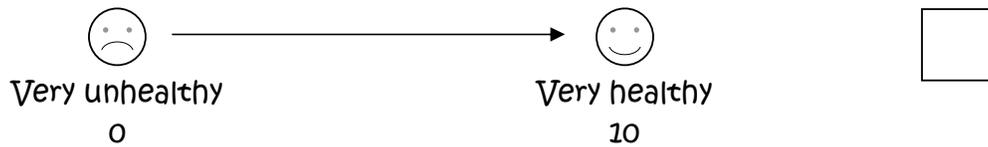
	Initials		
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What does 'being healthy' mean to you?

Are people generally healthy in Dover IRC?



Do you think you are healthy?



What things are important for good health?

What could be done at Dover IRC to make people healthier?

If you had a problem with your health, who would you go to first?

Block officer			Trainer	
Mate/friend			Healthcare nurse	
Doctor			Mental health	
Casework			Family	
Someone else			No-one	

How important do you think the following are to keep people healthy?

	Not important		A bit important		Quite important		Really important	
Jabs/immunisations								
Exercise								
Good/healthy food								
Nurses/Doctors/Dentists								
Friend to talk to								
Advice on being healthy								
Safe sex								
Good buildings & environment								

Have you been to Healthcare at Dover IRC?

What did you think of it?



Bad
0



Good
10

What was good?

What was bad?

Have you ever been to a doctor or nurse outside Dover IRC?

How did it compare?

Better outside

Better here

What single thing would help make you healthier?

Tell me a bit more about one of these in Dover IRC:

Bullying	<input type="checkbox"/>	<input type="checkbox"/>	Smoking	<input type="checkbox"/>
STDs/sex	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Being a father	<input type="checkbox"/>
Visiting hours	<input type="checkbox"/>	<input type="checkbox"/>	Privacy	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	Food	<input type="checkbox"/>
Something else	<input type="checkbox"/>	<input type="checkbox"/>	Nothing	<input type="checkbox"/>

Are any of these a problem in Dover IRC?

	Not a problem			Small problem			Big problem		
Bullying									
STDs									
Drugs									
Depression/low mood									
Alcohol									

Do you think any of the following would be useful at Dover IRC?

More doctors/nurses			More exercise	
Male healthcare staff			A ban on smoking	
More contact with family/friends				

And what about more advice on...

...how to stop smoking?			...dealing with anger?	
...sexual and physical abuse?			...feeling low/depressed	
...being a father?			...safe sex?	
...managing money?				

Anything else?

Any other comments?

THE END. THANK YOU FOR YOUR HELP!

Age

Indent: Left: 0 cm, Hanging: 0.95 cm, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.63 cm + Tab after: 1.27 cm + Indent at: 1.27 cm, Tabs: 0.95 cm, List tab + Not at 1.27 cm