Tamlyn Cairns Partnership

HMP PARC HEALTH AND SOCIAL CARE NEEDS ASSESSMENT

Commissioned by Cwm Taf Morgannwg Health Board

Final Version 3.0

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Tamlyn Cairns is a trading name for a collaboration between Richard Tamlyn Ltd and Claire Cairns Associates Ltd

List of Abbreviations and Acronyms

Acronym	Definition
AA	Alcoholics Anonymous
A&E	Accident and Emergency (hospital department)
ACCT	Assessment Care in Custody and Teamwork
ACE	Adverse Childhood Experiences
ADHD	Attention Deficit Hyperactivity Disorder
AGP	Aerosol Generating Process
APB	Area Planning Board
ASD	Autism Spectrum Disorder
AUDIT	Alcohol Use Disorders Identification Test
BBV	Blood Borne Virus
BMI	Body Mass Index
CHD	Coronary Heart Disease
CMS	Custodial Management System
CTMHB	Cwm Taf Morgannwg Health Board
COPD	Chronic Obstructive Pulmonary Disease
CPAP	Continuous Positive Airway Pressure
CPN	Community Psychiatric Nurse
CQC	Care Quality Commission
CVOP	Clinically Vulnerable and Older Prisoners
DNA	Did Not Attend
FTE	Full-Time Equivalent
GAD7	Generalised Anxiety Disorder 7 (an anxiety assessment tool)
GP	General Practice/Practitioner
HCA	Healthcare Assistant
HCV	Hepatitis C
HIV	Human Immunodeficiency Virus
HMIP	Her Majesty's Inspectorate of Prisons
HMP	Her Majesty's Prison
HMPPS	Her Majesty's Prison and Probation Service
HSCNA	Health and Social Care Needs Assessment
IDD	Intellectual and Developmental Disability (also called LD)
IMB	Independent Monitoring Board
IP	In-Possession (medication)
LD	Learning Disability (also called IDD)
LTC	Long-Term Condition
MH	Mental Health
MHM	Mental Health Measure
MHIRT	Mental Health In-Reach Team
MMR	Measles, Mumps and Rubella
MOJ	Ministry of Justice
NA	Narcotics Anonymous
NEWS	National Early Warning Score
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NL	Nurse Led
NOMS	National Offender Management Service
NPS/PS	New Psychoactive Substances
OMU	Offender Management Unit
ONS	Office for National Statistics
OOH	Out of Hours
OST	Opiate Substitution Therapy
OT	Occupational Therapy
PCR	Polymerase Chain Reaction
PEEP	Personal Emergency Evacuation Plan

Acronym	Definition
PFI	Private Finance Initiative
PHE	Public Health England
PHW	Public Heath Wales
PHQ 9	Patient Health Questionnaire 9 (primary care tool for assessing depression)
PLL	Patient Liaison Lead
PPE	Personal Protection Equipment
PPO	Prisons and Probation Ombudsman
PSF	Parc Supporting Families
PTSD	Post-Traumatic Stress Disorder
QOF	Quality and Outcomes Framework
RCU	Reverse Cohorting Unit
RECOOP	Resettlement and Care for Older Ex-Offenders and Prisoners
RMN/RNMH	Mental Health Nurse
SALT	Speech, Language and Communication Therapy
SBUHB	Swansea Bay University Health Board
SMS	Substance Misuse Service
TB	Tuberculosis
TIA	Transient Ischaemic Attack
TOC	Test Outbreak Committee
TTO	To Take Out (medication)
VC	Visiting Clinic
VP	Vulnerable Prisoner
VPU	Vulnerable Prisoner Unit
WIMD	Welsh Indices of Multiple Deprivation

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PART A
Specific Information for HMP Parc

Chapter One – Introduction

1.1 Aims

This Health and Social Care Needs Assessment (HSCNA) was commissioned to better understand the health needs of the resident population in Her Majesty's Prison (HMP) Parc and to assess the extent to which the current need and demand for health and social care in the prison establishment(s) were being met.

The methodology used for the adult population is the Public Health England (PHE) 'toolkit' in the absence of a national equivalent for Wales,[1] and National Institute for Health and Care Excellence (NICE) which summarises:

> *A health needs assessment is a systematic method for reviewing the health issues facing a population leading to agreed priorities and resource allocation that will improve health and reduce inequalities.*[2]

It should be noted that health needs may be *met* or *unmet* and that there is a difference between a *need* and a *demand* for a service. These concepts are addressed later in this report.

The introduction to our HSCNA approach in Report Part B contains further details on the rationale for, and the intended purpose of, this prison health and social care needs assessment.

1.2 Scope

As is always the case, there is a fine line between undertaking a health needs assessment and a service audit/review. This report focuses on describing the likely and actual health needs of residents and the extent to which they appear to be being met, rather than assessing service efficacy, albeit there is a little overlap in places.

Informed by a well-developed evidence base, our HSCNAs describe *known* health needs. In the near future the health needs arising (whether directly or indirectly) from the covid-19 pandemic are likely to eclipse these. However, informed by the current extremely limited knowledge base, we are not in a position to make any projections about the longer-term impact of the global pandemic. We cannot predict the health needs arising from infection by the virus, the knock-on effects across wider health delivery or the requirements necessary for managing the pandemic.

This report specifically relates to the adult (i.e. over 18) population in the establishment. There is a separate report covering those under 18. Whilst the needs of the children in the Young Offenders Institution (YOI) section of the establishment are considered separately, much of the data in this report could not be disaggregated by age and had to cover the entire population. At the time of writing less than 2% of the population in HMP & YOI Parc were under 18 years; because of their age and general good health these children are largely absent from much of the data describing health conditions. This report uses the term HMP & YOI Parc to describe *the whole establishment* and HMP Parc to describe the *adult* side.

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[1] PHE (2014) Health needs assessment toolkit for prescribed places of detention (parts 1 and 2). [Accessed 15/12/20].

[2] Cavanagh, S. & Chadwick, K. (2005) Health needs assessment: a practical guide. [Accessed 15/12/20].

1.3 Methodology

The full methodology and rationale for this is included in Report Part B.

Appendix A contains the full list of those interviewed in HMP & YOI Parc.

Resident views were gathered in the prison by means of a survey which was distributed across the prison, resulting in 253 completed questionnaires from residents. This equates to 14.9% of the population based on the operational capacity (op cap) of 1,693. The survey results can be considered to be representative at a confidence level of 90% and confidence interval of +/-5%.

1.3.1 Comparative

The list of 'comparator prisons' most recently defined by the Ministry of Justice (MOJ) is broad, grouping establishments by type (e.g. all local prisons). For the purposes of this report, we have agreed with stakeholders to use three English prisons and HMP Berwyn (these are MOJ-defined comparators for which we have conducted HSCNAs within the past two years, and thus have access to recent, comparable data). We also include recent data from our HSCNA in HMP Swansea, since it is recognised that some issues are very specific to Wales. The comparators used are listed below.

Figure 1 – HMP Parc Comparator Prisons

Prison	Comparator type	HSCNA for comparison
HMP Altcourse	MOJ comparator prison	Yes (TamlynCairns 2020)
HMP Berwyn	MOJ comparator prison, Welsh prison	Yes (TamlynCairns 2019)
HMP Elmley	MOJ comparator prison	Yes (TamlynCairns 2019)
HMP Hull	MOJ comparator prison	Yes (TamlynCairns 2019)
HMP Swansea	Welsh prison	Yes (TamlynCairns 2020)

Whilst there is a wider group of comparator prisons for HMP Parc by the MOJ, the above comparators used are limited to those where our organisation has undertaken the HSCNA (thus we are assured of comparing like with like).

1.4 Context

The context of this HSCNA sits within the Partnership Agreement (2019)[3] which has been agreed between the Welsh Government, the Health Board and the Prison Service in Wales. The document 'Prosperity for All: the National Strategy for Wales' seeks to ensure that prisons and prison healthcare teams sign up to the following priorities, each led by a workstream group:

- Ensuring prison environments in Wales promote health and wellbeing for all.
- Developing consistent mental health, mental wellbeing and learning disability services across all prisons that are tailored to need.

[3] Public Health Wales (2019) Partnership Agreement for Prison Health in Wales.[Accessed 2/2/2021].

- Producing a standardised clinical pathway for the management of substance misuse in prisons in Wales.
- Developing standards for medicines management for prisons in Wales.

1.5 Report Overview

This report (Report Part A) describes the 'story' of the establishment, specifically looking at:

- Resident Demographics
- Healthcare Overview
- Physical Health (LTCs)
- Mental Health Needs
- Learning Disability
- Substance Misuse Needs
- Communicable Diseases
- Self-Harm and Self-Inflicted Deaths
- Wellbeing and Health Promotion
- Social Care Needs

There is a rationale and evidence base for the predictions we have used throughout Report Part A; these are discussed and outlined in full in Report Part B, following the same themes as those in Report Part A. This includes reference to research, national policy and service standards.

Chapter Two – Overview of HMP Parc and the Catchment Area

2.1 Prison Overview

HMP & YOI Parc is a Category B local establishment located in Bridgend, Mid Glamorgan, Wales. Parc Prison is operated by G4S.

HMP & YOI Parc comprises of two facilities contained in one site. The adult prison for those over the age of 18 years is separate from the YOI unit which accommodates children aged 15 to 17 years. This HSCNA report considers the needs of the adult population, a separate report focusses on the children.

The operational capacity (op cap) of HMP & YOI Parc has reduced slightly from 1699 at the time of the last full HMIP (Her Majesty's Inspectorate of Prisons) Inspection in November 2019[4] to 1693 at the end of November 2020.[5] The actual population has increased from 1604 in November 2019, as reported in the HMIP inspection report, to 1634 at November 2020 as reported by the MOJ.[6]

At the time of snapshot data being supplied for our HSCNA (in early December 2020), the Offender Management Unit (OMU) reported 1606 residents in the prison, and at the time of our data snapshot (24th November) there were 1625 patients active on SystmOne. As noted in Chapter One, data in this report includes all residents in Parc, this includes some 30 children at any one time, the proportion who are children is too small to make a significant difference to the overall picture.

The most recent full HMIP Inspection report for the adult side of the establishment was conducted jointly with General Pharmaceutical Council and Healthcare Inspectorate Wales and describes a wide range of residents including: young offenders, remands, convicted prisoners including 'a large number of sex offenders',[7] the vulnerable prisoner unit (VPU) can accommodate 387 residents.[8] This HSCNA takes into consideration the very different need characteristic which this diverse population will present with. The HMIP report is broadly praising about both the adult establishment and delivery of healthcare, it draws attention to a paucity of mental health provision. Their detailed findings are cross referenced through this report.

During the covid-19 pandemic, HMIP have been conducting 'Short Scrutiny' visits to range of establishments, this included the young offender side, but not the adult side of Parc.[9]

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[4] HMIP (2019) HMIP (2019) Report On An Unannounced Inspection Of HMP Parc by HM Chief Inspector of Prisons. [Accessed 8/1/21].

[5] MOJ (2020) Prison population figures November 2020. Available online. [Accessed 8/1/21].

[6] MOJ (2020) Prison population figures November 2020. Available online. [Accessed 8/1/21].

[7] HMIP (2020) Report of an unannounced inspection of HMP Parc by HM Chief Inspector of Prisons 11-22 November 2019. [Accessed 11/2/21].

[8] IMB (2019) Annual Report of the Independent Monitoring Board at HMP & YOI Parc for the reporting year 1 March 2018 to 28 February 2019. [Accessed 11/2/21].

[9] HMIP (2020) Report on short scrutiny visits to Young offender institutions holding children. [Accessed 11/2/21].

2.2 Catchment area for HMP Parc

Data supplied by the prison indicates that 84% of the residents originate from Wales, though the data for Wales is not broken down further. Those who are not from Wales are from across England. The adult residents generally come from the two local prisons in South Wales: HMPs Cardiff and Swansea. The fact that 16% of residents originate from England will create some additional challenges especially in respect of release planning as many aspects of legislation and policy differ between Wales and England (for example the Mental Health Measure (MHM)).

As described in Report Part B, the health profile for prison residents generally reflects the worst seen in the local community. However, the general health in the communities served will give some indicator as to the relative health profile for residents in HMP Parc and also highlight where there might be differences in the population compared to that in the comparator prisons.

As an overarching indicator of health, Office for National Statistics (ONS) describe the life expectancy of males at birth in Wales as 78.51 years, a little over a year less than the figure of 79.67 years for England.[10]

There could be many reasons for the lower life expectancy; health is strongly correlated with deprivation:

> *The gap in life expectancy at birth between the least and most deprived areas in Wales was 9 years for males and 7.4 years for females, with the inequality gap remaining stable for both sexes in 2016 to 2018 compared with 2013 to 2015.*[11]

The ONS report goes on to note that males in the most deprived areas can expect 18.2 fewer years in 'good health' compared to those in the least deprived areas.

Part B of this report describes the impact of Adverse Childhood Experiences (ACEs). There has been a great deal of work done in Wales exploring the impact of ACEs on life chances and research indicates a strong correlation between ACEs and incarceration. Under 4% of those with no ACEs had been incarcerated, yet this rose to 38.5% of those with four or more ACEs. In terms of health, this same correlation exists across a range of health harming behaviours, in other words the more ACEs experienced as a child, the more likely an adult is to smoke, drink excessively, use illicit drugs and have a poor diet.[12]

The following illustration shows the health in the communities which form the catchment area for HMP Parc, RAG rated against the Welsh average:

[10] ONS (2020) National life expectancy tables – life expectancy in the UK: 2017-2019. Figure 4 data. [Accessed 15/12/20].

[11] ONS (2020) Health state expectancies by national deprivation deciles, Wales: 2016 to 2018. [Accessed 15/12/20].

[12] Bellis et al (2015) Adverse childhood experiences and their impact on health-harming behaviours in the Welsh population. [Accessed 15/12/20].

Figure 2 – Health in the Community

	General Health		Illness				
	Health in general – Good or Very Good	Health in general – Bad or Very Bad	Any longstanding illnesses	2 or more longstanding illnesses	Limited at all by longstanding illness	Limited a lot by longstanding illness	Musculoskeletal complaints
Wales	71.7	8.8	46.6	19.7	34.1	18.4	16.3
Powys	76.0	6.8	43.6	16.8	31.1	14.5	15.4
Ceredigion	72.6	8.6	43.8	16.4	30.7	19.6	14.9
Pembrokeshire	73.2	7.7	48.5	20.5	33.4	18.5	18.1
Carmarthenshire	68.3	9.4	50.4	23.5	35.8	21.6	17.1
Swansea	70.9	9.7	50.4	23.4	36.4	21.6	18.3
Neath Port Talbot	67.6	9.4	52.4	25.1	40.5	24.3	17.0
Bridgend	70.0	10.5	47.1	19.6	36.3	21.9	17.1
Vale of Glamorgan	71.6	7.1	47.8	21.0	36.6	18.8	16.4
Cardiff	74.9	7.8	44.8	17.5	32.4	15.6	15.8
Rhondda Cynon Taf	68.5	10.7	46.9	22.4	35.2	19.8	17.7
Merthyr Tydfil	67.2	11.8	44.4	16.0	35.0	19.9	16.5
Caerphilly	66.7	10.9	52.0	24.6	39.9	24.0	19.1

	More than 1% worse
	0.5% either side of all Wales figure
	More than 1% better

At present, the risks in prison are not just of rapid transmission of the covid-19 virus in the densely populated confined space but also general poor health amongst residents leads to greater risk of serious illness and death from covid-19 infection.

2.3 Turnover Rate

The following table shows annual numbers of receptions, transfers and discharges from HMP & YOI Parc, as reported by the offender management unit (OMU).

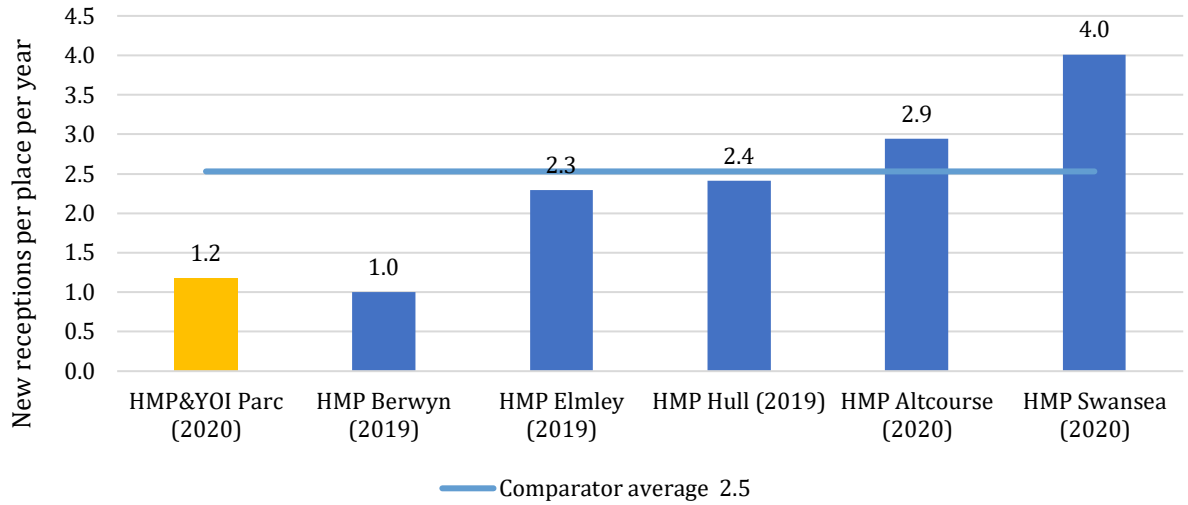
Figure 2 – Receptions and Transfers/Releases (OMU data)

Total numbers	2018	2019	2020
Receptions in from the community	1539	1711	803
Receptions in from other prisons	1941	1754	985
Transfers out to other prisons	885	914	384
Discharges/releases to the community	1584	1298	884
Recalls	534	467	265

The total number of residents entering the establishment should almost exactly match the numbers leaving. As is frequently the case, the data supplied does not exactly describe this, so the estimate of turnover is informed by new residents recorded on SystmOne. This will not include recidivists who enter a number of times in a one-year period, but the calculation does allow comparison to other establishments.

The turnover rate based on new residents recorded on SystmOne was 1.2 for 2019/20 (1.2 new receptions per place per year). This is lower than comparator prisons.

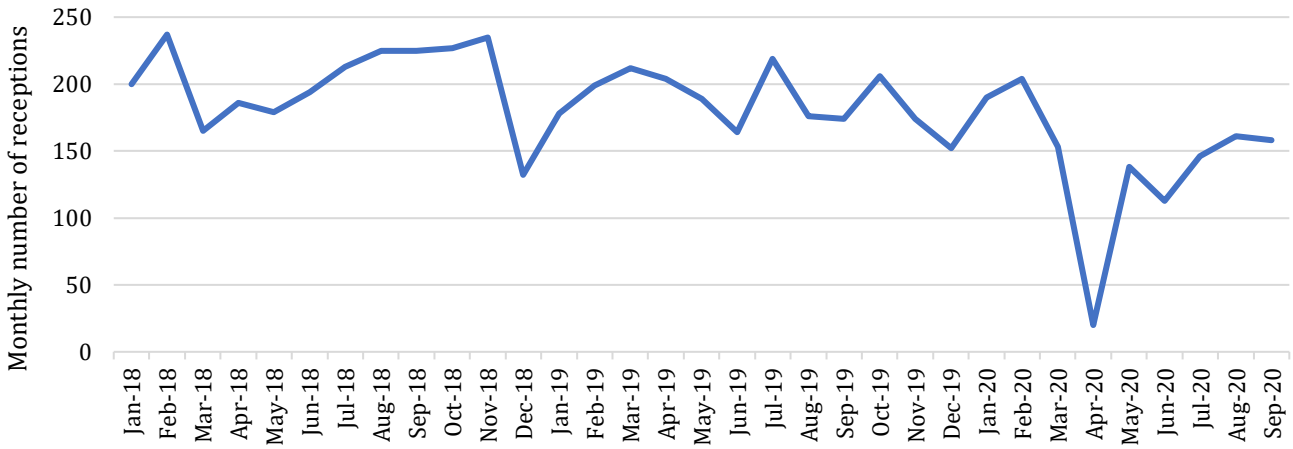
Figure 3 – Turnover Rate Comparison (SystmOne data)



Monthly receptions data provided by the prison highlights the impact of the covid-19 pandemic on the prison population, with a dramatic reduction in receptions visible in April 2020, aligned to the activity in the courts freezing. Whilst some court activity has since re-established, the reality of cohorting and isolating new arrivals for 14-days as part of covid-19 measures (i.e. reverse cohorting) and the reduction in inter prison transfers means that the population is below capacity.

"We were typically getting 12 receptions per day, now we get 12 twice a week" (Head of Healthcare)

Figure 2 – Monthly Numbers of Receptions to HMP & YOI Parc (OMU data)



The prison has been an outbreak site and as a result testing for covid-19 is informed by guidance from the Test Outbreak Committee (TOC) which is part of Public Health Wales (PHW).

All new arrivals are tested in Reception, then at 4-5 days. The general population is only tested if symptomatic.

The well-developed reception process is severely impacted by reverse cohorting which effectively isolates arrivals into small groups. In normal circumstances the Patient Liaison

Lead (PLL) would see all new arrivals and explain about healthcare. Now new arrivals just receive this information in a leaflet.

2.4 Resident Demographics

This section draws on data from a range of sources including the prison's equality data.

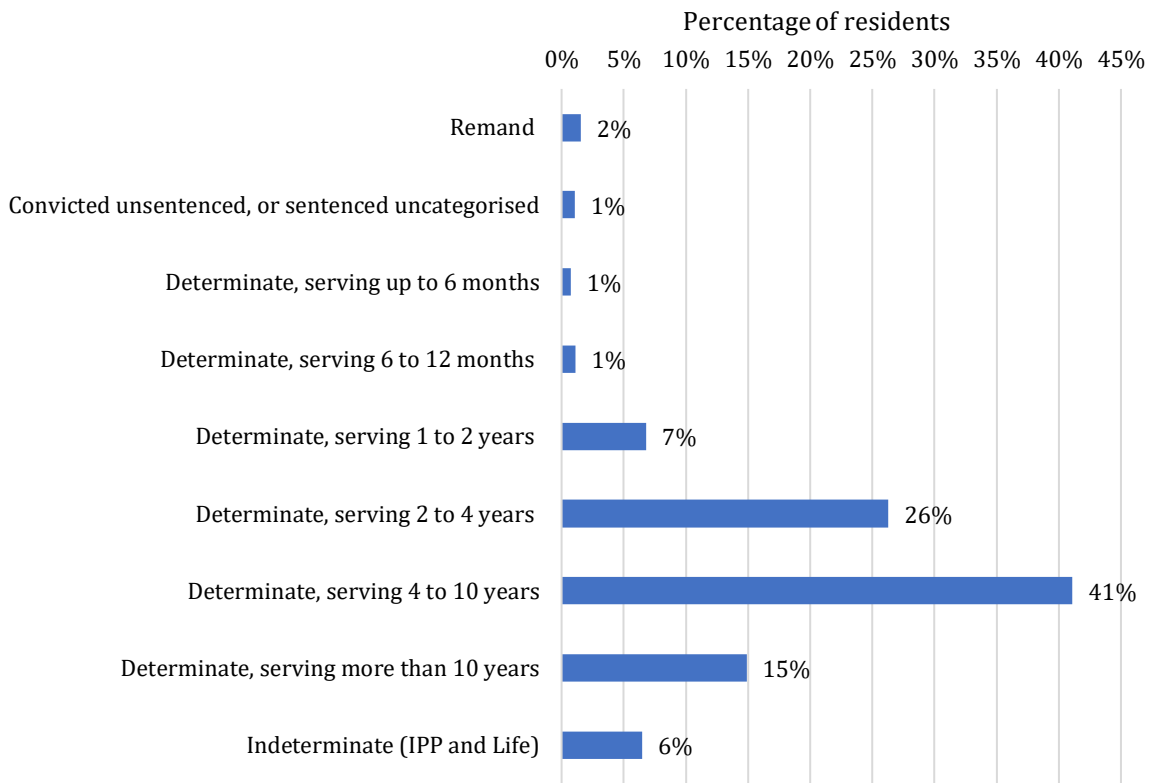
2.4.1 Resident Sentencing Status

The adult prison holds sentenced 'main' prisoners and both remand and sentenced vulnerable prisoners. The 'main' prisoners generally arrive from HMP Swansea or HMP Cardiff. Vulnerable prisoners may arrive from the community, HMP Parc is the local vulnerable prisoner (VP) remand facility.

Eighty-nine per cent of the population of HMP & YOI Parc are serving either sentences of two years or more or indeterminate sentences. Sixty eight percent of those serving indeterminate sentences are over tariff.

In normal operation (i.e. prior to the onset of covid-19) HMP & YOI Parc would have a resettlement function and receive residents in last three months of long sentences, thus also increasing the turnover rate. The prison described 43% of the population (n=687) as 'resettlement'.

Figure 3 – Population Status (OMU data)



It was reported that (in Feb 2021) 450 residents were licence recalls.

When it comes to considering health needs in any one establishment, the length of stay is often more relevant than the length of sentence. This is shown in the table below, where 41% of current residents have been in HMP & YOI Parc for less than six months. Short stays place the main emphasis of healthcare on the identification and management of immediate health needs. Stays of a short length make it more difficult to pick up on hidden and long-term conditions, particularly those where screening may be infrequent.

Fifty-nine per cent of residents have been in HMP & YOI Parc for more than six months. Longer stays provide opportunity for structured care, for example in the management of long-term conditions or oral hygiene.

Figure 4 – Length of Stay (OMU data)

Length of stay	Number of prisoners	Percentage of prisoners
Less than 1 month	107	7%
1 month to 3 months	218	14%
3 months to 6 months	327	20%
6 months to 1 year	426	27%
1 year to 2 years	350	22%
2 years to 4 years	140	9%
More than 4 years	38	2%

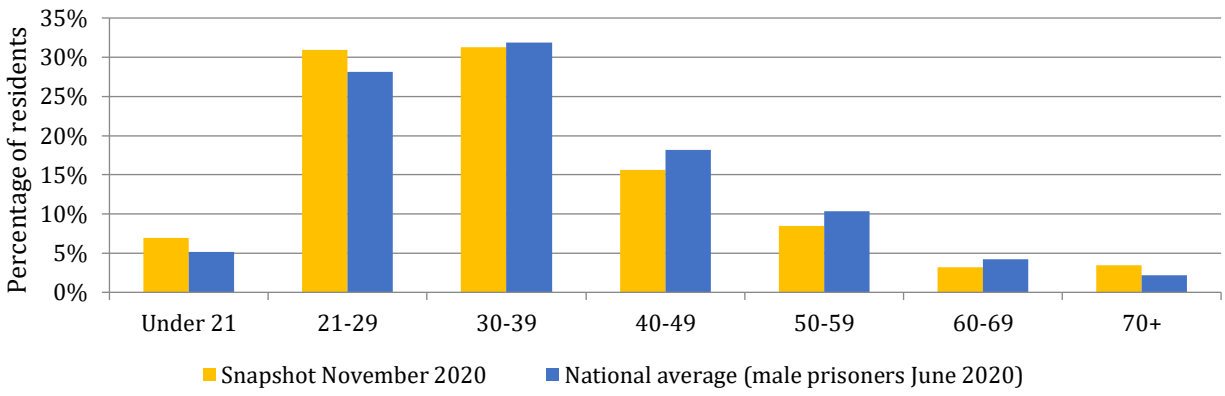
2.4.2 Age

Age is a key indicator for likely health needs. The prison accommodates a mixed demographic of adults, as shown in the figure below. The population is younger than the prison population nationally (across England and Wales), with higher rates of under 21 to 29 year-olds and lower rates of over 30 year olds. With large numbers of young residents, the prison say they use maturity screens to help identify needs.

The prison has a specific YO function and holds residents aged under 18. At the time of our snapshot in November 2020, 1.4% of the population (n=23) were aged under 18.

Fifteen per cent of the population of HMP & YOI Parc is aged 50 or over compared with 17% for male prisoners on average.

Figure 5 – Age Profile in Comparison to National Average[13]



[13] MOJ (2020) Offender management statistics quarterly. [Accessed 18/12/20].

In HMP & YOI Parc at the time of our SystmOne snapshot (October 2020) the youngest resident was aged 15 years, and the oldest 86 years. The chart below shows a more detailed age breakdown of children and younger residents. NB as noted earlier the focus of this report is on those over 18 years, there is a separate report exploring the needs of residents who are under 18 years.

Figure 6 – Age Profile YOIs

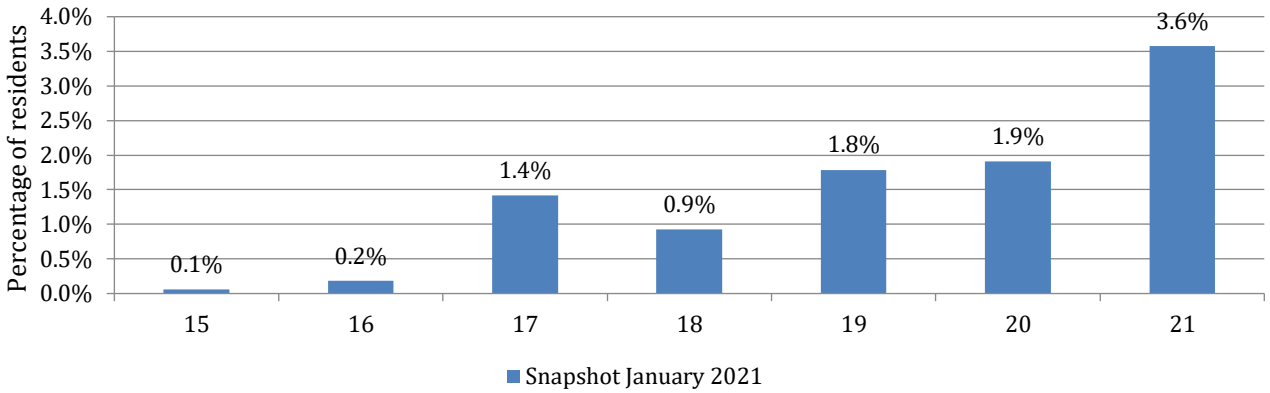
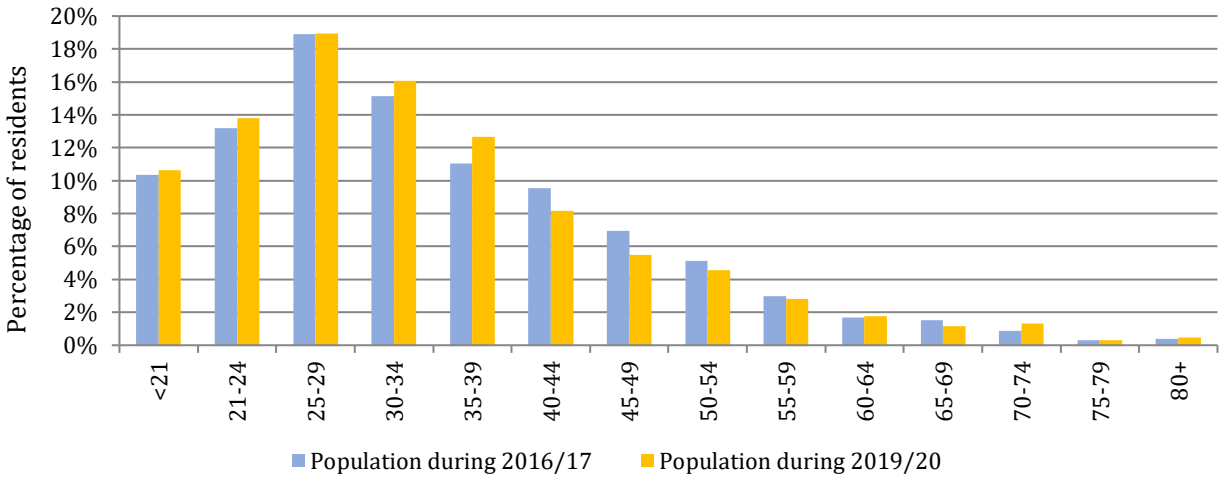


Figure 7 compares the age profile of the population in the most recent full year (2019/20) and the population in 2016/17. This shows little change, with a slight increase in those under 40 years old and those over 70 years old. The national backdrop is an ageing prison population.

Figure 7 – Age Profile of Recent and Previous Populations (all residents in year, SystmOne data)



For the purposes of this report, the definition of 'older' is 50+. When describing the prison population, this definition has been adopted by Her Majesty's Prison and Probation Service (HMPPS)[14] and HMIP,[15] and is consistent with those of: AGE UK, the Prison Reform Trust and the charity RECOOP (Resettlement and Care for Older Ex-Offenders and Prisoners).[16]

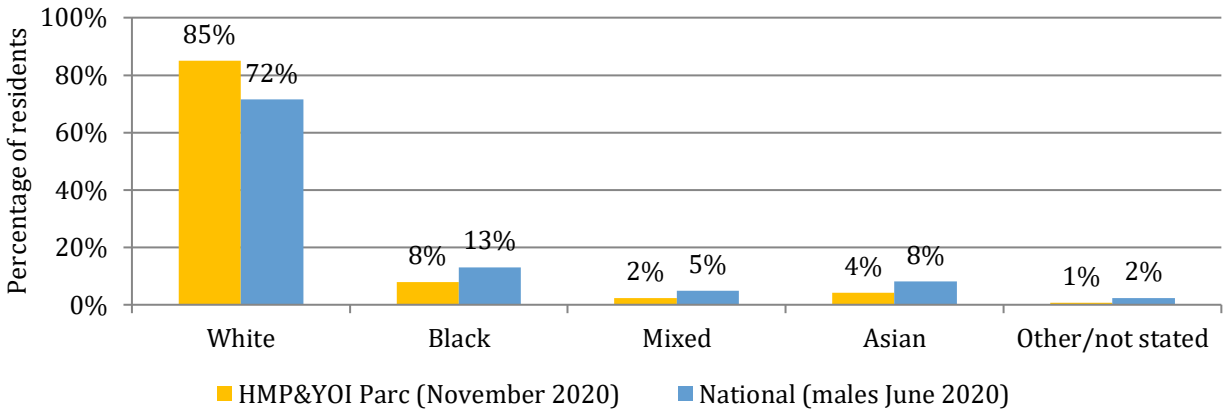
2.4.3 Ethnicity and Nationality

The ethnic profile of residents in HMP & YOI Parc is much less diverse than the national prison average, with 85% of residents recorded as being from white ethnic backgrounds,

[14] PHE (2017) Health and social care needs assessments of the older prison population. [Accessed 18/12/20].
[15] HMIP and CQC (2018) Social care in prisons in England and Wales. [Accessed 18/12/20].
[16] UK Parliament (2013) Written submission from RECOOP. [Accessed 18/12/20].

compared to 72% nationally.[17] This reflects the local communities around the establishment, the Welsh Government says that 95.6% of the population in Wales describe themselves as 'white'.[18]

Figure 8 – Proportion of Residents in Each Ethnic Group



HMPPS states that across the prison estate nationally, 12% of the prisoner population consists of foreign nationals.[19] The same data showed that, at September 2020, 5% (n=87) of the population at HMP & YOI Parc were foreign nationals, much lower than the national average. Prison data reported 8% of the population (n=128) at the time of the October 2020 snapshot as foreign nationals.

2.4.4 Disability

In Wales 18.8% of men ages 16-64 identify as disabled.[20] The equalities team at HMP & YOI Parc supplied data showing that 31% of the population at October 2020 was recorded as having some form of disability. Data provided by healthcare indicates that 26% of residents had some level of disability recorded at a December snapshot (including learning disabilities but not mental health condition disabilities, which may explain some of the difference between OMU and healthcare data).

The equalities data is lower than the 40% of respondents self-reporting any disability in the 2019 HMIP survey, and similar to the HMIP comparator (which reported 33%). The HMIP 2018/19 Annual Report showed 34% of male prisoners self-reporting a disability.[21]

Figure 9 – Residents with a Disability

HMP	HMIP 2019 self-report survey	Equalities data (snapshot November 2020)	SystmOne data (snapshot November 2020)
Residents with disabilities	40% (n=68)	31% (n=510)	26% (n=433)

This variation in the definition of disability occurs in many prisons and is to be expected as the information is collected, collated and used for different purposes. What is of more relevance is the liaison, communication and joint working between the prison and the

[17] Prison data provided by equalities team. National data from MOJ (2018) Her Majesty's prison and probation service offender equalities annual report 2017/18. [Accessed 18/12/20].

[18] Welsh Government (2019) Equality and Diversity Statistics 2015 to 2017. [Accessed 02/2/2021].

[19] This figure is for September 2020. MOJ (2020) Prison population figures November 2020. Available online. [Accessed 08/1/21].

[20] Welsh Government (2019) Equality and Diversity Statistics 2015 to 2017. [Accessed 02/2/2021].

[21] HMIP (2019) HM Chief Inspector of prisons for England and Wales annual report 2018/19. Page 116. [Accessed 18/12/20].

healthcare provider to meet the needs of residents with disabilities within the establishment. This is discussed further in Chapter Eleven of the HSCNA.

The equalities team at HMP & YOI Parc stated that 39 residents (2.4%) have a current Personal Emergency Evacuation Plan (PEEP) and have a level of disability indicating they would need help and support to evacuate to a safe place during an emergency.

Data recording on SystmOne of residents with learning disabilities was very low, suggesting an unrecognised need; however, there is a comprehensive service for this group as discussed in section 6.2.

Figure 10 – Residents With Learning Disability

HMP & YOI Parc	Population during 2019/20	Residents at snapshot November 2020	Residents at snapshot November 2020 (QOF register)
Learning Disabilities (LD)	0.5% (n=16)	0.9% (n=14)	0.6% (n=9)
Autistic Spectrum Disorders (ASD)	1.0% (n=32)	1.3% (n=21)	N/A

It is imperative that there is a shared understanding between the prison and healthcare of residents with learning disabilities within the establishment. Varying definitions and recording systems are confusing the overall picture, thus the likely need is almost certainly unmet.

Recommendation One – All data on disabilities (including learning disabilities) collated by the prison should routinely be shared with healthcare, the operational and healthcare side would benefit from a common understanding of need.

2.4.5 Sexuality and Gender

In the 2019 HMIP/Care Quality Commission (CQC) inspection report, 3% of residents surveyed in HMP & YOI Parc identified themselves as 'homosexual', 'bisexual' or 'other' (terminology is as used by HMIP). This was similar to national data which describes 97.3%[22] of residents as heterosexual. More recent data from the equalities team showed 2.2% reported as gay or bisexual.

Figure 11 – Residents' Sexual Orientation

HMP & YOI Parc	HMIP 2019 self-report survey	Equalities data (snapshot November 2020)
Homosexual/gay	1% (n=1)	1.3% (n=21)
Bisexual	2% (n=3)	0.9% (n=15)
Heterosexual	97% (n=161)	98% (n=1595)
Not known	-	0% (n=3)

The equalities team reported that in HMP & YOI Parc in October 2020, there were five transgender residents (3.1 per 1000). The average prison rate is two per 1000.

The evidence base suggesting transgender individuals have a significant range of health needs and inequalities is robust and is summarised in Report Part B. Whilst the health services likely

[22] MOJ (2018) Her Majesty's prison and probation service offender equalities annual report 2017/18. [Accessed 18/12/20].

to be needed by this cohort are not greatly different, the likelihood of accessing these services is greatly reduced.

2.4.6 Homelessness

Homelessness is one of many factors that negatively impacts on health. SystmOne data indicates that, at November 2020, 13.5% of the residents at HMP & YOI Parc (n=220) were recorded as having disclosed being homeless during the year prior to imprisonment. This is less than comparator establishments: 17% at HMP Altcourse, 3% at HMP Berwyn, 18% at HMP Elmley, 32% at HMP Hull, and 37% at HMP Swansea. Homeless people, as noted in Report Part B have a significant range of health needs and health inequalities.

2.4.7 Armed Forces Veterans

Figure 12 sets out data regarding residents' veteran status from SystmOne and the most recent HMIP survey. The HMIP self-report of 4% is lower than the 6% self-reporting as veterans in the HMIP comparator data. The HMIP 2018/19 Annual Report showed 7% of male residents reported that they had been in the armed forces.[23] As noted in Report Part B, veterans who are imprisoned are more likely to be convicted of sexual or violent offences. SystmOne snapshot data shows 9% of residents as veterans, while data from the equalities team gave a considerably lower proportion (3%).

Anecdotally, it has previously been reported that residents may be reluctant to report their veteran status to prison staff on coming into prison due to the impact this has on their veterans' pension but may then later disclose this to healthcare whilst discussing healthcare needs. In HMP Parc The Parc Supporting Families (PSF) worker interviews all inductions to identify veterans, there is a veterans unit (T3), described by HMIP as *'excellent'*. Veterans can be offered a range of support including from a visiting organization of ex-service people, this organisation can access a counselling service for those who need it.

Figure 12 – Armed Forces Veterans

HMP Parc	HMIP self-report survey (2019)	Equalities data (snapshot November 2020)	SystmOne data (snapshot November 2020)
Armed forces veterans	4% (n=7)	3% (n=46)	9% (n=140)

2.4.8 Parents and Carers

This information is currently not recorded by offender management units (OMUs). The 2019 HMIP self-report survey contained one question regarding caring responsibility for children (*"Do you have children under the age of 18?").*

The proportion of residents in HMP & YOI Parc who reported being parents is 51%, which is close to both the national rate of 50% for males reported in the HMIP 2018/19 Annual Report,[24] and the HMIP comparator rate (52%).

[23] HMIP (2019) HM Chief Inspector of prisons for England and Wales annual report 2018/19. Page 116. [Accessed 18/12/20].
[24] HMIP (2019) HM Chief Inspector of prisons for England and Wales annual report 2018/19. Page 116. [Accessed 18/12/20].

Figure 13 – Residents with Parental Responsibility

HMP & YOI Parc	HMIP self-report survey (2019)
Children under 18 years	51% (n=83)
No children under 18 years	49%
Declined/missing data	-

2.5 Chapter Summary

- HMP Parc is a Cat B prison accommodating sentenced 'main' prisoners and both remand and sentenced Vulnerable Prisoners.
- There is an entirely separate YOI wing accommodating 15 to 18 year olds. The health and social care needs of this population are described in a separate report.
- The prison draws residents from a deprived subsection of the Welsh community. Prevalence of poor health and higher mortality are particularly evident in the parts of the catchment area for HMP Parc.
- The establishment has an op cap of 1693, at the time of writing the population was 1625. Unlike many other prisons, during the pandemic the population has not decreased.
- A key indicator for likely demand within prison healthcare is the turnover rate of residents; receptions and discharges generate increased demands on healthcare. In HMP Parc the turnover rate is 1.2 and is lower than most comparator prisons.
- At our snapshot, 68% of residents had been in the prison for less than a year.
- Noting the YO population, the ages in HMP & YOI Parc are younger than the prison population nationally (across England and Wales). Separate to the YOs there are higher rates of 21-29-year-olds and lower rates of over 40s. The exception is a higher rate of over 70s.
- Eighty four percent of the prison's residents originate from Wales.
- The population in HMP Parc is far less ethnically diverse than the national prisoner population, reflecting the local community from which residents are drawn. This is relevant to health needs as some conditions (e.g. diabetes) are more prevalent in certain ethnic minority groups.
- Whilst prison data is available on residents with disabilities (including learning disabilities) this does not correlate with the data collated by healthcare. A shared understanding of the needs of this cohort is essential. **See Recommendations**.

- Fourteen per cent of residents in HMP Parc were recorded as being homeless during the year prior to imprisonment, a lower rate than seen in most comparator prisons.

- Whilst datasets regarding armed forces veterans are conflicting, there appears to be an under reporting of residents in HMP Parc who previously served in the armed forces. The provision in HMP Parc has been praised by HMIP.

Chapter Three – Healthcare Provision

3.1 Overview of Healthcare

The main healthcare contract falls under the Private Finance Initiative (PFI) contract awarded to G4S. This was a 25 year contract which will run to 2023. A couple of areas of healthcare provision have been added subsequently and are contracted separately but still through MOJ. The expectation is that post 2023 the healthcare remit will fall to the National Health Service (NHS) (Cwm Taf University Health Board).

Current provision is delivered by G4S Medical Services UK which is a different arm of the G4S corporation to the one that runs the operational side of the prison. As detailed below, G4S Medical Services subcontract aspects of delivery to a range of providers.

Figure 14 – Healthcare Providers

Element	Provider
Primary Care	G4S Medical Services UK
Pharmacy	G4S Medical Services UK
General Practitioner	Marnell Medical Services
Dental	Time for Teeth
Optometry	Huw Bellamy
Physiotherapy	Calvin Hill Active Health Professionals
Podiatry	Premier Physical Health
Clinical Substance Misuse Service	G4S Medical Services UK
Psychosocial or Non-Clinical Substance Misuse Service	G4S Custody and Rehabilitation (Dydodol)
Secondary Mental Health	Swansea University Health Board

3.2 Healthcare in HMP Parc

Healthcare at HMP Parc is open seven days per week, 24 hours per day.

There are four dedicated health and social care beds. These are located on the wings and it was reported that their use is authorised only following assessment and recommendation from healthcare. One of these is a dedicated end of life bed and the other three are used for social care. As described in the Social Care chapter the beds are located on the assisted living units which is where many of those in need of social care input reside. Chapter Six describes a separate unit for those who are vulnerable due to LD or autism and benefit from targeted support.

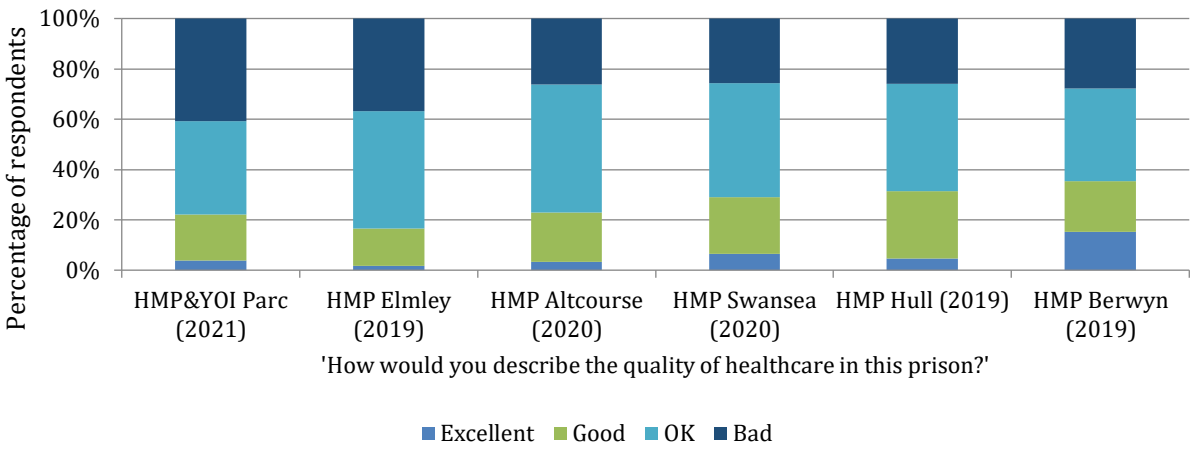
Healthcare is delivered from a central hub. Whilst a couple of wings have clinical rooms, due to the isolated locations of these rooms, they are not assessed as safe for consultations. There are medicine administration hatches on the wings, these are not clinical rooms. Some talking therapies can be delivered from interview rooms on the wings, though it was noted that there is always pressure on these limited facilities. It was commented that the holding room in healthcare is a barrier as many residents dislike it. Whilst our consultation (see Figure 17) did not highlight this as a particular issue it will not have been fully used for nearly a year. We were not able to visit, so relied on descriptions; it appears that space is at a premium, we

heard comments about lack of office space needed to call residents, exacerbated both by the need to deliver more services via the telephone and by new social distancing requirements. We heard about pressures on clinical rooms, this is currently masked because so few residents can visit healthcare but will definitely restrict any attempts to deliver more services. NB the escorts section of this chapter discusses opportunity for more visiting clinics; this will not be possible without more space. The dental service report having to restrict their offer as their clinic is fully utilised every weekday and the only option they now have is to extend services into the evenings and weekend both of which impact on the demand for operational staff to enable these.

In terms of covid-19 recovery it would be seductive to simply say that both internal and visiting services could deliver more sessions to clear the waiting lists which have accrued. This will not be possible within the current space that is available.

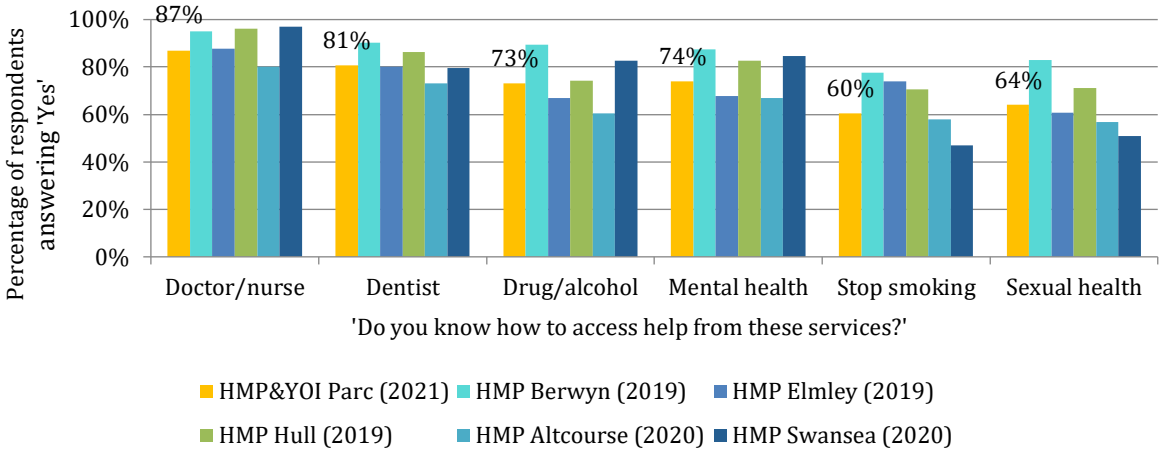
In the resident consultation, the percentage with positive views on healthcare was low next to most of the recently surveyed comparator prisons, with 21% of residents reporting that they thought healthcare was 'excellent' (4%) or 'good' (17%). A greater proportion thought the quality of the healthcare was bad than in any of comparator prisons. The context is that for nearly a year, healthcare provision has been severely impacted by the pandemic, so this is to be expected.

Figure 15 – Opinion of Healthcare Overall (survey data)



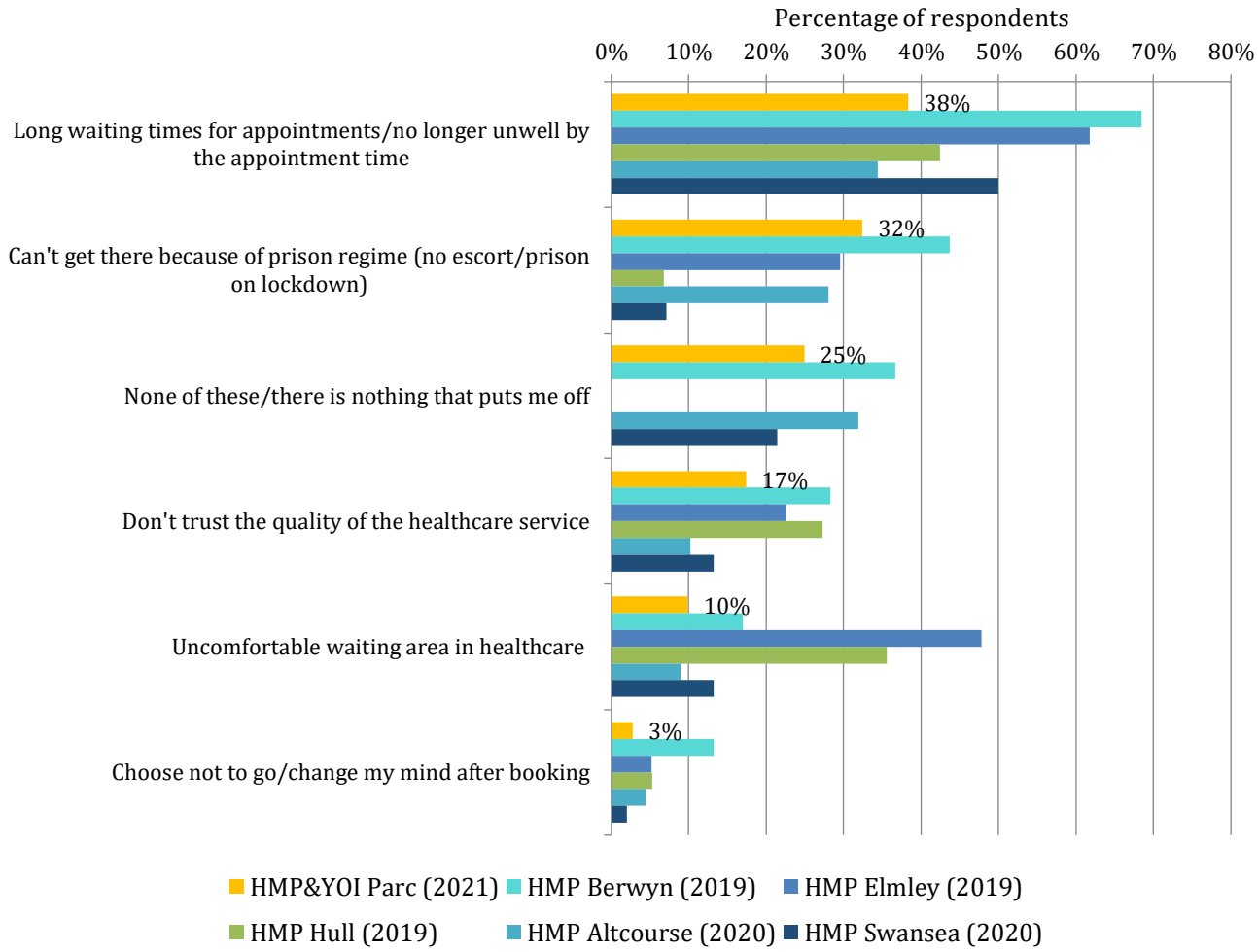
The proportion of residents who said they knew how to access healthcare services was, for the most part, average in relation to comparator prisons. Residents were most likely to say they were aware of how to access the GP (general practitioner), dentist and mental health services, and least likely to be aware of how to access smoking cessation or sexual health services. Prior to the pandemic when residents spent more time out of cell, a clear role for the healthcare mentors on each wing was to act as a navigator for residents and help them access healthcare. This role has been impacted by the pandemic as residents get little time out of cells and are in cohorts so access to the champion is very restricted.

Figure 16 – Confidence in Accessing Services (survey data)



In the survey, residents were asked 'What stops you going to healthcare' – the most common reason cited was a long waiting time for appointments; typically impediments were less commonly reported than in most comparator prisons.

Figure 17 – Reasons for Avoiding Healthcare Visits (survey data)



3.2.1 Primary Care Staffing

The following table describes the primary care staffing complement (dental, pharmacy, mental health (MH), substance misuse and social care staffing are discussed in the relevant chapters/sections).

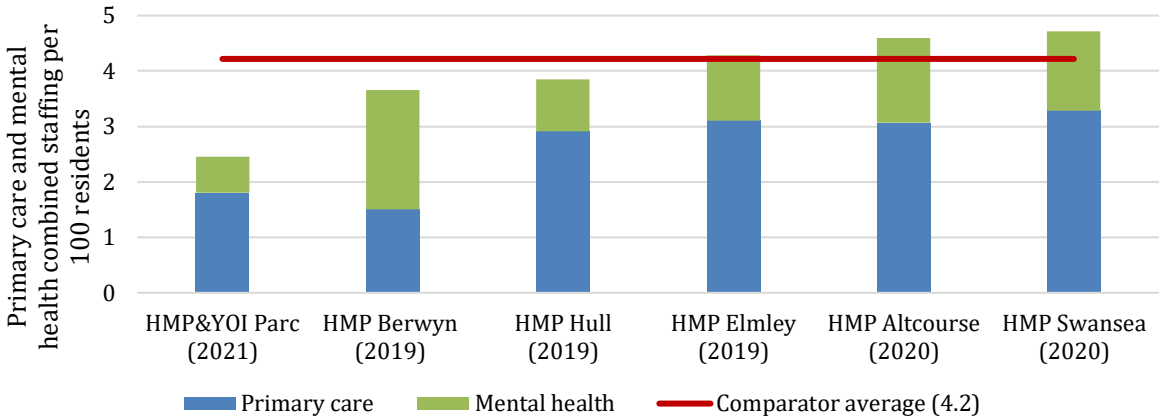
Figure 18 – Staffing HMP Parc Primary Care

Role	Band (or equivalent)	Full-time equivalents (FTE)	Comments
Head of Healthcare	8	1	
Practice Manager	8	1	
Clinical Lead	8	1	
Lead nurse	7	4	2 RMNs and 2 RNLDs. Whilst this is generic managerial role, for comparison, 2 FTE assumed to be primary MH.
Crisis team nurses	5/6	14.5	Of this group 8 are RMNs, so for comparison are assumed to be primary MH. 5 are RGNs. 1 is a paramedic. 1 is part-time RNLD. 2 RMNs assigned to the Safer Custody Unit. 2 cover other mental health issues.
Practice nurses	5/6	9	2 practice nurses in main healthcare. 2 practice nurses in X block healthcare (VPU). 2 RNLD nurses: 1 Care and Separation Unit, 1 Cynnwys (LD) Unit. 3 RMNs – assumed to be primary mental health. 1 SMS nurse, who elsewhere was described as having been replaced by pharmacy technicians. 1 RGN and 1 RMN (who are additional to the 9 described) cover the YO wing nurses.
Healthcare assistants (HCA)	4	8	1 FTE is a mental health HCA. Whilst nominally 2 cover social care provision the current hours of care will take up to 4 FTE.
Administrators		7	

Because the team is seen as one large and amalgamated resource, the opportunity to give comparison with other establishments is restricted. For the purposes of comparison, we have assumed the primary mental health provision comprises of two FTE Lead Nurse, four Crisis Nurses, two Practice Nurses and one HCA; however, we heard many different descriptions. We did hear a consistent description of the total numbers, to avoid any risk of confusion, the chart below combines general primary care and primary mental health staffing.

The chart below illustrates that the staffing ratio in HMP Parc is the lowest when compared to similar prisons for which this information is available. (In order to accurately describe the service for adults, this data takes the full nursing team but excludes the two nurses assigned to the YO wing).

Figure 19 – Primary Care Staffing in HMP Parc and Similar Prisons



Note that the above is the *theoretical* staffing model and does not account for vacancies (in any establishment). In HMP Parc there were reported to be no vacancies (Feb 2021); however, there are a number of appointees undergoing vetting and a number absents (maternity leave etc), the Independent Monitoring Board (IMB) previously drew attention to a high rate of staff turnover.[25] The covid-19 pandemic has impacted on the staff team in HMP Parc as seen in all other prisons.

[25] IMB (2019) Annual Report of the Independent Monitoring Board at HMP & YOI Parc for the reporting year 1 March 2018 to 28 February 2019. [Accessed 11/2/21].

3.3 Clinics, Waiting Times and Did Not Attend (DNA) Rates

There is a wide range of primary healthcare clinics in HMP Parc, as shown in the table below. A green RAG rating indicates that needs are normally met, red indicates they are not met. Amber is used where needs are just about met, as described in the oral health section, the dental service struggles to meet needs but generally keeps within accepted waiting time targets.

Figure 20 – Clinic Details Primary Care

Clinic	Reported frequency or FTE	Waiting time (current wait, working days)	DNA rate (May-20 to Oct-20)	Observations	Needs assessment (RAG)
Reception	Daily transfers into establishment (Monday –Friday)			Numbers greatly reduced due to pandemic. Currently receiving up to 20 transfers twice a week and some new admissions from court.	
Secondary screening	Daily clinics held		23% (0% Oct-Mar)	Some disruption during the pandemic with less face to face appointments.	
GP	20 sessions per week: 1 dedicated SMS, 1 YOs. 24 hour on-call	2 days	5% (20% Oct-Mar)	Provided by Marnell Medical Services. All GP's have had remote access to SystmOne during pandemic. 3 appointments per day were allocated to the YOs, now the routine is 1 session on a Wednesday morning.	
Dentist	10 sessions per week	Urgent 123 days, routine 214 days	13% (23% Oct-Mar; triage not reported May-Oct (32% Oct-Mar)	Provided by Time for Teeth. Limited access due to pandemic.	Pre covid-19 waits were 6 weeks red at present
Optician	4 per month	Routine 17 days	18% (25% Oct-Mar)	Restrictions during the pandemic have disrupted service.	Red at present
Retinal screening	Annual			Visiting clinic. Provided by Local Health Board.	
Physiotherapy	3 per week	24 days	4% (17% Oct-Mar)	Provided by Active Health Professionals. Restrictions during pandemic.	Red at present
Podiatry	2 sessions per month	301 days,	2% (34% Oct-Mar)	Provided by Premier Physical Health. Restrictions during pandemic.	Red at present
GUM	'As required'			Visiting clinic. Provided by LHB.	

The most recent IMB report raises concerns about high DNA rates and noted the work both healthcare the operational side of the prison were doing to tackle the issue.[26] Across the range of HSCNAs conducted by our team, we found that the average DNA rate across primary care clinics tends to be around 13%; among recent comparators it was 15% (average across HMPs: Altcourse, Elmley, Hull and Swansea in 2019 to 2020 – note it is likely that some of these may have reported lower DNA rates than usual due to covid-19 restrictions). HMP Parc reported an average DNA rate across primary care clinics of 5%, which is lower than average. As can be seen from

[26] IMB (2019) Annual Report of the Independent Monitoring Board at HMP & YOI Parc for the reporting year 1 March 2018 to 28 February 2019. [Accessed 11/2/21].

Figure 21, the rates vary from 0% to 30%. It appears that the DNA rate for some clinics may have been affected by the covid-19 pandemic. (DNA rates during an earlier six months, October 2019 to March 2020, were higher at 12% on average, though this is still lower than the comparator average.)

The average proportion of booked appointments actually fulfilled at HMP Parc was 93% over the last six months (85% during October to March); this varies considerably between clinics, as shown in the table below.

Figure 21 – Regular Clinics, Average Numbers Seen[27]

May-20 to Oct-20	Average clinic sessions per month	Average appointments booked per clinic session	Average seen per clinic session	Percent DNA	Percent 'no access'	Clinic occupancy
Dental clinic	34.2	4.9	4.2	13%	2%	85%
GP clinic	22.2	8.2	7.7	5%	1%	94%
GP telephone am	2.2	10.0	8.8	12%	0%	88%
NL 72 hours screening	2.8	8.3	6.4	23%	0%	77%
NL LTC clinic	1.5	7.3	6.3	14%	0%	86%
NL asthma	2.2	7.4	5.1	3%	28%	69%
NL diabetes	11.7	5.4	5.3	2%	0%	98%
NL epilepsy	1.7	2.6	1.8	8%	23%	69%
NL bloods	23.5	5.8	5.8	1%	0%	99%
NL daily nursing care	53.3	10.1	9.2	9%	0%	91%
NL dressings	42.0	7.4	7.2	2%	0%	98%
NL hepatitis B	2.8	4.2	3.7	11%	0%	89%
NL immunisations and vaccinations	2.8	18.1	17.6	0%	2%	97%
NL over 55's	1.0	8.3	6.8	18%	0%	82%
NL paramedic	33.0	17.9	17.7	1%	0%	99%
NL pre-release	5.3	12.1	12.1	0%	0%	100%
NL sexual health	24.7	8.2	7.8	5%	0%	95%
NL triage	21.8	9.1	8.9	1%	1%	98%
Pharmacist	10.7	11.3	8.7	23%	0%	77%
VC chiropody	1.7	5.8	5.5	2%	3%	95%
VC optician	1.2	10.6	8.7	18%	0%	82%
VC physiotherapy	12.5	5.6	5.4	4%	0%	96%

(NL= nurse led VC=visiting clinic)

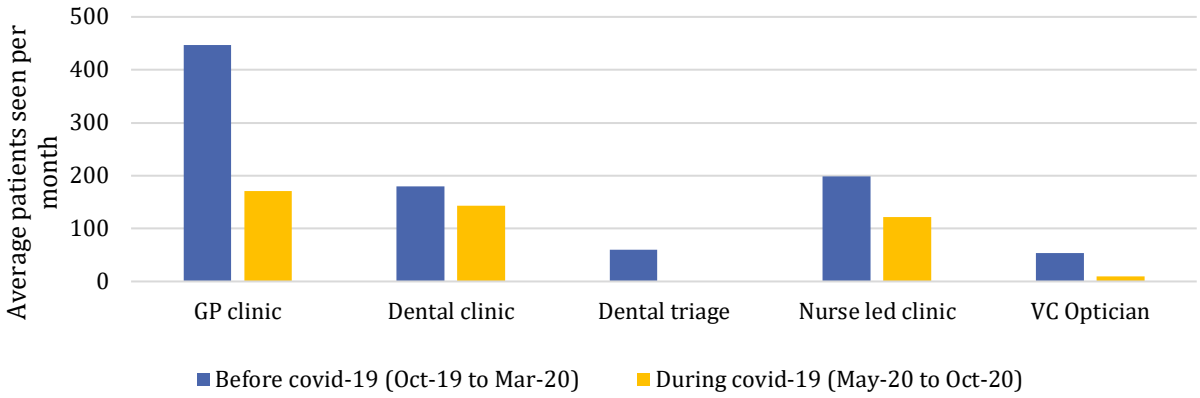
Key to RAG rating on above table:

	% residents actually seen < 70%		% residents actually seen between 70% & 80%		% residents actually seen > 80%

For some clinics, the clinic occupancy rates, DNA rates and numbers of appointments in the last six months were quite different from that in a six month period (October to March) before the covid-19 pandemic. The chart below shows the average number of residents seen per month in a variety of clinics, both before and during the pandemic, for clinics recorded on SystmOne. The dental triage clinic, for example, had no residents recorded on SystmOne as seen from May 2020 onwards.

[27] 'No access visits' refer to patients being unable to attend for reasons beyond their control.

Figure 22 – Patients Seen per Month in Clinics Before and During Covid-19 (SystmOne appointment data)



The capacity of healthcare services to meet needs is in part dependent on the number of residents booked into each clinic and then also on the proportion of booked residents who actually present to a clinic. Patient non-attendance can impact waiting times for a service and thus its ability to meet needs.

During the pandemic, healthcare has relied on telephone consultations to remain in contact with residents. This works up to a point but is hampered by technology. The current telephone system only allows a resident to call healthcare, not for healthcare to call a resident. Thus healthcare can ask a resident to call at a given time, but the residents frequently do not stick to the times, so staff are waiting for calls or handling a number trying to call in together. The solution is to have 'white phones' which is a term for telephones that can call out to the wings. One has been on order for some time but has not yet been installed.

The telephony challenges are not limited to these 'white phones', there simply are not enough telephones in healthcare; so, for example, as the dental service attempts to address their waiting list, their staff are working in the evening as this is the only time they can access telephones for residents to call them for dental triage.

Recommendation Two – Healthcare need more telephones, especially 'white phones'.

This is not a temporary fix, interviewees explained how they expect to continue to use telephones to deliver some services after the current restrictions are lifted.

3.4 Primary Healthcare

3.4.1 Arrival/Reception

The introduction of covid-19 testing for all residents on reception (and more recently, testing again on day five) has reportedly had an impact on the capacity of the primary care team.

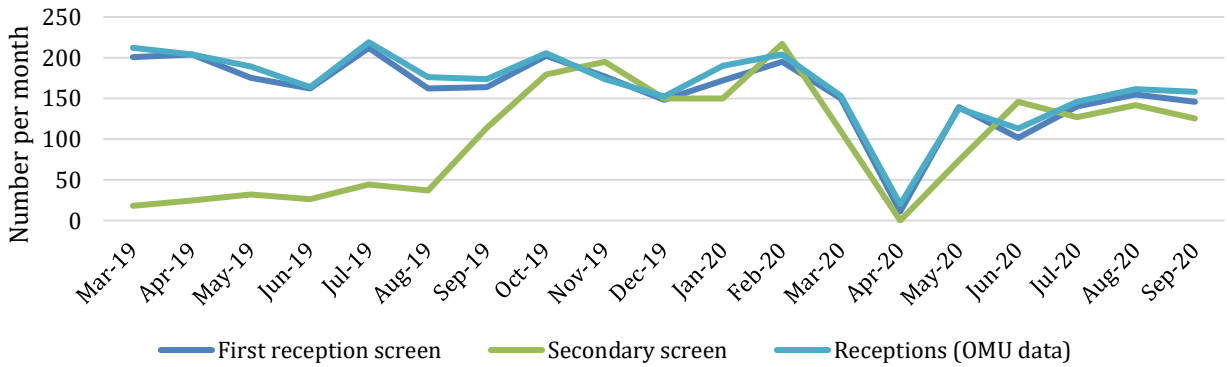
In normal circumstances, new receptions are initially accommodated on A2 or X1 for the first night. They then move on to an induction wing, generally for a period of two weeks, where healthcare will conduct the second screen. As part of induction HCAs include checks for social care needs, those who are appropriate can be directed to the Safer Custody Unit, Assisted Living Units or to the LD facility. As noted, covid-19 and the need for reverse cohorts has impacted on how induction can be managed.

SystmOne data indicates that during 2019/20, all newly registered residents were recorded as having received a first reception screening, and 63% as having received a secondary screen. In 2020/21 to date (April to October), 95% had a first screening on record, and 83% a secondary screen. However, although it appears that relatively low proportions of residents had a secondary screening explicitly recorded, the data suggest that high numbers of residents were offered interventions that would typically be done at a secondary screen, such as blood borne virus (BBV) screening. In 2019/20, for example, a higher number of residents were recorded as offered these screenings than entered the prison, suggesting all new receptions and some existing residents are likely offered appropriate screenings. It seems that the SystmOne READ code for first receptions screening was effectively used from March 2019, while the code specifically denoting secondary reception screening was used from September 2019, from which point both closely mirror the numbers of new receptions.

Interviewees were able to assure us that residents do not have to wait for medication; because of the very responsive out of hours (OOH) GP service they can obtain OOH prescriptions, if the medication is not in stock there is an medical prescription pad (FP10) and OOH critical medication can be obtained from a community pharmacy.

The drop in receptions in April 2020 is clearly visible in the chart below.

Figure 23 – Receptions and Reception Screenings (SystmOne data)

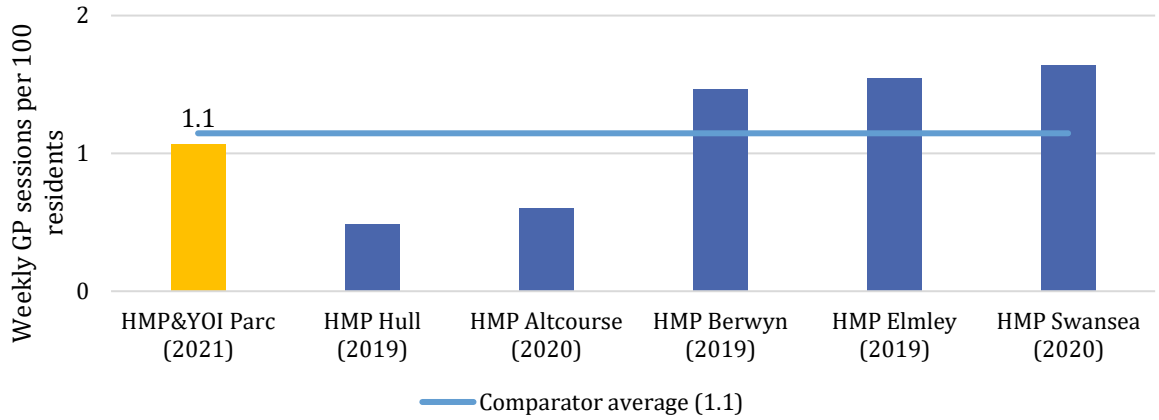


3.4.2 GP Provision

GP clinic provision is 20 sessions per week, of which 18 are for primary care (one for substance misuse and one dedicated for YOs), with a GP available on call 24 hours a day (see OOH section below).

The level of GP cover places the rate of provision in HMP Parc just below average among comparator prisons. There are eight GPs on the rota, in additional there is a prescribing pharmacist who covers all substance misuse reviews.

Figure 24 – GP Cover Comparison



The triage system appears rather limited, admin do a desk based triage of the applications, referring those with key words to the GPs and others that appear appropriate to nurses for triage. GPs would like access to the CMS machines to triage their own appointments. Post covid-19 there may be benefit is reviewing the triage pathway.

In prisons with more non-medical prescribing capacity, fewer residents would need GP input. During the covid-19 pandemic all GP appointments which can be conducted remotely are on the telephone, reflecting what has been seen in the community. The lead GP reiterated the comment that clinical staff need more telephones and especially 'white phones', to be able to call residents.

At present healthcare appear quite traditional, with a heavy reliance upon GPs for both prescribing and specialist input. As noted in the Mental Health chapter, the main tool available for managing primary mental health presentations is pharmacological as opposed to psychosocial, thus placing further demand upon GPs. Also, as noted in the Substance Misuse chapter, there is a prescribing pharmacist who undertakes all medication reviews for those in receipt of OST. Healthcare is endeavouring to spread the prescribing workload to include non-medical prescribers. The Physiotherapist is about to complete a non-medical prescribing (NMP) course. Once qualified he will expand his role to include reviews of opiate based pain relief, cardiovascular risks and respiratory diseases.

3.4.3 Out of Hours Cover

In hours and out of hours cover GP cover are both provided by Marnell Medical Services. Interviewees reported this works well. The lead GP covers most of the out of hours calls, she described getting a call most nights, the GPs have SystmOne terminals at home to see patent notes out of hours. Whilst very few require her to visit, most are to issue prescriptions. This is a level of service we have not seen in other prisons and both enables healthcare to be very responsive to resident needs whilst also reducing the out of hours escorts to hospital accident and emergency departments(A&E).

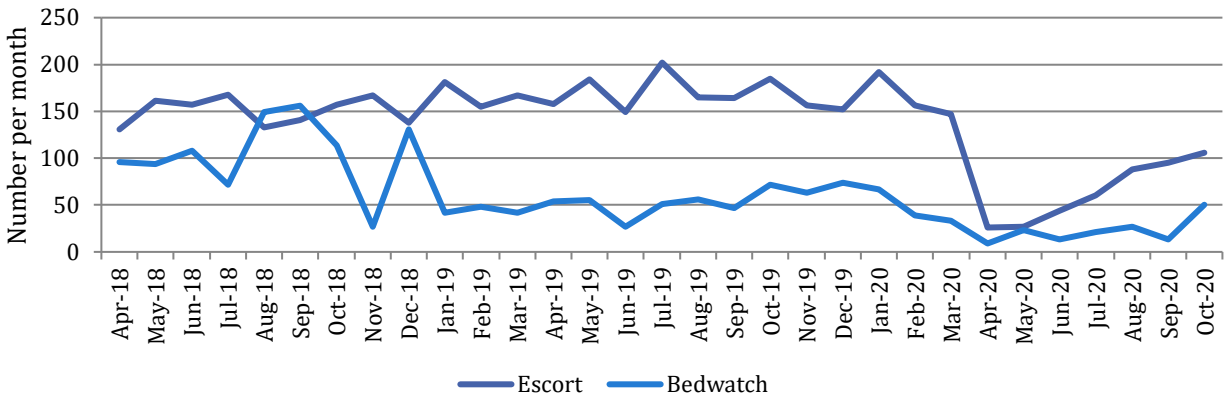
3.5 Secondary Care

3.5.1 Escorts and Bedwatches

Data provided by the prison described a recent dramatic reduction in the numbers of escorts in April 2020 and a gradual increase in the following months; this reflects anecdotal reports of

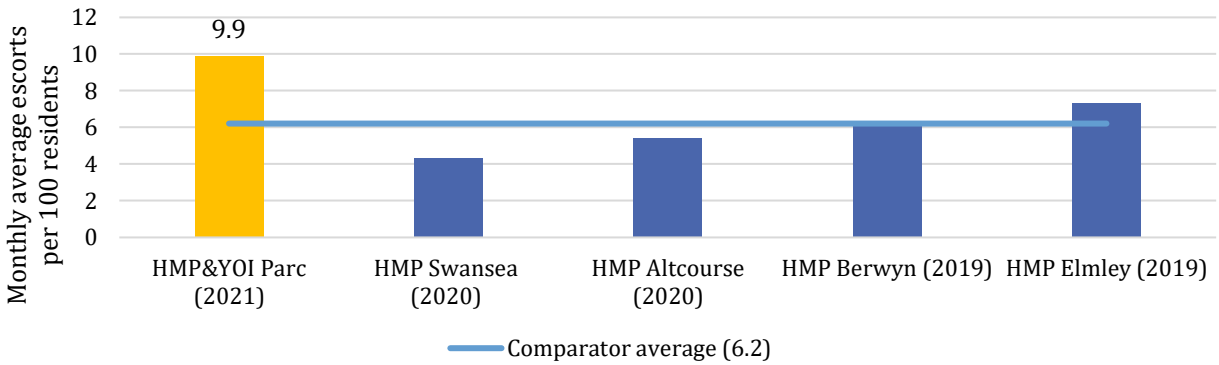
what happened across the whole of society. Prior to the covid-19 pandemic, there were an average of 168 escorts and 53 bedwatches reported per month; from April 2020 onwards this dropped to 64 and 30 respectively.

Figure 25 – Escorts and Bedwatches (OMU data)



An average of 168 escorts per month (taking the pre-covid-19, 2019/20 average as an indication of 'normal' activity) means that HMP Parc has a relatively high rate of escorts per 100 residents compared to the other prisons detailed below. Unlike state run prisons, escort costs in the private estate are not charged back to the NHS but have to be found from within the operational budget. This means it is in the interests of both healthcare and the Director to seek the most efficient way to deliver effective care. There is also an issue of dignity, prisoners being escorted to hospital are handcuffed to officers, this inevitably draws attention to them in hospital waiting rooms; thus many prisoners say they would prefer, where possible, to be treated on site.

Figure 26 – Escorts per Month per 100 Residents Comparison[28]



We generally find that hospital escorts are lowest in prisons where there are more secondary care services on site. HMP Berwyn is an excellent example of this whereby in an attempt to reduce demand on the local hospital, the prison has a very extensive range of secondary care services 'in house'. This is reflected in the above illustration showing that the rate of escorts from HMP Parc, where there are currently few initiatives to reduce escorts, the rate is above all comparators.

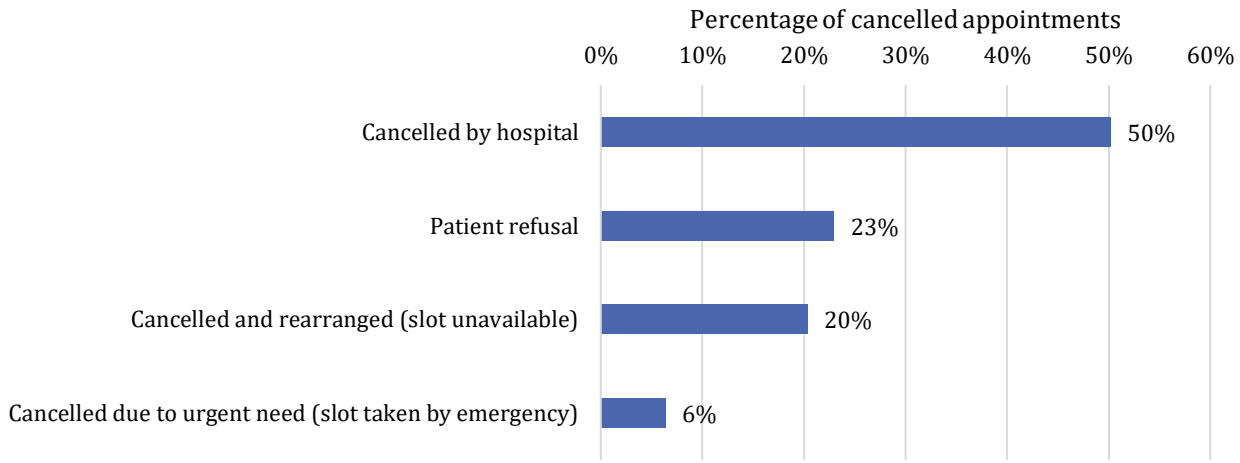
[28] Please note that while the current op cap of HMP & YOI Parc is 396, for the purposes of this calculation we have used an average of the op caps specified by the MOJ in Monthly Prison Population Figures for the months covered by the appointment data (September 2019 to March 2020). This gave an average op cap figure of 429. Also it should be noted that data for other prisons uses National Offender Management Service (NOMS) escort tracking records to determine numbers of escorts, while data for HMP & YOI Parc relies on hospital appointment records kept by healthcare.

During the pandemic radiology (X-Ray and Ultrasound) were said to be the only two secondary care services to have continued uninterrupted. Prior to March 2020 waiting times for other appointments were generally described as being within the local targets. Which are 26 weeks for a routine appointment and two weeks for an urgent appointment (typically suspected cancer). In common with anecdotal reports from the community, they have now 'gone through the roof'.

The prison reported that there were three morning and three afternoon escort slots per weekday for routine hospital appointments. This has reduced to two plus two which equates to 1.2 slots per 100 residents per week at the current op cap. HMP Swansea reported 2.5 slots per 100 residents per week (in late 2020). A&E escorts should be on top of routine allocations, but it was reported that there are often not the staff to accommodate these, so escorts will have to be prioritised. This likely suppresses need as residents are listed depending on the availability of escort slots which are limited.

Data provided by healthcare showed a total of 422 hospital appointments cancelled during the most recent available 11 months (January to November 2020). The most common reason for cancellations were cancellation by the hospital department, responsible for 50% of cancelled appointments. More than half of these (128 of the 212 hospital cancellations) occurred during March and April 2020.

Figure 27 – Hospital Appointments Cancellation Reasons (Healthcare data)



Access to secondary care services delivered 'in house' within HMP Parc is limited. Whilst it was reported that nursing staff are trained to do sutures and dressings other services which could be delivered on site require a hospital escort in the absence of, for example, visiting tissue viability services.

Telemedicine was described as not having taken off yet. Whilst this technology has had a chequered history in prison; where barriers have existed, these have generally been raised by local secondary care providers. One opportunity presented by the pandemic is that many secondary care providers are now more amenable than previously to any proposals that reduce physical footfall in their services.

There are no visiting diagnostics (X-ray, magnetic resonance imaging (MRI) etc). In other parts of the prison estate, monthly visiting diagnostic lorries have been found to significantly decrease demand for escorts and improve services by increasing access to this technology.

Visiting services can only impact on planned care, there will still be a need for urgent and unplanned diagnostics.

The dentist described how Time for Teeth are negotiating for an oral surgeon to visit on a Saturday. In one session more than five patents could be seen, each consultation is one less escort.

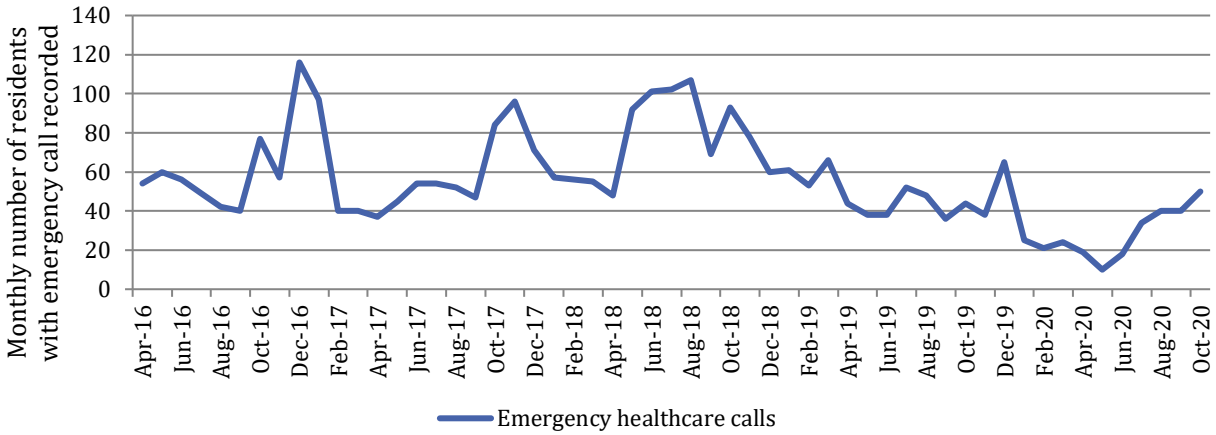
Escort generating secondary care is not just driven by the need to access specialist equipment, mental health provision currently generates demand for escorts, we were told that the Memory Clinic, which is critical for diagnosing dementia is only available in the community.

Recommendation Three – Explore opportunities to reduce the volume of escorts. This includes alternative means of healthcare delivery such as visiting diagnostic trucks and telemedicine.

3.5.2 Emergency Calls/Codes

SystmOne data indicates that during 2019/20, records showed an average of one code blue, fewer than one code red, and one ambulance call per month. Interviewees felt this is probably an under representation of the true number.

Figure 28 – Emergency Healthcare Calls (SystmOne data)



The 'crisis team' who are tasked to respond to emergency codes includes one paramedic. Interviewees described how the number of codes has reduced dramatically over the last five years and how healthcare has worked with the operational side to help officers understand what is appropriate to escalate to a 'code'. During this time, both the prison and healthcare have learned how to have a graduated approach to 'spice' incidents, including periods of enhanced observations. In addition to the reduction in codes resulting from this training, the number of ambulance call-outs has also reduced.

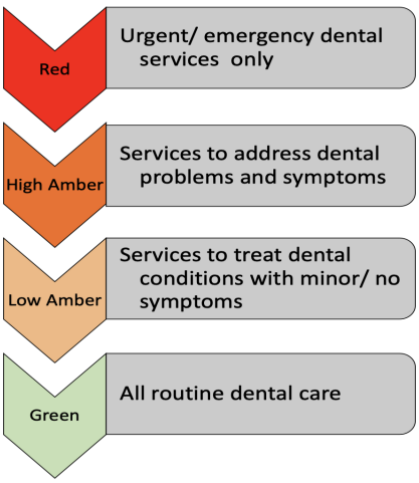
In normal times healthcare use the National Early Warning Score (NEWS) to assess code blue incidents, but this approach has been suspended during the pandemic.

3.6 Oral Health

Report Part B explores dental care need. Interviewees confirmed the evidence base, reporting the need amongst residents in HMP Parc to be particularly high.

In Wales, the chief dental officer, in response to the covid-19 pandemic, published the Wales De-escalation Pandemic Plan for Dentistry, which relates to community settings. The purpose of this is to ensure a risk-based approach to continuing dental care safely. Wales was in the 'red' phase initially and has now moved to amber (February 2021). The dentist is hoping that that a move to routine dental services (i.e. green) will happen in April.

Figure 29 – Dentistry De-escalation Plan (Wales)



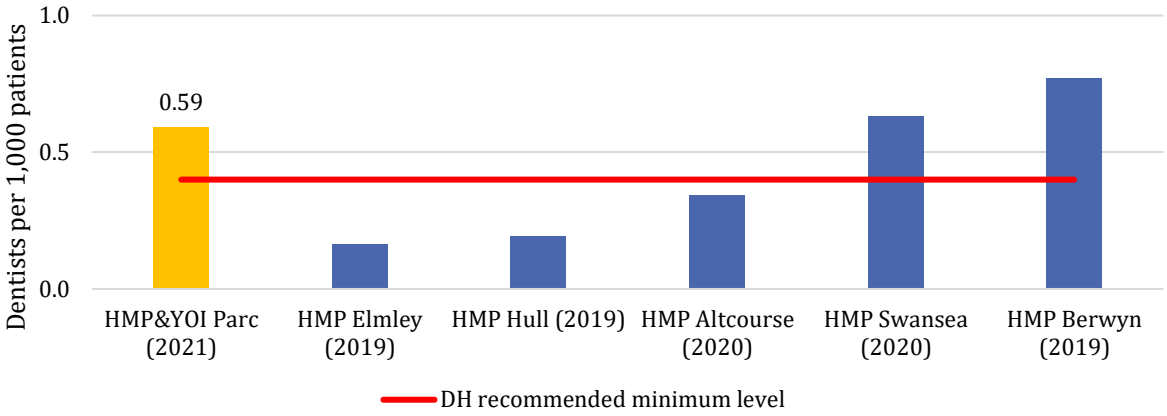
Dentistry is delivered by Time for Teeth who provide dental services for a large number of prisons across England and Wales. There are ten dental sessions per week provided by a dentist. Dental clinics normally allocate 9-10 am for the YO population and Friday afternoon for the VPs.

Following a virtual suspension of services, the service is now able to deliver a limited number of aerosol generating procedures (AGPs), thus the capacity per clinic is currently much lower than normal.

As a result of covid-19 and the constraints on AGPs waiting times have grown dramatically, as described in Figure 20. In normal times the dentist described routine waits of around six weeks from application to treatment. As described above the wait is currently in excess of 200 days. The dental nurses are now undertaking telephone triages to manage the lists, though the shortage of telephones, described elsewhere, hinders this and means the only available time is early evenings.

The chart below shows the level of dental cover in HMP Parc compared to other similar prisons (dentists per 1,000 patients; this does not include therapist or hygienist provision). Cover at HMP Parc is above average relative to comparator prisons and is also above the community average.

Figure 30 – Dentist Cover Comparison (dentists per 1,000 patients)



The limiting factor on any expansion of provision is that there is one suite in HMP Parc. This was described as being a good facility and fit for purpose. There is currently no obvious space for a second suite; however, without this there is no opportunity to extend the service.

Throughout the pandemic the service has not been able to deliver any AGPs. A new ventilation system is being installed in the dental suite which will allow these to recommence. Whilst this is positive it will not return activity levels to anything like those previously seen, there will need to be a rest period between each patient; therefore this will perhaps stop the waiting list increasing as previously; but it will not be a panacea to bring down the current waiting times.

The opinion of the dentist is that to meet needs there should be twice the number of sessions currently on offer. Our observation is that whilst the number of dentist sessions described above is relatively generous, this could be a little misleading because it is not supplemented by any dental therapist sessions (and cannot be because there is no space for additional clinics). Further, whilst comparison is interesting we rarely visit a prison where the dental provision is described as adequate.

Secondary care has not been accepting referrals, there are 'handful' of patients who would have gone out for oral surgery who remain waiting for treatment. Time for Teeth are negotiating for an oral surgeon to visit and deliver an onsite clinic on a Saturday morning. This would not only clear the list but moving forward would be more cost effective and efficient than sending residents out under escort.

3.7 Optometry

Huw Bellamy provides services into HMP Parc, the service appears to have met need before covid-19 but following the first lockdown there has reportedly initially been no provision at all and then latterly limited cover. A waiting list has now accrued. As noted previously, in common with other visiting clinics (including podiatry and physiotherapy), it will be a challenge to address this

Note that dependent upon the optician, retinal screening can form part of this service. As explained in Chapter Four residents with diabetes require annual retinal checks. Currently a specialist service visits annual Chapter Four includes a recommendation that the frequency should be increased to six monthly.

3.8 Pharmacy and Medicines Management

The prison benefits from an onsite dispensing pharmacy.

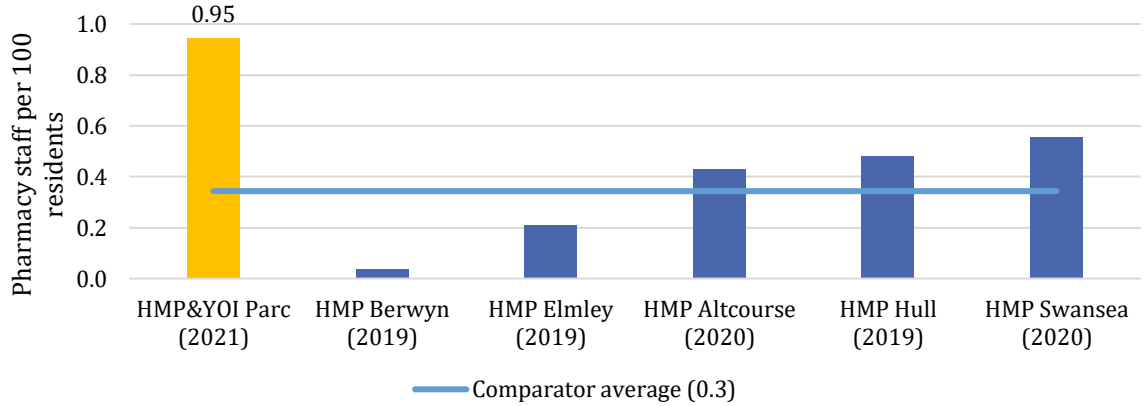
The current resourcing of the service is listed below:

Figure 31 – Pharmacy Staffing Team HMP Parc

Role	Band	Full-time equivalents	Comments
Pharmacy Manager	7	1	
Pharmacist	8	2	The resource recently increased from 1 to 2 pharmacists. The second post is filled by a locum.
Pharmacy Technicians (pharmacy based)	4	2	1 senior. This includes accuracy checker.
Dispensers (pharmacy based)		2	
Pharmacy Technicians (wing based)	5	9	These are wing based and undertake most of the Not In Possession (NIP) administrations.

The chart below shows the ratio of pharmacy staff per 100 residents for HMP Parc and comparator prisons for which this data was available. Provision at HMP Parc is very well-resourced compared to other similar prisons.

Figure 32 – Pharmacy Staffing Ratio



Pharmacy technicians have been in post for some 18 months and they do about ¾ of all administrations. The move to increase pharmacy technicians was, in part informed by feedback from nurses who were frustrated that their days were taken up with medication administrations rather than nursing duties. This has been part of a shift, originally nurses were running administrations whilst holding the radio, so could be called off to an incident, likewise clinic nurses could be called away. Separating out the crisis and core teams addressed these issues. Then nurses continued to fit clinics around administration duties, restricting clinic time, now clinics can start earlier and finish later, increasing capacity. The pharmacy technician initiative was said to have had a massive impact, for example improving responses to long term conditions and reducing medicines errors.

Interviewees estimated that the pharmacy team deliver about three quarters of all administrations. This includes the substance misuse service (SMS) methadone administrations which were previously delivered by two SMS nurses. The shift to using technicians was described as having worked 'amazingly well'. There are some hatches which

are still staffed by nurses, the suggestion was that any future planning should look to increase the proportion of all administrations which are delivered by the technicians.

Technician roles do not have to be restricted to medications, if there were more technicians, administrations would not fully utilise their time. In the same way that healthcare has creatively utilised HCAs, they would be available for other roles which do not have to fall to nursing. It was suggested that Technicians could: run warfarin clinics, do more compliance checks, do medicines reconciliations for new arrivals in person.

The pharmacy currently operates for core hours Monday to Friday. Recently there have been occasions for the team to work Saturday mornings and they have seen a benefit in this. It was suggested that this would be a useful extension to their hours. The wing based technicians already work a seven day per week shift pattern.

The pharmacy room was described as being adequate size, but there is a lack of space to store medication. It does not have functioning air-conditioning which is needed to store medication at the specified temperature.

Recommendation Four – The pharmacy need space to store medication and equipment. Both the pharmacy room and the store should have air-conditioning as many medications should be stored within prescribed temperature ranges.

The administration rooms and hatches on the wings were described as 'a project' in need of a revamp. Some need new flooring and units (appropriate flooring and units are vital if they are to comply with infection control requirements.) They need personal protective equipment. (PPE) dispensers. None have air-conditioning, this would be a benefit for storing medication, but so long as the medication is only held in the rooms for a short period it is probably not essential.

SystmOne data indicates that a very high proportion of residents had been assessed for their suitability for in-possession (IP) medication, with 99% of residents at a snapshot in October 2020 having an IP risk assessment on record. This is typical among most comparators: for example, 97% at HMP Elmley, and 99% at HMPs Altcourse, Berwyn and Hull in the last two years (the exception being HMP Swansea, as a local, with a relatively low 40% of patients assessed at a recent snapshot).

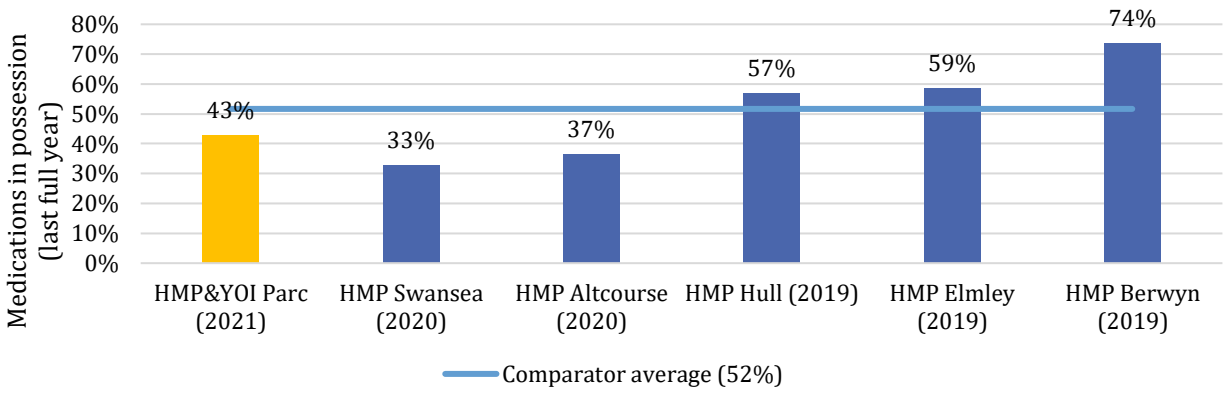
The actual rate of IP prescribing during 2019/20 was 43% according to SystmOne data; this increased to 52% in 2020/21 to date (April to October), and 59% of residents with ongoing prescription/s at our SystmOne snapshot in November 2020 had at least one medication IP. Interviewee comments were that the IP rate now (Feb 2021) stands at 60-70%.

IP medication is beneficial in supporting residents self-care, responsibility and autonomy (and reducing costs), but presents risks related to diversion, bullying and treatment compliance. In response to the covid-19 pandemic there was a desire to ensure, where safely possible, that more residents have IP to reduce risk of transmission within the medicines administration process This meant that healthcare faced risks by increasing IP rates and the days supplies in each administration; this has in many cases increased from seven days to 28 days. There have been remarkably few incidents, the residents feedback has been very positive and overall the approach has been a success.

Looking forward, healthcare would like to retain a high rate of IP meds; however, many cells do not have lockable storage cabinets and where there are cabinets the keys for many are missing. As the prison returns to more time out of cell, unless addressed this will present a security risk.

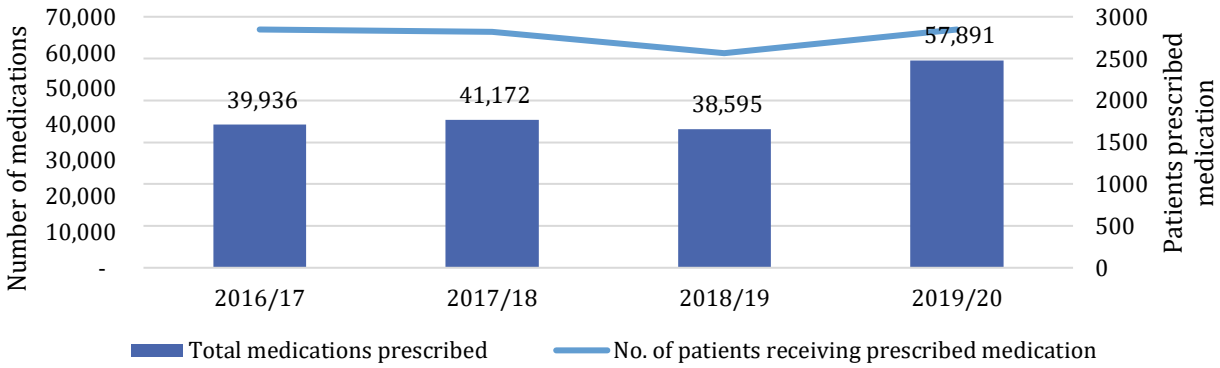
Currently increased IP rates do not free up staff time as medications are delivered to cells. In the future increased IP rates clearly free up pharmacy staff from administrations, this should not be treated as a gift and time should be re-invested into compliance checks. It was reported that this is not possible due to covid-19 restrictions. In the future these can only take place if officer time is also assigned to unlock cells and support the pharmacy staff.

Figure 33 – Medication Prescribed In-Possession (SystmOne data)



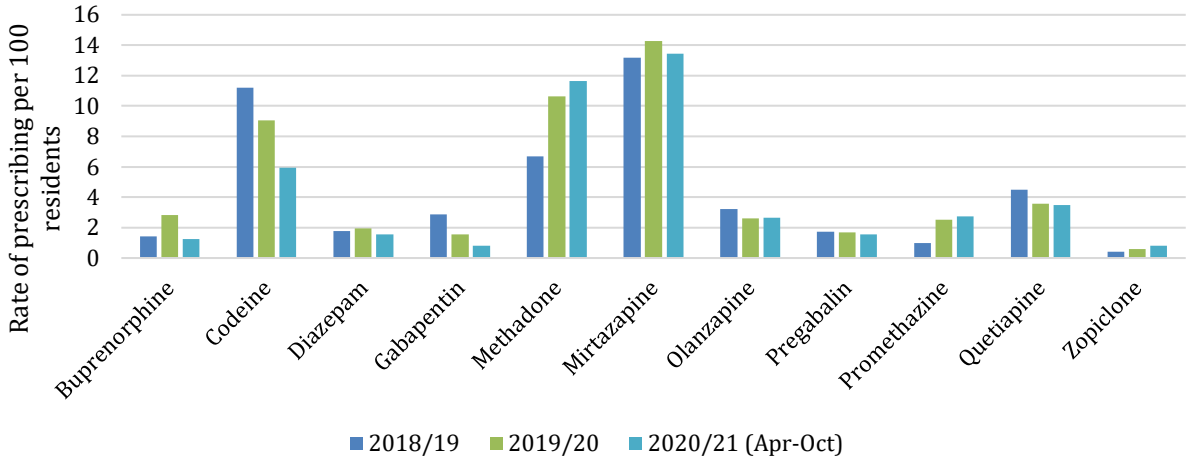
Prescribing data from SystmOne shows an increase in the numbers of medications prescribed (prescriptions issued) in 2019/20 compared to previous years. The number of residents receiving any medication does not seem to have increased overall.

Figure 34 – Total Prescribing (SystmOne data)



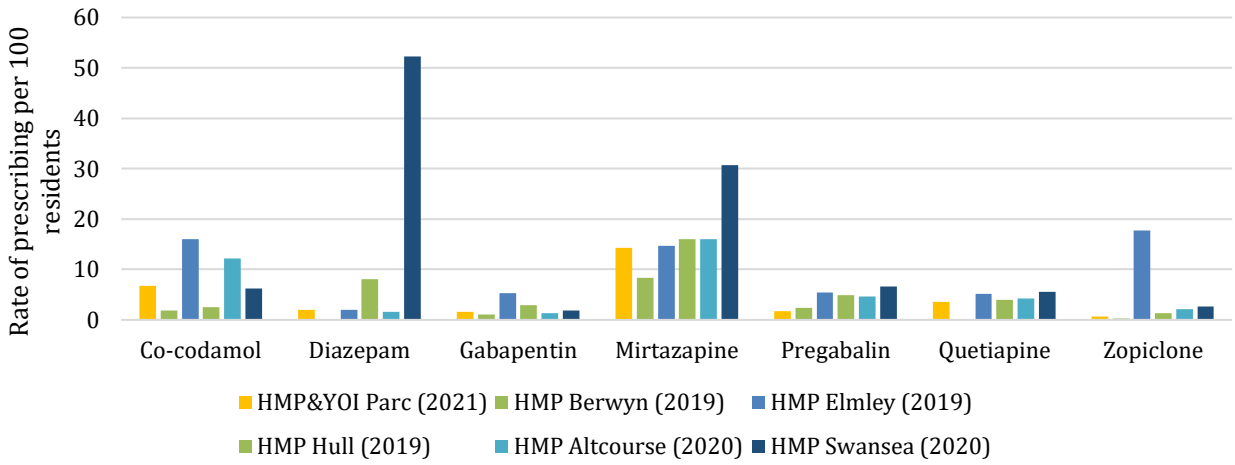
SystmOne shows a general reduction in the rate of residents prescribed several potentially tradable medications, though the prescribing rates of others have increased. The Head of Healthcare described how residents arrive from remand prisons where, due to short stays, tradable meds will not have been addressed, then in HMP Parc the GPs are 'robust' in addressing inappropriate prescribing. Throughout the covid-19 pandemic with restricted face to face consultations and the added stresses for residents, the GPs have taken a less stringent approach.

Figure 35 – Rate of Prescribing of Tradable Medications (SystmOne data)[29]



For context, the chart below compares the prescribing rate for 2019/20 against recent prescribing rates of potentially tradable medications in similar prisons for which this data was available. HMP Parc appears to have a low prescribing rate of most such medications.

Figure 36 – Tradable Medications Comparison



It was reported that there is a plan to do work on opiate based pain relief where new guidance indicates it should only be used for short-term pain relief. There are also plans to look more closely at mirtazapine use but without access to talking therapies, if prescribing is the first line response, then use is likely to remain high.

As noted above, the prison benefits from very good OOH access to a prescriber. There is an OOH medications cupboard with controlled access and weekly reconciliation checks.

Homely remedies are available, some from the canteen list, some from a pharmacy list and some from nurses. During the pandemic, the distribution by nurses has had to change as residents are no longer free to go to the hatch. SystmOne data indicates that 56% of residents spending time in HMP Parc between April and October 2020 had been prescribed paracetamol, and 36% had been prescribed ibuprofen. It was reported that the list of available items has been reduced following a directive from the Chief Pharmacist at G4S. This is contrary to what we see in other prisons, where there is a tendency to increase the range of homely remedies to reduce the burden on healthcare, and better reflect the community.

[29] Note 'buprenorphine' includes Espranor and 'codeine' includes co-codamol.

It was reported that all residents who are in receipt of medication are able to leave with a seven day supply of medication. Because of the increase in IP medications, this needs review as many residents do not need a specific TTO (to take out) supply because they have seven days' worth of medication in their possession so there is currently likely to be some oversupply.

3.9 Chapter Summary

- Healthcare forms a part of the PFI contract as is largely delivered by G4S Medical Services.
- Resident satisfaction with the healthcare provision in HMP Parc was a little lower than seen in most comparator prisons. This may be a consequence of the pandemic.
- There is evidence of reasonable knowledge amongst residents of how to access most healthcare services. We expect this to be slightly impacted by the pandemic.
- Healthcare is delivered from a central hub, which has restricted facilities. Not enough rooms, both offices and clinical rooms (especially with new measures to ensure social distancing). Not enough telephones, especially 'white phones' (to call residents). **See Recommendation.**
- Whilst the proportion of primary care staffing (per 100 residents) appears low in relation to comparators, not all comparators include their primary mental health service in this data.
- All new receptions receive a first and second reception screen where health needs are identified. At present, residents spend the first period in custody on the Reverse Cohorting Unit (RCU) and healthcare input is restricted.
- GP provision appears just above average in relation to comparators, though the healthcare model is one that is very GP dependent. There are moves to use non-medical prescribers.
- The number of planned prisoner escorts to the local hospital is high. There is limited secondary care provision within the establishment, there are opportunities to reduce demand by bringing more services on site. **See Recommendation.**
- The demand for dentistry in HMP Parc, as in all prisons, is high. Need may just about be met, demand is not met. The service has been limited (mirroring provision in the community during the covid-19 pandemic), subsequently leaving a significant waiting list for routine care (over 200 days).
- Visiting clinics (including optician, physiotherapist, podiatrist) have all been limited throughout the pandemic. They all now carry large waiting lists with no obvious way to bring these down once restrictions are lifted.
- The prison has a dispensing pharmacy. In order to store medications properly, this needs air conditioning. **See Recommendation.** The pharmacy team in HMP Parc has recently expanded in order to take responsibility for about three quarters of all administrations.

Chapter Four – Physical Health

4.1 Long-Term and Chronic Conditions (LTCs)

Throughout this chapter, we have estimated the expected prevalence for each condition specifically for HMP Parc, weighted for the age profile of the current prison population. Report Part B includes more general background context, prevalence estimates and commentary on methodology including age-weighted estimates. Where possible, the estimates are specifically for prison (and in some cases male prison) populations. These are generally UK studies but do not take account of local nuances in Wales, where information exists, each section in this chapter comments on the community profile for Wales.

We have compared this to the numbers of residents reported by SystmOne as being on the Quality and Outcomes Framework (QOF) register (indicating a current diagnosis of an 'active' condition) for each condition. It was reported by healthcare that although QOF used, it is not required in Welsh prisons, at HMP Parc it is used to track numbers of residents with each condition. Because QOF allows comparison with other establishments, and because it was reported that the numbers of residents on each register should accurately reflect those being managed for the condition, we have elected to use QOF data here to describe condition prevalence.

We have also noted the historical prevalence of the same conditions where possible, for the period October 2019 to March 2020 (based on the average number of residents on the QOF register during this time and the average population of the prison as reported by the MOJ),[30] as a benchmark to gauge whether current identification may have been impacted by the covid-19 pandemic. Due to recent changes in the QOF register it was not possible to provide this information for asthma or COPD.

As an overview, there is a strong correlation between LTCs and both increasing age and social inequalities. As noted in Chapter Two, the age profile in HMP Parc is dissimilar to the national average for residents, in that there are more under 21-29 year-olds and more 30+ year-olds.

In wider society, compared to the highest social class, those in the lowest social class have a 60% higher prevalence of LTCs and a 30% higher severity of conditions.[31] Typically, disproportionate numbers of prison residents are drawn from the most deprived areas.

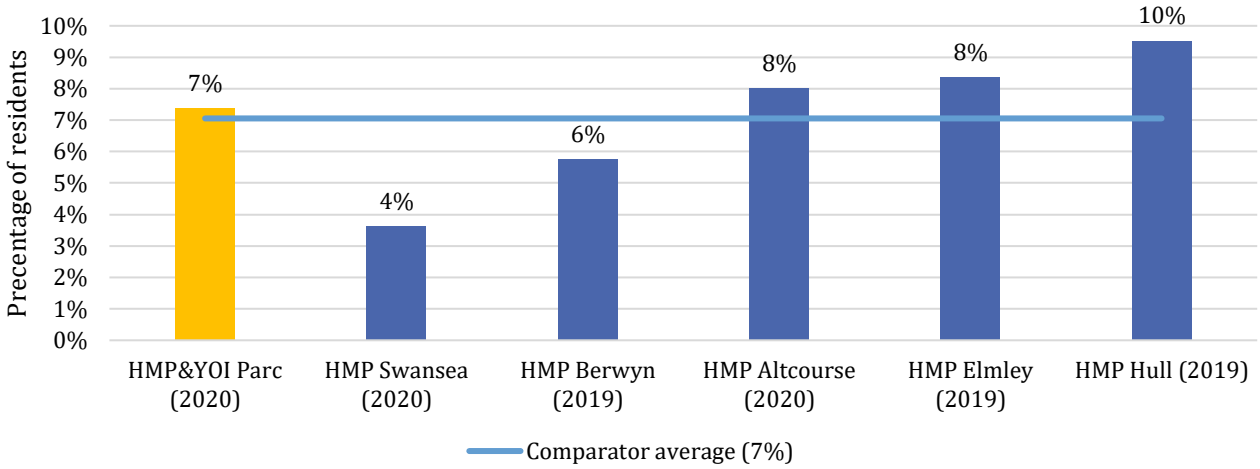
We looked at the data across a number of time frames including January to September 2020, this window was chosen to see if identified and treated rates fell during the pandemic, the overview is that there was no disenable difference, indicating that LTC provision has remained effective during the pandemic. Where there is something to note there is a specific comment under the condition heading.

[30] The average of MOJ (2020) Prison population figures. 'Population' from Monthly Population Bulletins. [Accessed 18/12/20].
[31] Department of Health (2012) Long-term conditions compendium of information: 3rd edition. [Accessed 18/12/20].

4.2 Comorbidity

The recorded prevalence of comorbid physical health conditions at HMP Parc is very close to the average across comparator prisons. We define this as the proportion of residents recorded on SystmOne as having two or more long-term physical health conditions.[32]

Figure 37 – Comorbidity Comparison (two or more long-term physical health conditions)



Given the socio-demographic profile of the local communities from which HMP Parc residents are drawn, we would expect that we might see a higher than average prevalence of co-morbidity. This suggests a possible under-identification and unmet need.

4.3 Asthma

Asthma prevalence in Wales is reported to be one of the highest in the world. Asthma UK Cymru findings suggest there are 260,000 people living with asthma in Wales, 205,000 adults and 55,000 children, which equates to one in 10 children and one in 12 adults currently being treated for doctor diagnosed asthma.

Findings of the Welsh Health Survey (2009) state that 13% of adults reported that they were currently being treated for a respiratory disease which includes asthma. In Wales, in adults there are 4,000 hospital admissions for asthma, a rate which is nearly 30% higher than the rest of the UK and 75% of these admissions could have been avoided.

Asthma deaths in Wales are more common than anywhere else in the UK.[33]

Report Part B includes more general background context, prevalence estimates and commentary on methodology.

Based on the age-related prevalence of asthma and the current snapshot population, we would expect to see 199 men (12%) diagnosed with asthma and 80 men (5%) treated. This will be a conservative estimate as it does not take account of the higher prevalence of asthma in Wales than the England and Wales average (noted above).

The rate of residents with a recorded diagnosis on SystmOne was higher in HMP Parc than predicted, with 240 (15%) having a record of asthma. However, the actual treated rate was close to that predicted, with 95 (6%) of residents reported on the QOF register as being

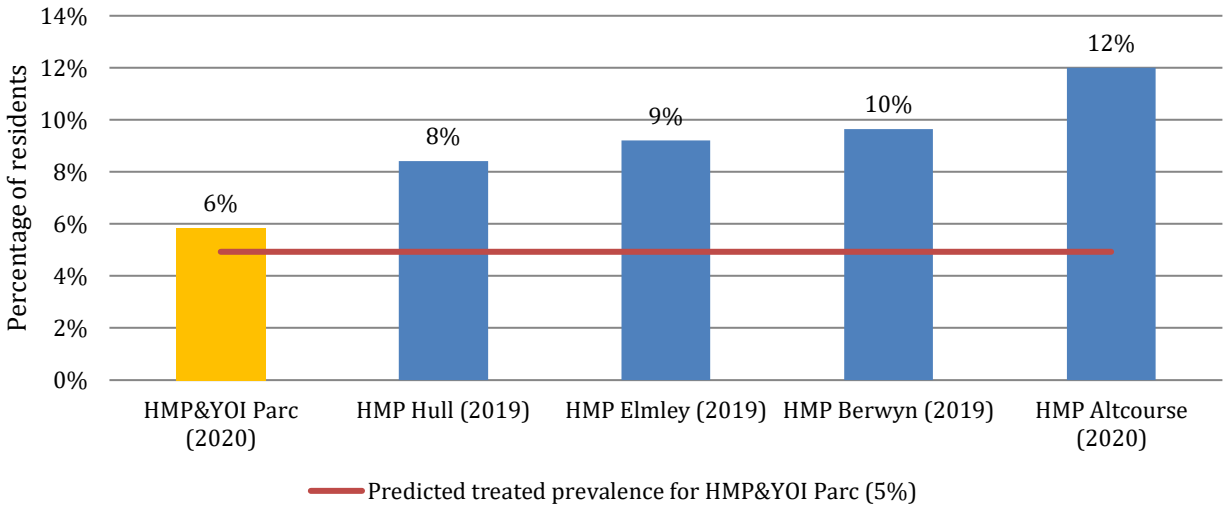
[32] Conditions included are asthma, COPD, CHD, hypertension, diabetes, epilepsy, and sickle cell anaemia.

[33] NHS Wales (N.D.) Asthma. [Accessed 18/12/20].

currently treated. This section relies on a snapshot of data, it the case of asthma we note that the data provided by healthcare showed an average of 139 residents on the asthma register between January and September 2020. This has been followed by a very recent and quite large decrease (143 Sept to Oct 2020 down to 95 in mid Nov 2020), the only possible explanation for this is recent paper based resident reviews which could have removed cases who did not have a diagnosis.

Although it is above the predicted rate for treated asthma, the rate in HMP Parc is lower than similar prisons.

Figure 38 – Asthma Prevalence Comparison (QOF data)



Given what we know about prevalence in the local community, this data suggests a likely under-identification of men with asthma in HMP Parc as opposed to less need.

4.4 Chronic Obstructive Pulmonary Disease (COPD)

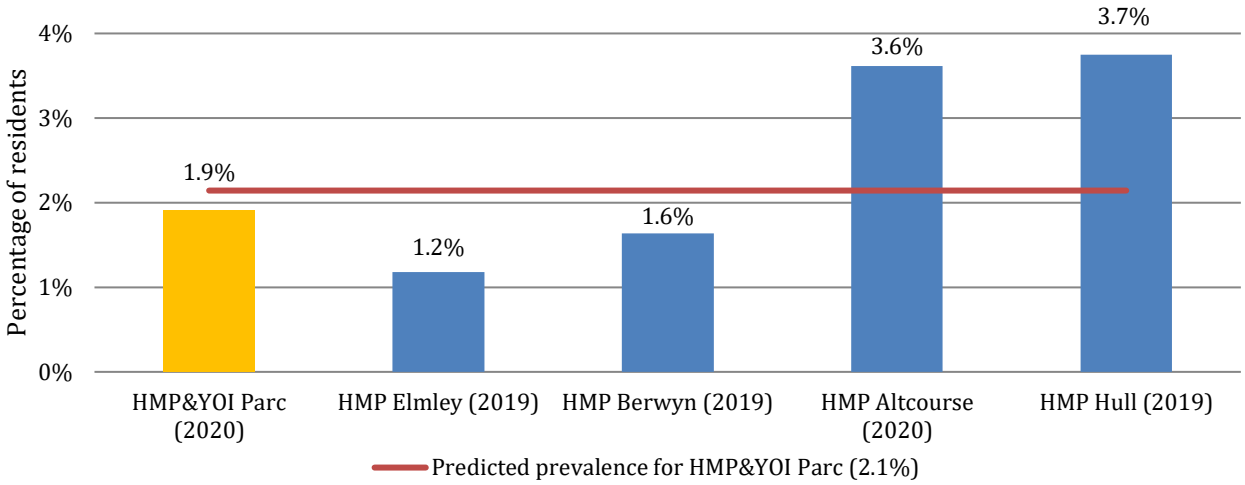
In Wales, the observed prevalence of COPD is similar to that of the whole of the UK, though rates of hospital admissions and mortality due to COPD are higher than the UK average.[34]

Report Part B includes more general background context, prevalence estimates and commentary on methodology.

Based on the age-related prevalence of COPD and the current snapshot population, we found that the number of men in HMP Parc identified with COPD was very slightly lower than the predicted estimate of 2.1% (35 residents). At the November 2020 snapshot, there were 31 men (1.9% of the population) with a recorded diagnosis on SystmOne, all of whom were on the QOF register as being treated for the condition. The rate of identified and treated COPD in HMP Parc is in the mid-range of comparators.

[34] British Lung Foundation (2020) Chronic obstructive pulmonary disease (COPD) statistics. [Accessed 18/12/20].

Figure 39 – COPD Prevalence Comparison (QOF data)



Data provided by healthcare showed an average of 28 residents on the COPD register between January and September 2020. Interviewees noted that while some nurses have been trained in spirometry they are not familiar with the equipment in HMP & YOI Parc, so this testing generally falls to the GPs. Because a spirometry test is one part of the diagnostic testing for COPD, this may be presenting a hurdle. Therefore, as part of the recommendation below, we suggest that at least one nurse should be able to deliver spirometry.

Note that COPD and asthma are correlated and the seemingly low identification of COPD is sometimes accounted for by an above average identification of asthma. The data indicates that this not the case in HMP Parc where identified rates are both a little lower than expected. However, in interview it was stated that the rate of COPD diagnosis has increased recently and there are currently more residents on continuous positive airway pressure (CPAP) machines.

Recommendation Five – Healthcare should prioritise the identification of respiratory conditions to ensure likely need is met. This should include ensuring that at least one nurse is trained in spirometry and able to use the equipment in the prison.

4.5 Diabetes

More than 198,883 people in Wales are living with diabetes. This is 7.6% of the population aged 17 and over - the highest prevalence in the UK - and the numbers are rising every year. Around 90% of these people have type 2 diabetes. Estimates suggest a further 61,501 people in Wales have type 2 diabetes but have not yet been diagnosed. This brings the total number living with diabetes in Wales up to more than 260,000 … This is the most devastating and fastest-growing health crisis Wales is facing.[35]

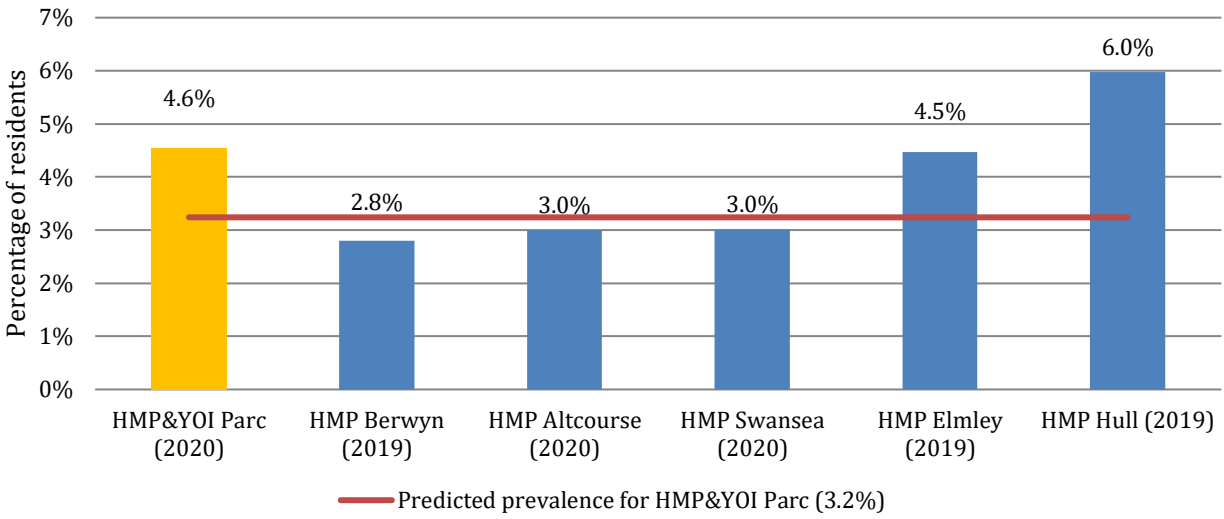
Report Part B includes more general background context, prevalence estimates and commentary on methodology.

The rate of diabetes is increasing rapidly in society at large, meaning that we frequently find that actual identified rates exceed predictions. The predicted prevalence of diabetes based on age-specific prevalence data and the current age profile of residents at HMP Parc is 53 men (3.2% of the population). We found 77 residents identified (4.7% with a read-coded diagnosis

[35] Diabetes.org (N.D.) Diabetes in Wales. [Accessed 18/12/20].

on SystmOne) and 74 residents with a current indication of being treated for the condition (4.6% on the QOF register). Thus, rates in HMP Parc are above the predicted prevalence. Identified prevalence is also a little higher than the comparator average.

Figure 40 – Diabetes Prevalence Comparison (QOF data)



The average recorded prevalence of diabetes during October 2019 to September 2020 (prior to the covid-19 pandemic) was very similar to our November 2020 snapshot indicating that the diabetes prevalence in the prison is very stable.

Note that diabetes is linked with ethnicity and given that white males are overrepresented in HMP Parc against the prison estate average, we might anticipate seeing lower than 'expected' prevalence. Given this and the data above, we conclude that the likely need for diabetes is currently met.

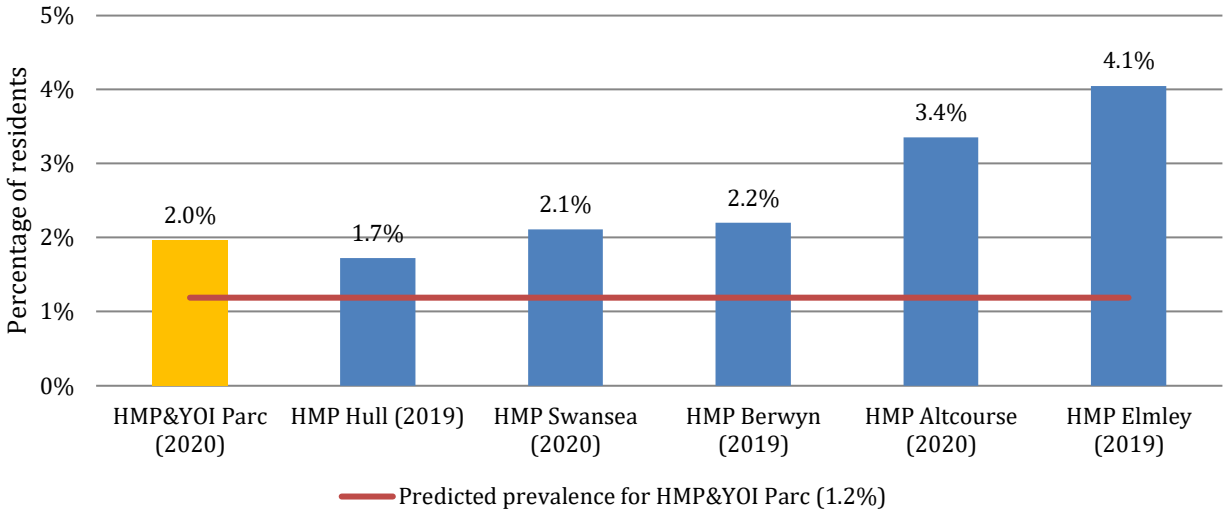
4.6 Epilepsy

Report Part B includes more general background context, prevalence estimates and commentary on methodology.

Identified rates of epilepsy are higher than the predicted prevalence, with 2.0% of the population (32 men) treated for epilepsy, compared to 1.2% (19 men) predicted. This is; however, a little lower than the average of 2.7% among comparator establishments.

The figures used refer to those on the QOF register as being prescribed medication for epilepsy and thus should only include cases that have been medically verified (and exclude those who are prescribed anti-seizure medication for unrelated conditions e.g. bi-polar).

Figure 41 – Epilepsy Prevalence Comparison (QOF data)



The identified prevalence of epilepsy appears to have remained consistent as a proportion of the population: between October 2019 and March 2020, an average of 2.1% of the population were on the epilepsy register (an average of 36 residents at any one time).

The need is therefore likely met.

4.7 Hypertension and Coronary Heart Disease (CHD)

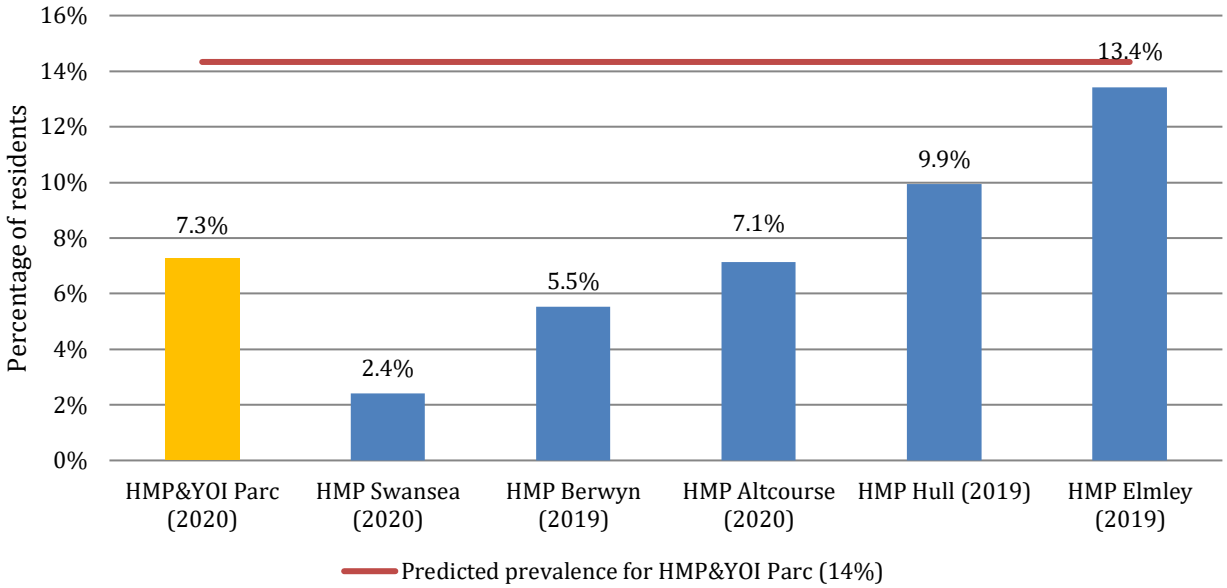
Report Part B includes more general background context, prevalence estimates and commentary on methodology.

The local context is that in the general population of Wales, the proportion of men over 16 years of age with high blood pressure was 20%.[36]

The identification rate for hypertension is below the expected prevalence based on the population age profile – we would expect 233 men with hypertension (14.3%), while only 121 (7.4%) had a SystmOne record indicating hypertension, and 118 (7.3%) were on the hypertension register indicating current treatment. This is; however, average among comparators. Historical data for October 2019 to March 2020 indicates that identification is typically a little lower than at snapshot, with an average of 6.7% of the population on the hypertension register during this time. As illustrated below, our observation is that under identification is common across all comparators, there is no clear explanation for why this is the case.

[36] StatsWales (N.D.) Illness by gender and year. [Accessed 18/12/20].

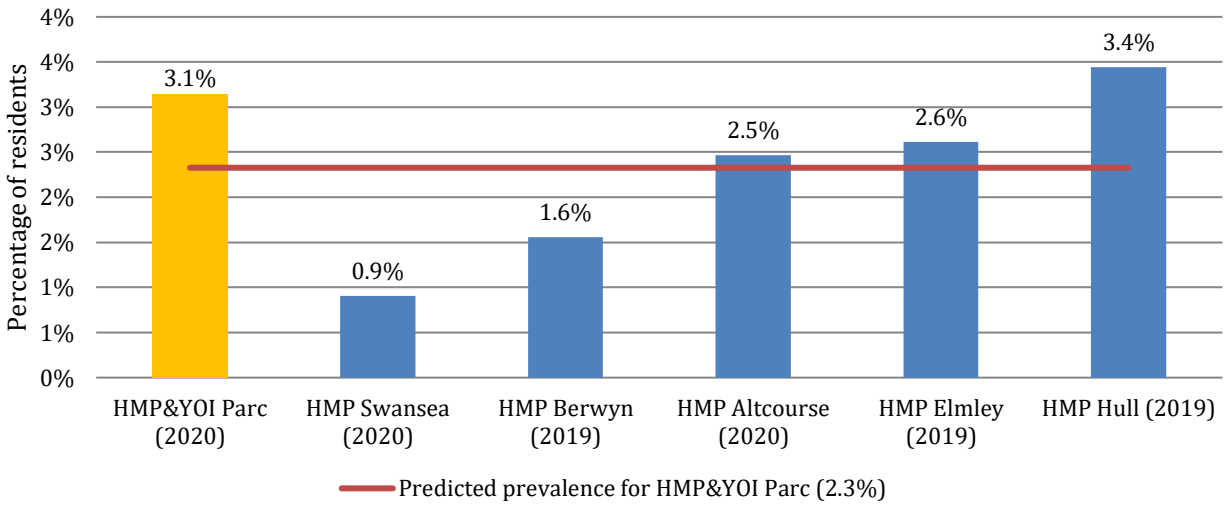
Figure 42 – Hypertension Prevalence Comparison (QOF data)



Identification for CHD is higher than expected with 3.2% (52 men) diagnosed and 3.1% (51 men) treated against a predicted rate of 2.3% (38 men). Identification was higher than almost all comparators. Historical data for October 2019 to March 2020 suggests that the rate of identification is typically lower, with an average of 42 residents (2.4%) on the register.

Data provided by healthcare showed an average of 119 residents on the hypertension register and five on the CHD register between January and September 2020. As illustrated below the rate of residents on the QOF register in HMP & YOI Parc is above comparator average.

Figure 43 – CHD Prevalence Comparison (QOF data)



At our November 2020 snapshot, 14 men were on the stroke and transient ischaemic attack (TIA) QOF register at HMP Parc. This likely reflects an unmet need.

4.8 Cancer

Report Part B includes more general background context, prevalence estimates and commentary on methodology.

As above, identification for cancer is lower than predicted rates with 0.3% (five men) of the population being treated and a rate of 0.7% (11 men) predicted. Data provided by healthcare showed a consistent five residents on the cancer register between January and September 2020, while pre-pandemic QOF data (October to March) showed an average of four.

Interviewees described how residents with cancer are managed, this includes utilisation of the palliative care facilities described below. The indication is that needs are met.

4.9 Management of LTCs

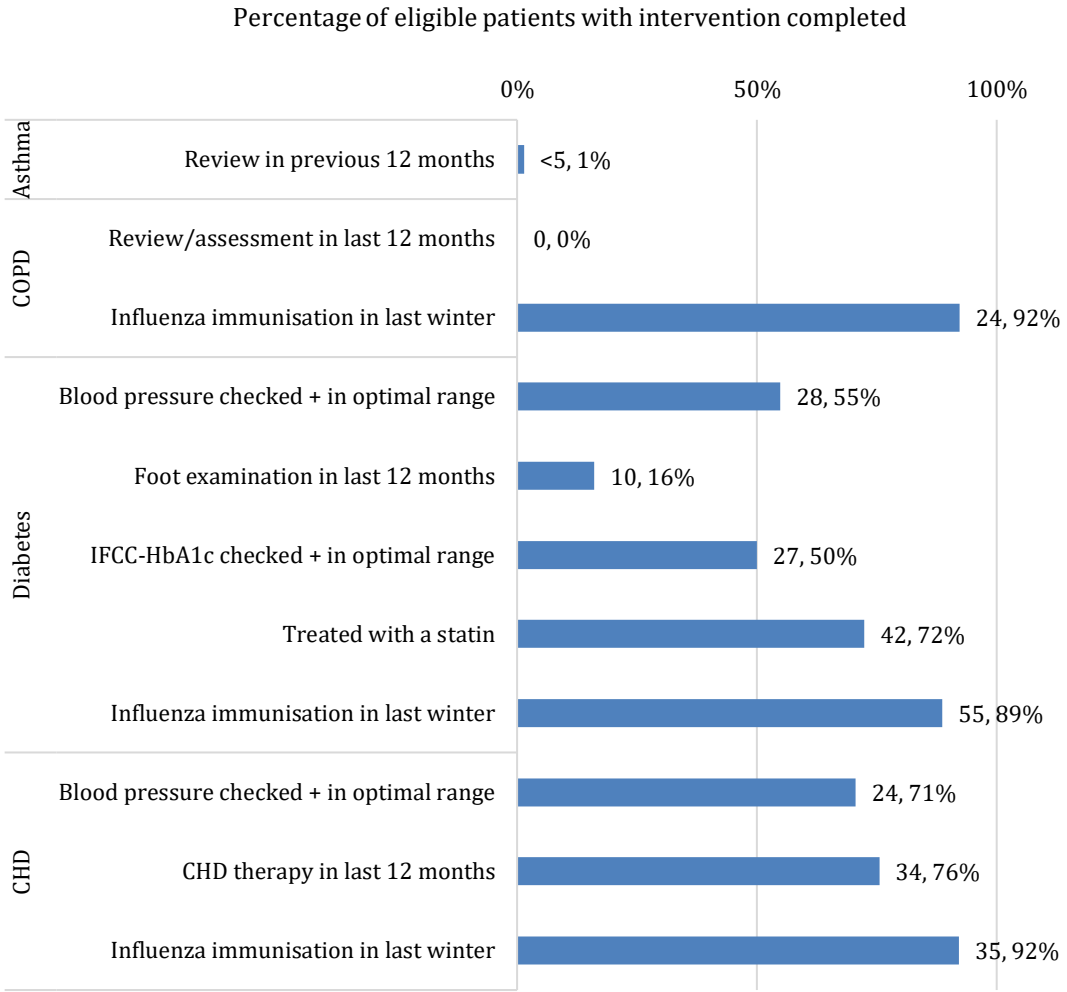
In the English community and more recently in most English prisons, the QOF is used as a driver for the management of long-term conditions. There is no such process in the Welsh community and therefore in Welsh prisons, without such a process, subsequent management of LTCs risks being ad hoc and unstructured. HMP Parc report that they are using QOF to inform LTC management, though the restrictions imposed by the pandemic have made this difficult. Currently much of the LTC monitoring is dependent of self-reporting during telephone consultations, interviewees expressed concern about the accuracy of this when they cannot actually see their patients. As described in Chapter Three, the current telephone situation is far from ideal.

The current response within HMP Parc should fall to the lead nurses who are the most experienced and senior nurses, two cover the main population and two cover the VP population, which is smaller but where, due to their ages, the prevalence rates are greater. The current arrangements are a little ad hoc and benefit from the special interests of individual nurses. For example, there is currently a nurse with a special interest in diabetes who subsequently take the lead for this condition. Likewise there are nurses with expertise in epilepsy and respiratory conditions. This appears to be a consequence of good fortune rather than the consequence of a systematic approach. With a large population and the numbers living with LTCs, as described earlier in this chapter, HMP Parc would benefit from a formal approach to ensuring expertise and a lead/champion for each of the major LTCs. Examples of the disadvantage of the current approach is noted above with the example of there being no nurse lead for spirometry, so this responsibility often falls to the GPs which is unnecessary. Some large prisons choose to have one LTC lead, our observation is that whilst this may work well on a good day it places all their eggs in one basket, leaving gaps during absence and a problem with continuity if and when the one champion moves on. This is why we suggest leads for each condition; however with this later approach there needs to be consideration regarding the management of co-morbid patients.

Recommendation Six – There should be a nurse lead for each LTC.

The chart below is based on the 'How Am I Driving' QOF report, which states the number of residents eligible for various interventions related to the management of health conditions (such as patient reviews, diabetic foot checks etc.) and then numbers for whom a record of these interventions exist on SystmOne. A selection of relevant indicators is shown for each condition. It should be noted that due to recent changes in QOF reporting nationally, interventions for asthma or COPD that took place prior to the changes (in September 2020) will not be shown, thus numbers of interventions shown for these conditions will be artificially low. In spite of the constraints imposed by the pandemic, all the other figures depict a reasonable percentage of eligible residents receiving the required interventions.

Figure 44 – Eligible Patients with LTC Management Interventions Completed (QOF data)



It should be noted that due to recent changes in QOF reporting nationally, interventions for asthma or COPD that took place prior to the changes (in September 2020) will not be shown, thus numbers of interventions shown for these conditions, in the chart above, will be artificially low.

The rate of diabetic foot checks is low; as noted, the podiatrist has not been visiting during the pandemic, nurses could be trained to conduct this activity.

Recommendation Seven – Train some nurses to undertake diabetic foot checks.

Interviewees said that retinal screening services visited annually, this is unusual, in most prisons, especially large ones, these services visit at least every six months. Given that some residents will arrive with a screen due, there is the likelihood that a number will have to wait well over a year for a screen. If the service visited every six months this risk would be significantly reduced.

Recommendation Eight – Increase the frequency of retinal screening service visits to be once every six months.

The rate of influenza vaccination is impressive.

4.10 End of Life Care

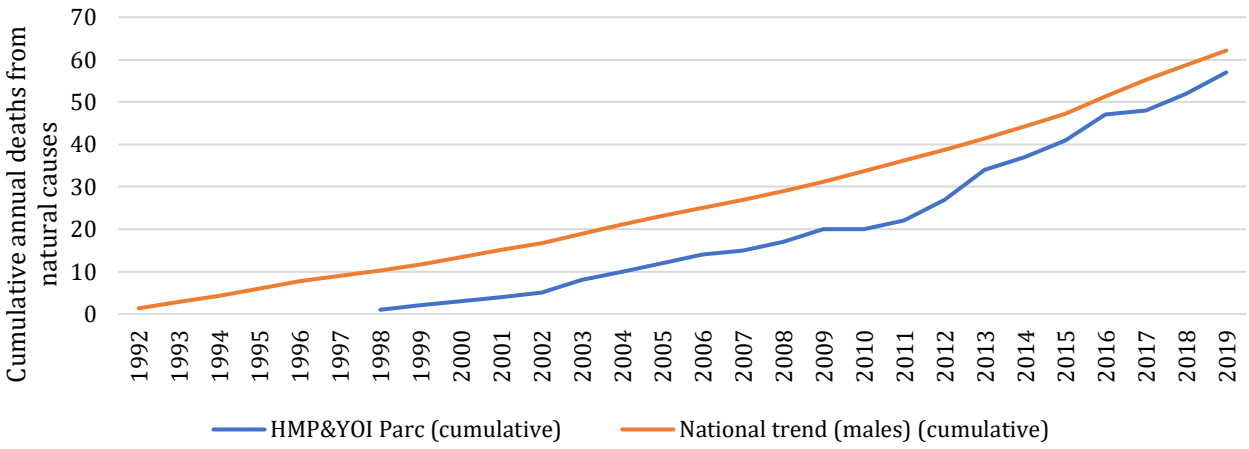
The prison has a palliative care bed, there were no records of any residents receiving palliative care at HMP Parc as of November 2020. Whilst historical QOF data indicates such residents are extremely rare, interviewees described how the suite has been used to care for residents in their last days. It was described how some residents have requested to return to the prison from outside hospital to spend their final days with peers they know.

There were reported to be good links with MacMillan nurses, examples of specialist input include supervising use of syringe drivers.

4.11 Deaths from Natural Causes

As can be seen in the chart below, the national trend is for an increasing number of deaths from natural causes (the national trend line describes the number of deaths that would have occurred in a population the size of the prison's op cap if HMP & YOI Parc followed the national trend). Note that although we would expect the younger age population in HMP & YOI Parc (compared to the national average) to contribute to a lower prevalence of deaths from natural causes there has been an increase in the number of deaths from natural causes at HMP & YOI Parc (shown by increases in the gradient of the cumulative total).

Figure 45 – Deaths from Natural Causes (cumulative 1992-2019)[37]



The Prison and Probation Ombudsman (PPO) reported four deaths from natural causes in HMP & YOI Parc since January 2019.

[37] MOJ (2019) Safety in custody quarterly. [Accessed 18/12/20].

Figure 46 – Natural Cause Deaths with PPO Report

Initials	Date deceased	Recommendations
FL	07/10/2019	None
DJ	25/08/2019	The Head of Healthcare should ensure that all new prisoners at HMP & YOI Parc have their history of serious health issues documented in the medical records on admission to prison. The Head of Healthcare should ensure that all existing prisoners at HMP & YOI Parc have their history of serious health issues documented in their medical records. The Head of Healthcare should ensure that immediate steps are taken to assess, monitor and improve knowledge among healthcare staff about GP referrals and when one is needed. The Head of Healthcare should ensure that healthcare staff review the circumstances surrounding [DJ's] case and ensure that there is a process in place to follow up referrals for CT scans and postponed appointments in a timely manner.
RE	05/02/2019	The Head of Healthcare should ensure that there is a system in place to identify and monitor blood tests that have been requested but not undertaken. The Head of Healthcare should ensure that the reception screening includes a recording of weight and that every time a weight recording is undertaken, it is documented clearly in the clinical record.
CM	01/01/2019	The Head of Healthcare should ensure that all prisoners with long-term conditions have clear, personalised care plans, with stated aims, planned interventions and regular monitoring. Care plans should be created when a condition first becomes apparent or on admission to prison if present then. The Head of Healthcare should ensure that there is a policy and process in place to make sure that all blood tests are actioned by clinical staff in a timely manner. The Head of Healthcare should ensure that clinical staff consistently use assessment tools, in particular the National Early Warning Score (NEWS) to ensure the appropriate and timely escalation of unwell patients. The Head of Healthcare should ensure that when an ambulance is called for an unwell prisoner, the prisoner has regular physical monitoring until the paramedics arrive.

The prison and healthcare teams reported one recent death whose cause has not yet been confirmed and one death due to natural causes. Deaths known not to be from natural causes are detailed elsewhere in this report.

Figure 47 – Deaths from Natural Causes awaiting PPO Reports

Date deceased	Presumed to be natural causes/not known
15/08/2020	Natural
26/10/2020	Natural
24/12/2020	Natural
25/12/2020	Natural
26/12/2020	Natural

Two of the men who died over the Christmas period were recorded as covid-19 related, they had received a positive covid-19 test within the preceding 28 days.

4.12 Chapter Summary

- Given the discussions earlier in the report relating to the deprivation profiles of the catchment areas for residents in HMP Parc, we would expect the prevalence of comorbidity and LTCs to be higher in HMP & YOI Parc that the overall predicted prison prevalence (which is based on England and Wales as a whole) and we would expect rates to be higher than comparator prisons. The current identified rate of co-morbidity is a little above average.

- QOF is used in HMP & YOI Parc to drive the management of long-term conditions. Unlike the system in England (both community and prison) this is not generally the case across the rest of provision in Wales.

- The identified prevalence of asthma amongst residents in HMP & YOI Parc (6%) is below what we typically see in comparator establishments. Whilst the rate of COPD (1.9%) is a little higher. The need of residents with respiratory conditions may be slightly under identified. Recent changes to QOF have not allowed for a review of the management of these two conditions.

- Identified prevalence of residents with diabetes (4.7% of population) is greater than expected and what is found in comparator prisons. The QOF rate of 4.6% illustrates appropriate management.

- Two per cent of residents are known to be treated for epilepsy within HMP & YOI Parc. Again, this is little greater than the predicted prevalence and in line with comparator establishments. The need of residents with epilepsy is likely met.

- The identified prevalence of hypertension is well below the predicted prevalence that we see in comparator establishments. Rates of CHD are above prediction and that seen in comparator prisons. The combined picture suggests that need is probably not identified or fully met.

- Due to very low numbers which can fluctuate very quickly, it is inappropriate to compare prevalence of cancer (0.3% of currently HMP & YOI Parc population) with expected and comparator prevalence. There were no men on the palliative care register at the time of our HSCNA. It does appear that healthcare is able to meet the need and demand when it arises.

- The prison benefits from a palliative care suite.

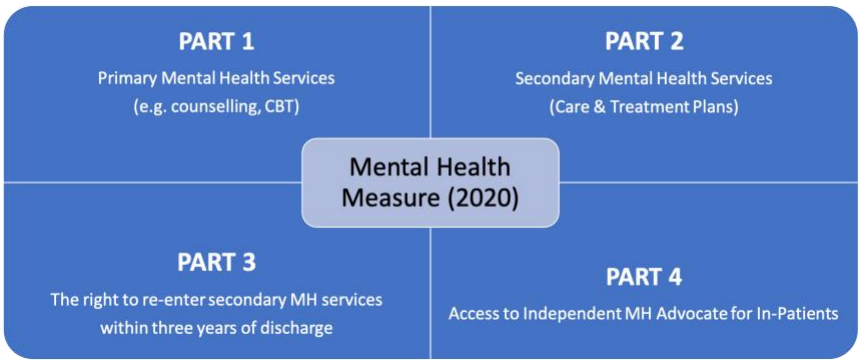
- There is a lower prevalence of deaths from natural causes in HMP & YOI Parc than the national average. This is to be expected given that HMP & YOI Parc has a younger age profile than the national average.

Chapter Five – Mental Health

5.1 Service Provision

All mental health service provision in Wales, including in the secure estate, comes under the MHM which is in four parts:

Figure 48 – Mental Health Measure (Wales)



5.1.1 Primary Mental Health Provision

The primary mental health team works with residents under Part 1 of the MHM. The team in HMP Parc consists of eleven whole time equivalent posts as follows (noting the numbers were described differently by different interviewees and there are a number of posts going through vetting):

- 2 x Lead RMNs
- 4 x RMNs who cover crisis work (Inc. the Safer Custody unit)
- 5 x RMNs who cover the main population

As noted elsewhere a number of staff are assigned to specialist roles so on the day of interview there was one RMN on duty in the core team and one in the crisis team, between them covering the whole of the general population.

The workload of the team is reported to be very high, with staff working under increasingly intense pressure, which in turn has led to a high turnover of staff.

As a result of the lack of capacity there is little provision in the way of any therapeutic interventions; the work is generally doing assessments and referring to other services, with only a minimal number of residents receiving interventions by the primary mental health team itself. The first line response is pharmacological (prescribing).

> *"The primary mental health service focus on medicines and assessments, we have no time for interventions there is no psychologist and no IAPT." (Mental Health Nurse)*

> *"As a consequence of childhood trauma and ADHD, our greatest need is for psychological therapies and counselling, without these our only option is medication." (GP)*

Need was described as having doubled so for example there were 70 appointments in February prior to the pandemic and 140 in October.

> *"Waits are longer and there are less staff." (Mental Health Nurse)*

There are no psychological wellbeing type services. The only counselling provision is a service run by New Pathways and overseen by the substance misuse service. One day per week is allocated to bereavement counselling and two days to substance misuse. This is reported as the default option; however, there are long waiting lists and priority is given to clients with substance misuse problems.

Prior to the onset of covid-19 the team ran groups and there was a group work pathway. There were depression, anxiety, sleep and trauma groups. During the pandemic group work has obviously ceased.

> *"Groups were really effective we were able to see more people." (Mental Health Nurse)*

Recommendation Nine – The primary mental health provision needs an alternative to medication. It should include talking therapies – we recommend psychological wellbeing practitioners skilled in interventions such as cognitive behavioural therapy (CBT).

Noting the rate of trauma described below, there needs to be greater access to trauma informed therapies.

Recommendation Ten – There needs to be trauma informed interventions. We suggest eye movement desensitisation and reprocessing (EMDR).

Psychological therapies described above should fall under the supervision of a clinical psychologist.

There is currently no psychiatrist or clinical psychology input for residents under Part 1 of the MHM. This limits capacity for diagnosis and impacts on opportunity to initiate new pharmacological interventions. Diagnosis is especially important for release planning; services in the community will be more ready to accept referrals for those with diagnosis than for those with traits of a condition.

Recommendation Eleven – There needs to be both clinical psychologist and psychiatrist input for residents under Part 1 of the MHM. (Both may only need to be quite limited.)

During the pandemic the GPs report seeing a massive increase in mental health presentations.

5.1.2 Secondary Mental Health Provision

The most recent HMIP report includes the stark statement:

> *The team was under-resourced, and also covered another prison. There were insufficient psychiatry sessions, and there was a lack of provision for patients with attention-deficit hyperactivity disorder and older adults, with no occupational therapist, minimal psychology input and no dual diagnosis pathway (for those with co-existing mental health and substance misuse problems.*[38]

[38] HMIP (2020) Report of an unannounced inspection of HMP Parc by HM Chief Inspector of Prisons 11-22 November 2019. [Accessed 11/2/21].

Secondary care is provided by the mental health in-reach team (MHIRT) and delivered by Swansea Bay Health Board (SBUHB). The MHIRT also provides cover for HMP Swansea thus the resources illustrated below are shared across both prisons.

Figure 49 – Mental Health Team Staffing HMP Parc (in-reach team)

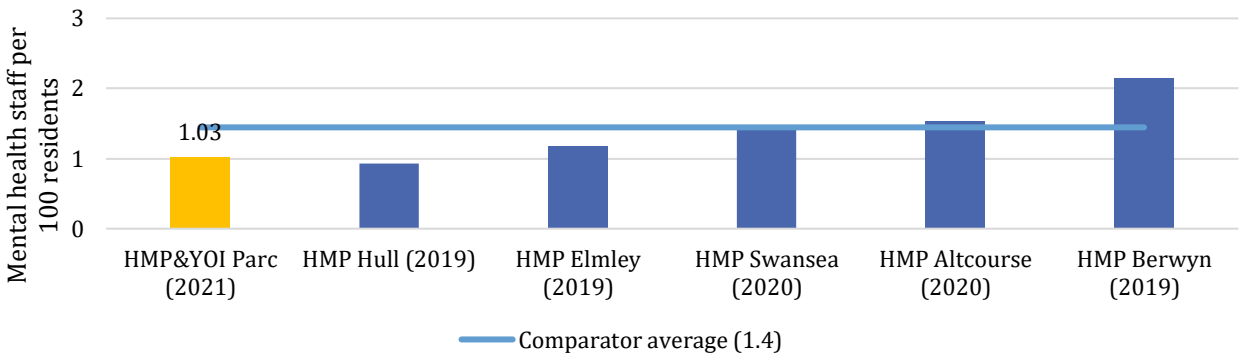
Role	Band	Full-time equivalents	Comments
Team Manager/Practitioner	Band 7	1 FTE	
In-reach Community Psychiatric Nurse (CPN)	Band 6	4.6 FTE	
Occupational Therapist	Band 6	1 FTE	Being interviewed end Jan.
Forensic Psychologist	Band 7/8a	0.4 (15 hrs)	Started in post.
Consultant Psychiatrist	As below	5 sessions a week specifically for PARC	Don't have permanent psychiatrist for Parc . Were 3 sessions per week now being increased to 5 sessions a week specifically for Parc.
Support Worker	Band 3	0.6	Newly developing post.

There was reported to be a good working relationship between the primary mental health team and the in-reach team.

Since the onset of covid-19 the in-reach team were described as pulling away from the prison. Assessments stopped and support has been remote, note that whilst this may mirror practice in many parts of the community, residents have very limited access to telephones and video conferencing.

The chart below illustrates the combined mental health staffing available for HMP Parc per 100 men against comparator prisons. Note that because the in-reach team is split across both prisons, we have assumed a notional split of 77% HMP Parc and 23% HMP Swansea which is the direct correlation of the population size proportion.[39]

Figure 50 – Combined Mental Health Staffing Comparison



The report repeats the recommendation previously made elsewhere:

Recommendation Twelve – There needs to be a review of resourcing, with a view to substantially increasing the resourcing of services for those receiving care under Part 2 of the MHM.

[39] Based on the population size of each prison prior to the impact of covid-19; December 2019 op caps of 1,699 (HMP & YOI Parc) and 497 (HMP & YOI Parc) as reported in MOJ (2020) Prison population monthly bulletin December 2019. [Accessed 18/12/20].

Recommendation Thirteen – Services for those receiving care under Part 2 of the MHM should be based in the prison, rather than reaching in.

Integrated mental health provision is seen in many prisons whereby primary and secondary care have, over time, either partially integrated by merging closer together or fully integrated under one umbrella. We acknowledge that there is a separation between Part 1 and Part 2 of the MHM but are concerned that too many residents are falling between services (see examples under ADHD and older person's Mental Health).

A partial integration can include a common referral pathway whereby referrers including residents and prison officers submit all concerns to one joint inbox. These referrals should be reviewed daily for any urgent cases or can all be triaged by the primary mental health nurse from the Primary Care Crisis Team. The cases are taken to a weekly multidisciplinary allocations meeting to decide who should work with the resident. If the resident's needs change they can be taken back to the allocations meeting for review. In some settings the Multi-Disciplinary Team meeting may also involve the substance misuse service.

Recommendation Fourteen – Services for those who fall under Part 1 and Part 2 of the MHM should be integrated.

As previously noted, in addition to need, there is system generated demand; for example, the in-reach team noted an increase in the demand for parole reports.

5.1.3 Trauma Therapy

Separately contracted by the prison and independent from both of the above, there is a three day per week input from, Forensic Psychology Consultancy UK an independent forensic psychology provider reporting to offender management. Their primary function was to assist in reports for parole, their input has expanded such that it is now:

- One day one to one input, writing reports for parole and working with residents identified as experiencing the effects of trauma.
- One day per week training and input for the prison on trauma informed approaches.
- One day per week input into safer custody and high risk area, including participation in the high risk area meeting. Some targeted work aiming to stabilise residents who are experiencing the effects of trauma using a programme called feeling safe.

This work is separate to other mental health services and no interviewees from either primary or inreach teams made any reference to referring to it.

5.1.4 Service Access

At our snapshot in November 2020, the reported waiting time for a mental health nurse appointment was five working days according to SystmOne waiting list and appointment data. This has reported to have increased since the data was collected with waiting time now being much longer.

DNA rates for nurse-led mental health clinics increased during the covid-19 pandemic (from 5% DNA during October 2019 to March 2020 to 10% in May to October); however, the

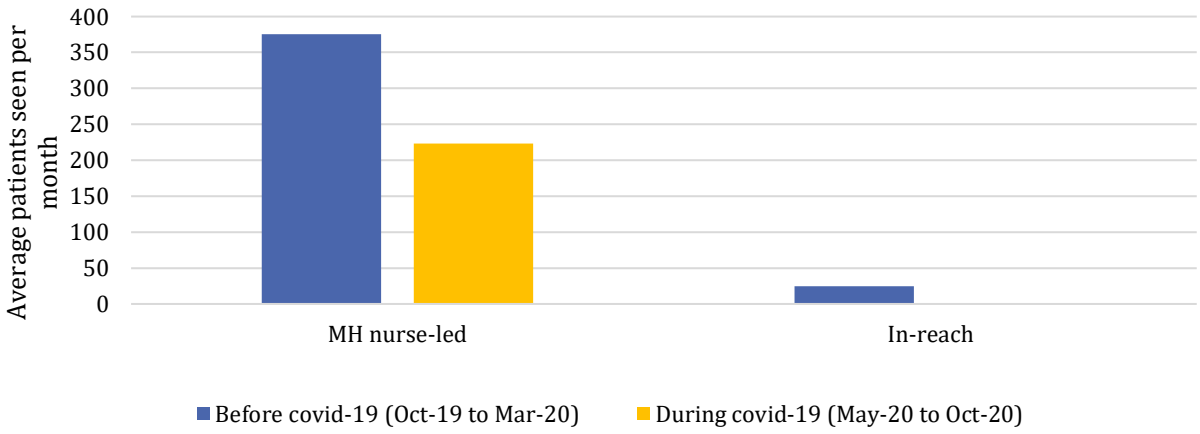
numbers of booked appointments also reduced during this time. The numbers of appointments booked for in-reach also dropped dramatically (as illustrated in Figure 51 below), and with relatively small numbers of residents, the DNA rate increased from 43% to 57%.

In our resident survey, 74% of respondents said they knew how to access mental health services. This is higher than the average of 78% across five comparators. However, some of the free text responses in our resident survey suggests that while prisoners know how to access the service, this does not mean they are getting help:

> *"My mental health is all over the place and nobody seems to care."*
>
> *"I have asked and asked for the mental health team to come and see me but they haven't. Really bad service."*
>
> *"I waited nine months for a mental health appointment it is resolved now."*
>
> *"Mental health are terrible they never get back to you."*
>
> *"Mental health is or seems to be a lottery very bad service."*
>
> *"I'm suffering with mental health and finding it really hard to speak to somebody from mental health they made me phone appointment but when I ring nobody answers the phone."*
>
> *"Keep on being told to put apps in even though I just wish to get help before it's too late. i.e. I end killing myself. I've been neglected since I was seven. I just want help."*
>
> *"I've got mental health issues which I don't get any help with even though I keep asking."*

For some mental health clinics, the average numbers of appointments in the last six months have decreased compared to a six-month period (October to March) before the covid-19 pandemic.

Figure 51 – Patients Seen per Month in Clinics Before and During Covid-19 (SystmOne appt. data)



Currently referrals are via a Threshold Assessment Grid (TAG) referral system on the CMS system which includes seven domains for mental health generating a score which leads to the idea of low medium or high risk.

> *"We have got a problem whereby prisoners know how to manipulate the system and answer questions to ensure they are 'high risk' so the TAG has not really worked." (Mental Health Nurse)*

Initially during the pandemic CMS stopped and the team moved to paper-based referrals. At that point mental health were able to do a questionnaire which had the advantage of being longer and allowing residents to make more considered responses. They have now returned to CMS.

The team are doing a lot of telephone consultation; however, as noted elsewhere there is a huge shortage of telephones and the team cannot ring the residents; residents have to ring them. At present the primary mental health team only have access to two telephone lines which they have to share, further restricting the ability to offer a comprehensive service. There is an earlier recommendation for more telephones and especially more 'white phones'. Throughout the pandemic the in-reach team have not been visiting and, instead, offering telephone support.

5.2 Prevalence

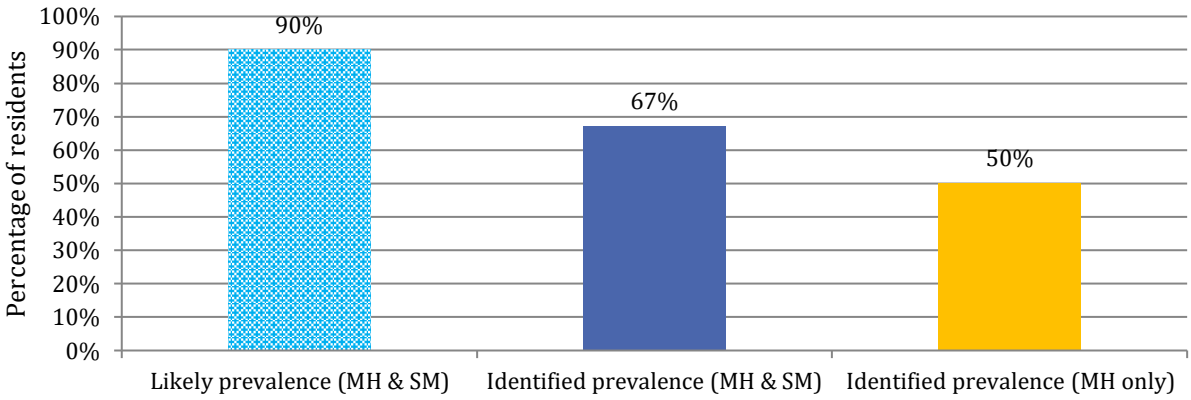
Prevalence estimates from research show 90% of residents in the secure estate have some mental health problem (including substance misuse).[40] It should be noted that although this study is almost two decades old, it remains the most relevant prevalence study, conducted in all the (then) 131 prisons.

HMIP noted of HMP Parc:

> *more prisoners than at similar prisons saying that they had been depressed, ... or had other mental health problems.*[41]

The chart below shows this in the context of actual identified prevalence in HMP Parc. When diagnoses including substance misuse are excluded, 50% of residents in HMP Parc are identified with mental health issues.

Figure 52 – Expected and Actual Mental Health Prevalence (including substance misuse)



Of the 815 residents (50% of the population) who had a mental health condition recorded on SystmOne, 556 (68% of these) had at least one of their diagnoses recorded at HMP & YOI Parc, while the other 259 had their identified condition/s recorded at another establishment.

HMIP stated that

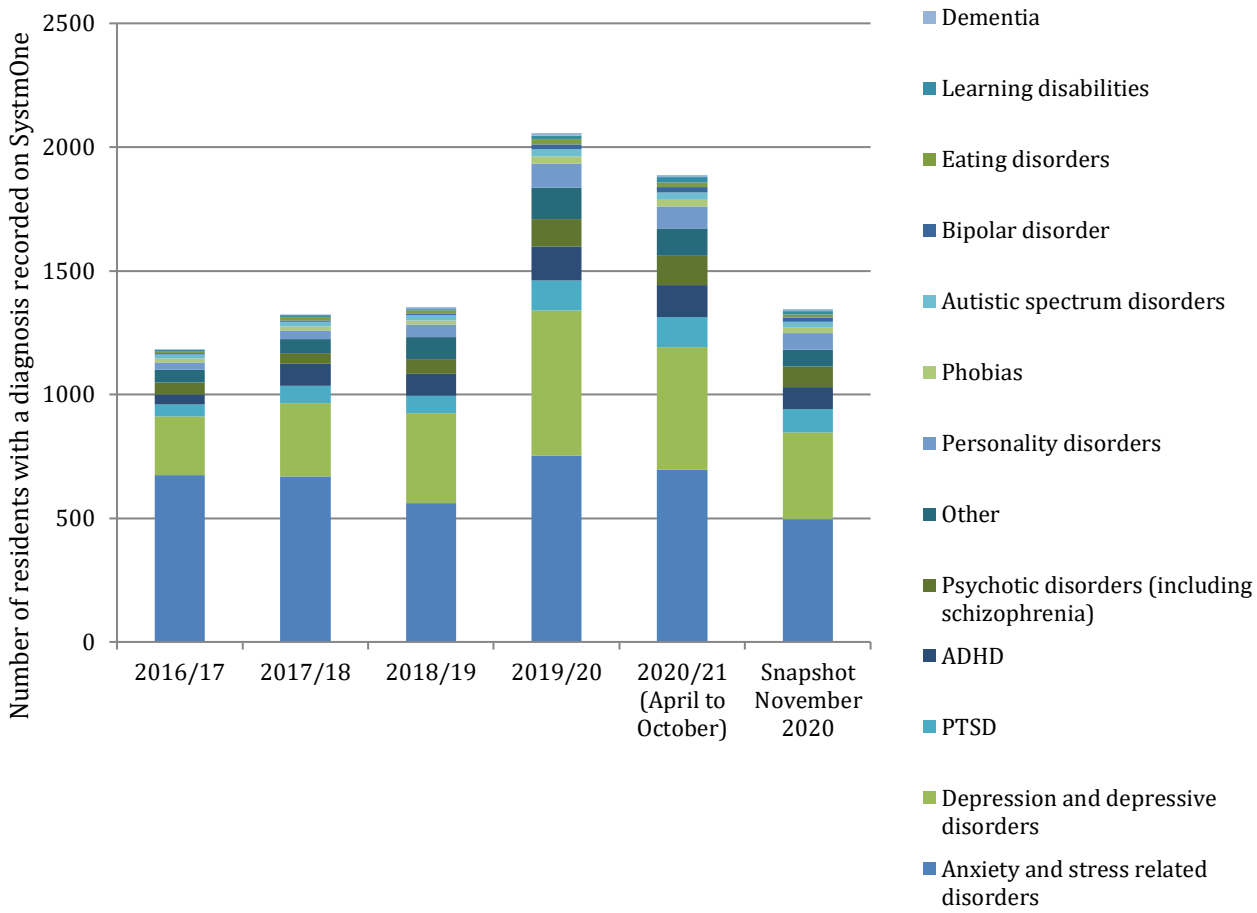
[40] Singleton, N. *et al.* (1998) Psychiatric morbidity among residents in England and Wales. [Accessed 18/12/20].

[41] HMIP (2020) Report of an unannounced inspection of HMP Parc by HM Chief Inspector of Prisons 11-22 November 2019. [Accessed 11/2/21].

In our survey, 52% of respondents said that they had a mental health problem, yet only 23% said that they had received help with this (compared with 41% at similar prisons).[42]

The chart below shows the number of residents recorded on SystmOne as being diagnosed with various mental health conditions during recent years and at a current snapshot. Note that one resident may be diagnosed with multiple conditions.

Figure 53 – Recorded Mental Health Diagnoses (SystmOne data)



This indicates the numbers of recorded diagnoses have increased each year (noting that 2020/21 is an incomplete year), with depression and anxiety being the most commonly diagnosed conditions.

This is a unique time, as the months of restrictions continue the impact of the pandemic on prisoners' mental health is building:

The most disturbing effect of the restrictions was the decline in prisoners' emotional, psychological and physical well-being. They were chronically bored and exhausted by spending hours locked in their cells. They described being drained, depleted, lacking in purpose and sometimes resigned to their situation.[43]

Using prevalence estimates for individual conditions (from the same research study[44]), we provide a further breakdown of common mental health conditions below. For individual

[42] HMIP (2020) Report of an unannounced inspection of HMP Parc by HM Chief Inspector of Prisons 11-22 November 2019. [Accessed 11/2/21].

[43] HMIP (2021) What Happens to prisoners in a pandemic?. [Accessed 22/2/2021].

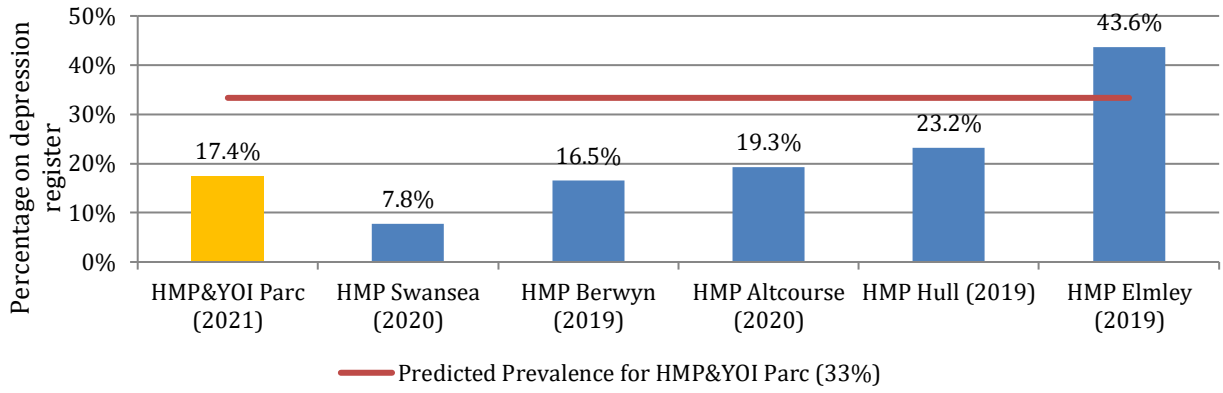
[44] Singleton, N. *et al.* (1998) Psychiatric morbidity among residents in England and Wales. [Accessed 18/12/20].

conditions, we have estimated the likely prevalence based on the sentencing characteristics of the prison's population, since remand and sentenced residents are known to have differing prevalence rates for many mental health conditions.[45] The key message across all the following sections are that there is significant under-identification of almost all likely recorded mental health conditions.

5.2.1 Depression

Although use of QOF registers for condition management is not compulsory in Wales, it was reported that these are used to keep track of patients. At the time of our snapshot in November 2020, 17.4% of residents (n=282) were shown as being on the QOF register as receiving current treatment for depression (compared to 21.5% with recorded read codes indicating depression on SystmOne – this slight disparity is normal). As can be seen in the chart below, the proportion of the population on the QOF register is below the predicted rate of depression, and also below average next to comparator prisons (the average across comparators was 22%).

Figure 54 – Depression Prevalence Based on QOF Register



Past QOF data indicates that the rate of identified depression at the time of our snapshot is likely lower than is typical; the average proportion of the population on the QOF register during a pre-pandemic six-month period (October 2019 to March 2020) was 15%, similar to that at the time of our snapshot.

Stakeholders reported, during interviews, that there is use of diagnostic screening tools such as patient health assessment questionnaire 9 for depression (PHQ 9) to support diagnosis of depression and monitor change over time. Referrals are then made to the GP for prescribing, where needed.

Given some feedback from residents during our consultation it is likely that the seemingly low prevalence rate may be accounted for by those who do not make it as far as getting to the mental health service, thus service access appears to be problematic. One prisoner stated:

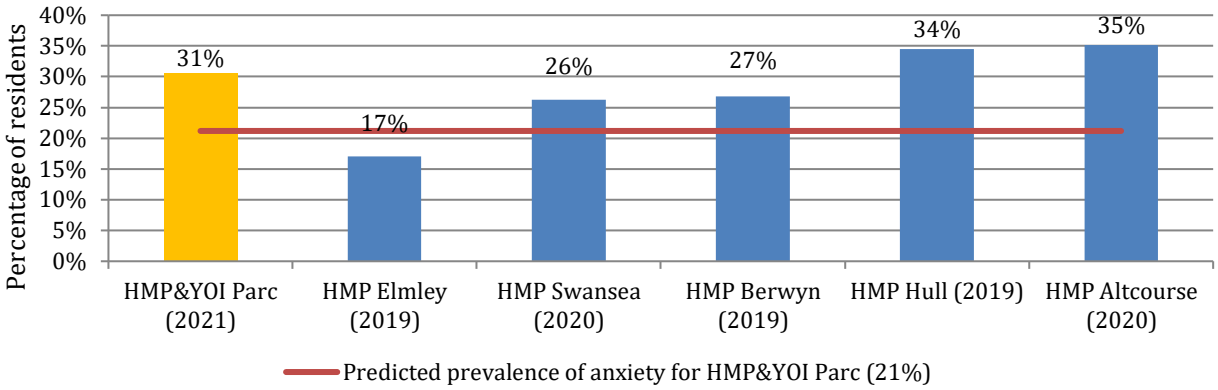
"I think it would be good if there was someone to ask you in private if you need help every day."

[45] Note that while YOIs also have different likely prevalence of mental health conditions, the numbers are very low and this has not been taken into account when estimating prevalence.

5.2.2 Anxiety

The numbers of residents identified with anxiety and stress-related disorders are higher than expected at HMP Parc (497 residents, or 31%, compared to 21% expected). This is not unusual among similar prisons. However, the rate of identified anxiety is also a little higher than the average of 28% among comparator prisons.

Figure 55 – Identified Prevalence of Anxiety (SystmOne data)



The team are using GAD7 (generalised anxiety disorder 7 assessment tool) to identify anxiety.

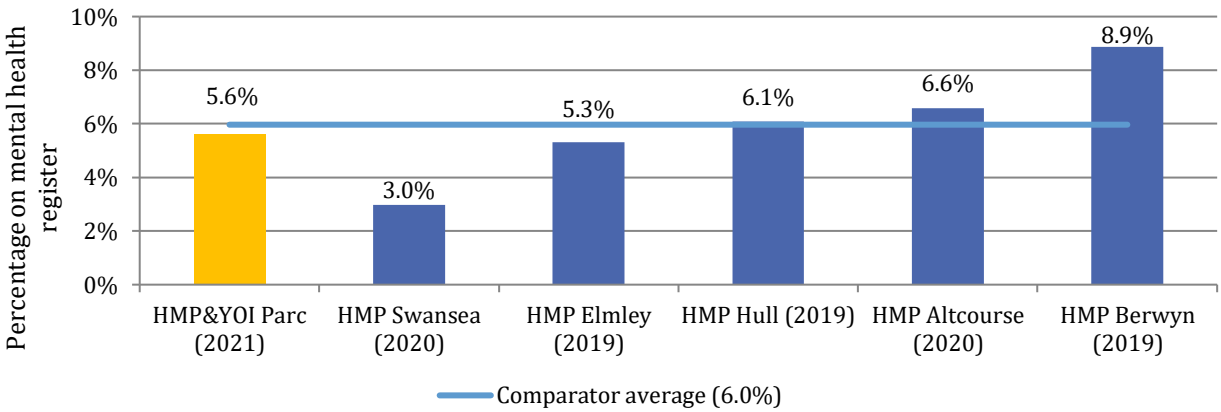
During the pandemic the team have been doing work with Prison Parc Radio to do shows on anxiety, mental health matters, in cell exercises and so on.

5.2.3 Severe and Enduring Mental Health Issues

QOF data reported that 5.6% of the population (n=91) were identified as having severe and enduring mental health problems (including schizophrenia, bipolar affective disorder or other psychoses). This is about average next to comparator prisons.

The average identified prevalence during an earlier six-month period (October 2019 to March 2020) was 4.4%, a little lower than at the time of our snapshot.

Figure 56 – Severe and Enduring Mental Health Prevalence Based on QOF Register

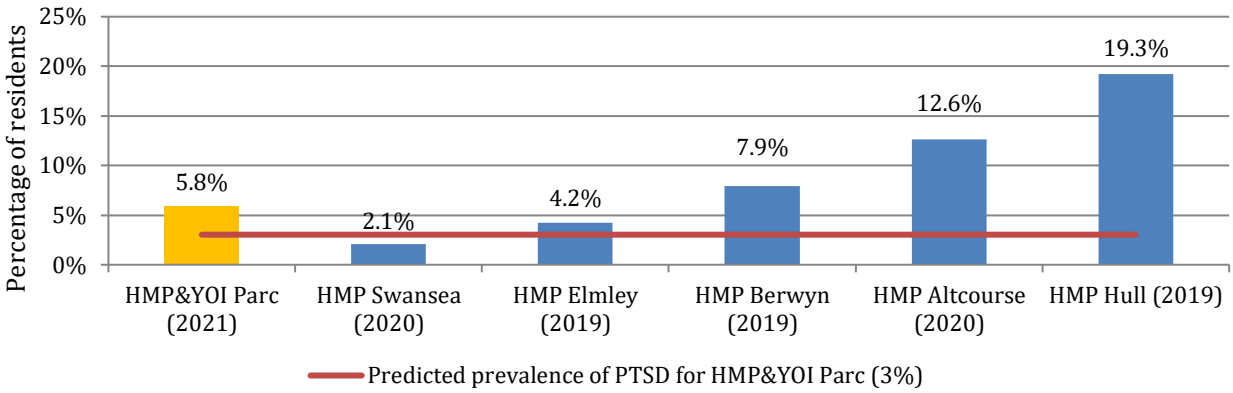


The points made above in the section on psychotic disorders also apply here, not least as the populations overlap. We conclude that need is being identified, the pathways are there, but the meeting of need is partially undermined by staff shortages and may continue to be.

5.2.4 Post-Traumatic Stress Disorders (PTSD)

The rate of residents with a recorded diagnosis of PTSD is higher than predicted, with 95 residents, or 5.8% identified (compared to 3.0% predicted). However, this was still low compared to the average of 9.2% among comparators).

Figure 57 – Rate of Identified PTSD (SystmOne data)

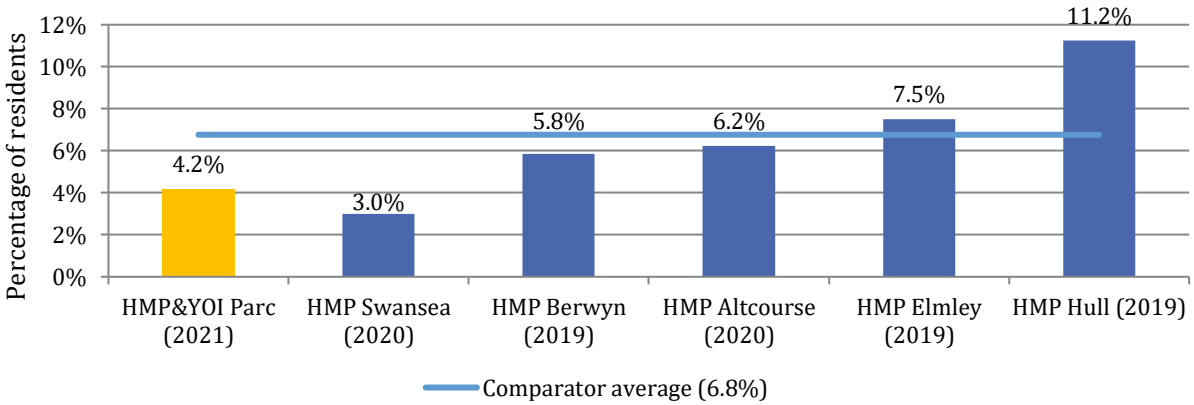


There has been a lot of work on Adverse Childhood Experiences (ACEs) in Wales, this has resulted in an awareness of the impact of trauma in adults. See previous recommendation for trauma informed therapies.

5.2.5 Personality Disorders

Research suggests that we might expect around 64% of the population of HMP Parc to have a personality disorder. However, it should be noted that the predictions include a wide range of personality disorders (including anti-social personality disorder which could include criminal behaviour), whereas those identified in HMP Parc (68 residents or 4.2%) will have a formal diagnosis. Whilst the rate of identification at comparators is also lower than the predictions, the rate at HMP Parc is below the average of 6.8% among comparator prisons.

Figure 58 – Rate of Identified Personality Disorder (SystmOne data)



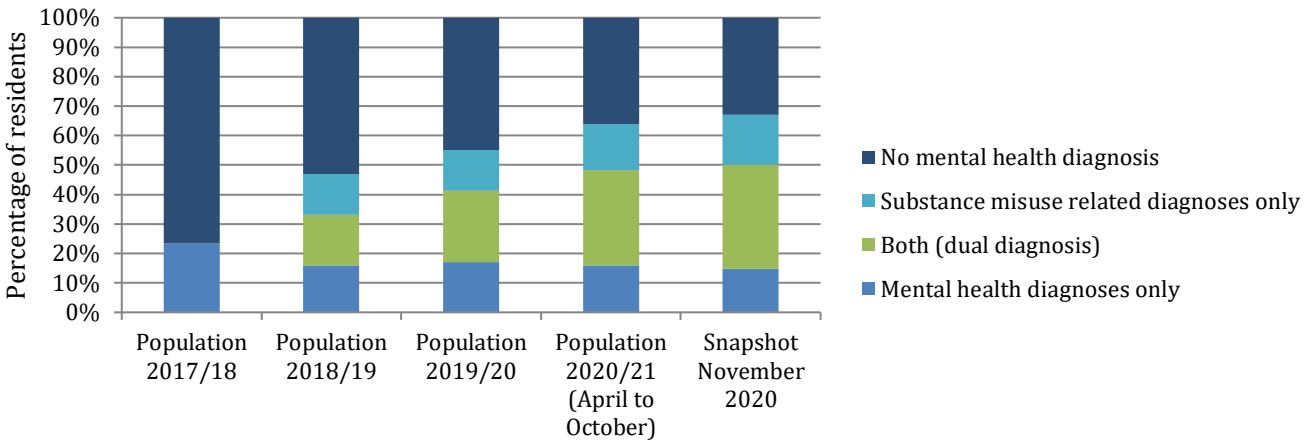
The in-reach team do not work with personality disorder, so this presents a gap in provision.

Recommendation Fifteen – There needs to be a service for residents with a personality disorder.

5.2.6 Dual Diagnosis

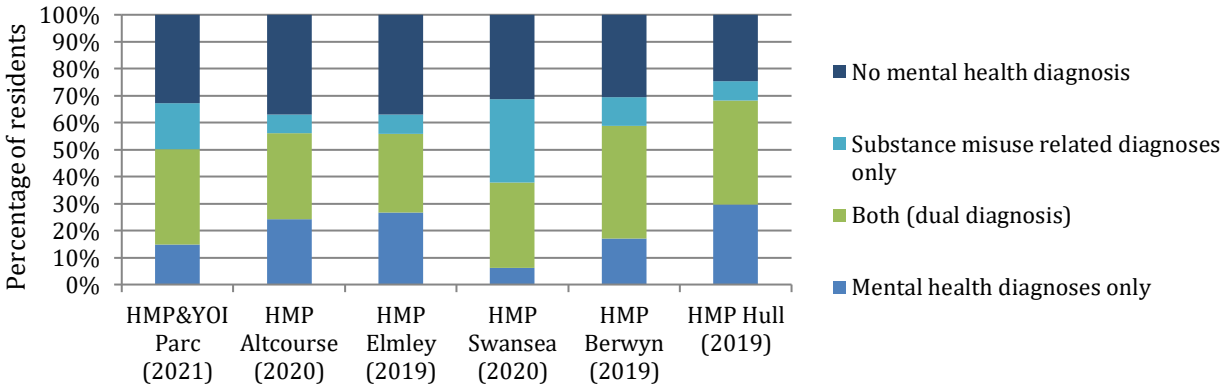
The chart below shows the proportion of the population recorded on SystmOne as having mental health and/or substance misuse problems over the past few years. This shows that the identification rate has increased rapidly, with most of the change being in greater identification of dual diagnosis (concurrent mental health and substance misuse problems). This is likely to have been impacted on by improvements in recording as well as identification.

Figure 59 – Mental Health and Dual Diagnosis Prevalence Over Time



Though the recorded prevalence of mental health problems overall (including substance misuse) is now average at HMP Parc next to comparators, the profile of identified conditions seems to be more skewed towards substance misuse disorders than most:

Figure 60 – Mental Health Diagnosis Comparison (SystmOne data)



Section 7.3.2 describes how dual diagnosis can describe those with any mental health issues who also use substances or can just describe residents who fall under Part 2 of the MHM and are drug or alcohol dependent. The section explores a range of options.

There is one dual diagnosis nurse within the team, given the numbers described above, it is not surprising that this was reported to be insufficient to meet current demand.

"There is enough work here for at least two dual diagnosis post." (Mental health lead Nurse)

5.2.7 Older Person's Mental Health Including Dementia

The IMB previously described the lack of mental health provision for older residents as *'a major concern'*.[46]

Interviewees noted that just a few years ago there were very few elderly prisoners but the number has grown rapidly. For example, the prison now accommodates residents who are in the early stages of dementia when they are sentenced. Whilst the individual needs may be great, because the numbers are low, the data does not illustrate this. Adult social care said that addressing older person's mental health needs was a problem at both primary and secondary levels, neither service is set up to address their needs. Access had been negotiated to an older persons psychiatrist within the hospital; however, this was rarely used as the specialist psychiatrist would not usually come into the establishment and would refer people into the community-based memory clinic which would require hospital escorts (already under pressure) to facilitate.

QOF data from SystmOne indicates that, in January 2021, seven residents (0.5% of population) had a recorded diagnosis of dementia. As is the case for most other conditions, stakeholders, when interviewed, felt that the need was far higher than this, due to undiagnosed conditions.

> *"There are many men that come in here that have not engaged with their GP or any community services for many years." (Mental Health Lead Nurse)*

The current process is that the primary mental health team refer residents with dementia to the in-reach team who report that they are funded and set up to work with working age adults only.

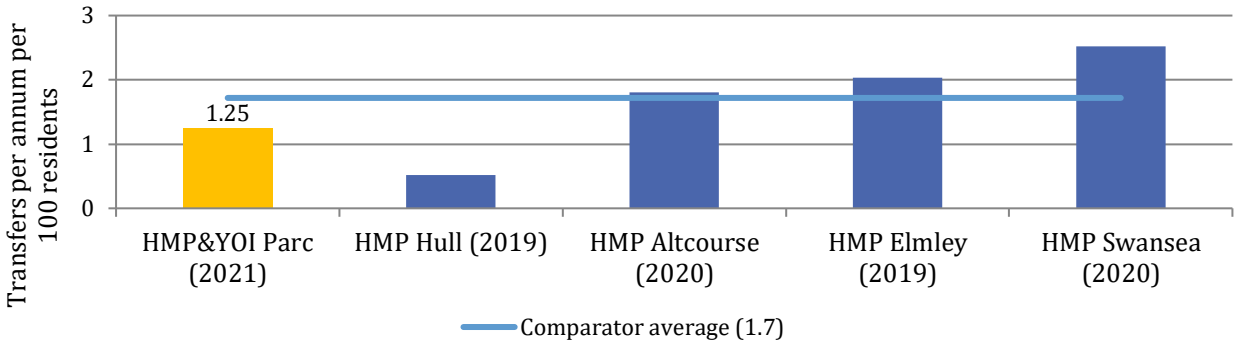
It was reported that in an attempt to better meet the needs of older residents, plans had been made to start a new dementia service within the prison; however, this was halted due to the covid-19 pandemic. Any dementia service will need to sit within a wider older persons' mental health pathway.

Recommendation Sixteen – An older person's mental health pathway (which includes a response for dementia) should be reviewed to ensure (a) that there is appropriate recognition of need (b) that 'in house' support is available to support cognitive functioning and (c) that there is access to an Older Persons Specialist from the community service where needed.

5.3 Mental Health Act Transfers

Healthcare reported 23 residents put forward for transfer under the Mental Health Act (MHA) during the past 13 months (January 2020 to January 2021). This indicates a below average annual rate of residents compared to similar prisons.

[46] IMB (2019) Annual Report of the Independent Monitoring Board at HMP & YOI Parc for the reporting year 1 March 2018 to 28 February 2019. [Accessed 11/2/21].



More than half of residents who had been transferred (n=11) had been transferred within four weeks. None were reported to have waited longer than nine weeks; however, four residents were still waiting at the time of writing. The average wait at comparator prisons was 32 days.

It was noted in interviews that, since the onset of the covid-19 pandemic, MHA transfers are taking far longer than usual, due to the national shortage of Psychiatric Intensive Care (PICU) and low-secure beds which now have further reduced capacity.

Residents awaiting transfer under the MHA are generally housed within the Safer Custody Unit. Of the 14 residents in the Safer Custody unit in February 2021, 12 were under the care of the in-reach team.

> *"The Safer Custody Unit used to be for people who were deemed vulnerable, such as men in debt who were afraid and would be in Safer Custody as a temporary place of safety. Now the number of men who are very unwell and are awaiting transfer to a hospital is huge." (Mental Health Nurse)*

Stakeholders reported that Safer Custody is frequently seen as a place of safety, which it is not under the definition that would be used in the MHM.

There is a waiting list for the Safer Custody Unit due to the increasing demand. A risk-based approach is used for allocation within the unit.

> *"Psychosis, from drug abuse seems to have become more 'normal' since the covid pandemic and we are seeing a lot more men in Safer Custody with this." (Mental Health Nurse)*

There are current discussions ongoing about making some modifications to the Safer Custody Unit to become more therapeutically appealing (sensory spaces, calming colours etc.).

It should be noted that under Part 4 of the MHM, residents should have access to an independent mental health advocate when in in-patient settings. Whilst residents in HMP Parc are not classed as 'in-patients' from the point they are awaiting a transfer, they are arguably eligible for such advocacy under this MHM, though some interviewees questioned if this role is covered by the wider brief of IMB.

5.4 Chapter Summary

- There is very limited primary mental health provision to serve residents with needs under Part 1 of the MHM. Prior to the pandemic there was limited group work provision, this is currently suspended. There is no psychological wellbeing provision. There is just one counsellor for the whole prison (part of Chaplaincy). The first line response is prescribing. **See Recommendations.**

- The in-reach team serve the needs of those who fall under Part 2 of the MHM. As has been previously reported, this is also a poorly resourced and over stretched area of service. The service has been delivered remotely throughout the pandemic. **See Recommendations**.

- Interviewees identified unmet needs. There are frequently not the required competencies to formally diagnose residents who fall under Part 1, this is particularly a problem when release planning. Certain medication is licenced for GP continued prescribing but not initiation, residents cannot receive some medications. These and other issues indicate that an integrated response would be a useful development. **See Recommendation.**

- The indications are that there is a high level of mental health need in the population. Interviews noted this has escalated "massively" during the pandemic.

- The primary team use a range of tools to identify needs, this means the READ coding should accurately describe identified need.

- There are very limited responses for trauma, there is no service for residents with personality disorders. **See Recommendations.**

- Substance use is endemic amongst residents presenting with mental health issues. At the tip of this iceberg, there is a dual diagnosis nurse specialist but with the massive increase in presentations to the substance misuse services, demand now outstrips the capacity. **See Recommendation** in the Substance Misuse Chapter.

- The community older persons mental health team do not visit the prison, meaning that residents can only access the service via escorts. Anecdotally we understand there is not the capacity to facilitate this.

- Whilst still not meeting targets, compared to other prisons access to hospital beds for residents transferred under the Mental Health Act is relatively speedy. This is outside of the control of the prison. Those waiting are generally accommodated in the Safer Custody Unit.

Chapter Six – Learning Difficulties & Disabilities

6.1 Prevalence

Literature uses the terms learning disabilities (LD) and intellectual and developmental disability (IDD) interchangeably, thus this chapter covers both.

It is widely accepted that there is under-identification of the needs of individuals with learning disabilities within the criminal justice system:

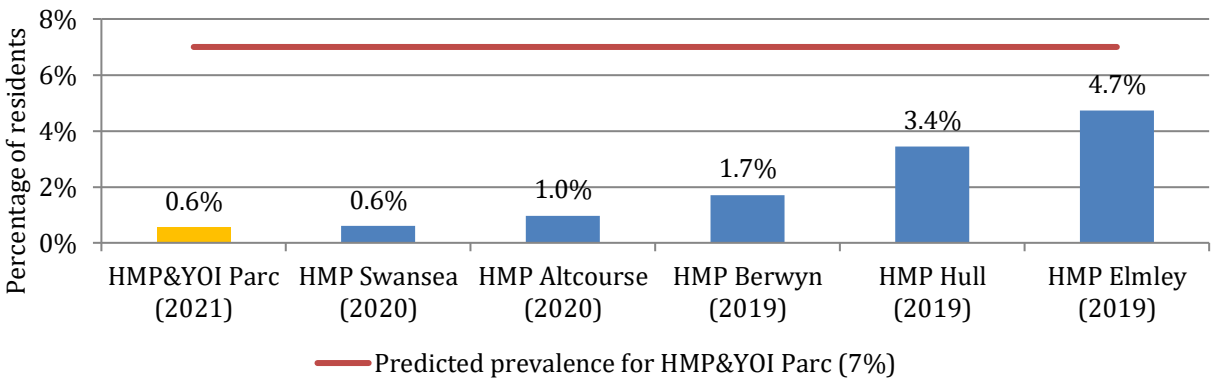
> *It has been estimated that only about 20% of adults with learning disabilities are known to learning disability services (Hatton et al, 2016), so it is likely that many defendants in the CJS who have learning disabilities have not been diagnosed as such and are not known to specialist services.*[47]

HMP Parc report that all new residents are assessed using the Do It Profiler[48] during induction. This tool identifies neurodiversity and can lead to an MDT to explore support and appropriate location for residents with a range of different issues.

6.1.1 Learning Disability Prevalence

The rate of learning disability in HMP Parc at our November snapshot was less than 1% (nine residents) on the QOF register identified as having a learning disability. This is well below the predicted 7% based on literature. While comparator prisons also reported a lower proportion than predicted, the rate at HMP Parc was below the comparator average of 2.3%.

Figure 61 – Learning Disability (QOF register)



We would expect a smaller number of identified residents to be reported on the QOF register, indicating their condition was currently 'active', compared to the proportion with any related diagnosis recorded on SystmOne. At HMP Parc there were 14 residents (0.9%) with any recorded learning disability on SystmOne.

In our resident survey, 18% (n=46) of respondents reported that they had a learning difficulty or disability. This is a little lower than the average of 23% across comparators (30% at HMP Elmley, 14% at HMP Hull, 26% at HMP Altcourse, and 23% at HMP Swansea).

[47] Nursing Times (2019) Learning disabilities: supporting people in the criminal justice system [Accessed 10/2/21]

[48] See website [Accessed 16/3/21]

It was recognised by staff within HMP Parc that the identified prevalence of LD (through SystmOne) was incorrect and a gross under representation of need. A new system was devised late 2020 involving an LD questionnaire which now includes QOF coding. This will allow for more accurate electronic identification of any form of leaning and intellectual/development disability. It is in the very early stages of roll-out:

> *"This is a long-term project and requires a lot of resource to go through childhood records, social services notes and so on." (LD Nurse)*

Recommendation Seventeen – Review the identified prevalence of LD in the establishment once the new recording system has been embedded to ensure there is a clear picture of likely need.

6.1.2 Autistic Spectrum Disorder Prevalence

HMP & YOI Parc is accredited by the National Autistic Society;[49] we understand it is one of only two prisons to have achieve this recognition.

The identified prevalence of autism spectrum disorders (ASD) at HMP Parc is similar to the UK average, with 21 identified residents (1.3%) recorded on SystmOne, against an average prevalence of 1% across the UK.[50] The rate is also similar to the 1.7% average among comparators.

However, this data masks a real issue in terms of access to diagnosis for any form of autism, which is problematic in HMP & YOI Parc, an interviewee commented.

> *"We have lots of boys with undiagnosed autism here and we really can't get them diagnosed. We previously had two specially trained nurses (noting the diagnosis required two nurses) and they used to do the diagnosis; however, they are no longer in post. Our current process is to go to the community services; however, they have waiting lists of around three years and because prisoners here are deemed 'safe' they generally never reach to top of any waiting list."*

Stakeholders generally agreed that the likely prevalence of ASD was much higher than the data suggests.

Despite the absence of a formal diagnosis, needs are met whilst residents are in the establishment, by means of making reasonable adjustments, access to sensory facilities, behaviour management plans and so on. However, needs become unmet at the point that residents leave the establishment when, due to the absence of a formal diagnoses they, are ineligible for the equivalent support in the community.

Recommendation Eighteen – Training and skill development should be offered to ensure that the team have the qualifications necessary to do ASD diagnosis in the future. This should be regularly reviewed to ensure staff turnover does not result in this facility being 'lost' in the future. This could be achieved with specialist LD Psychiatry input, specialist training for current nurses, or, ideally, a combination of both.

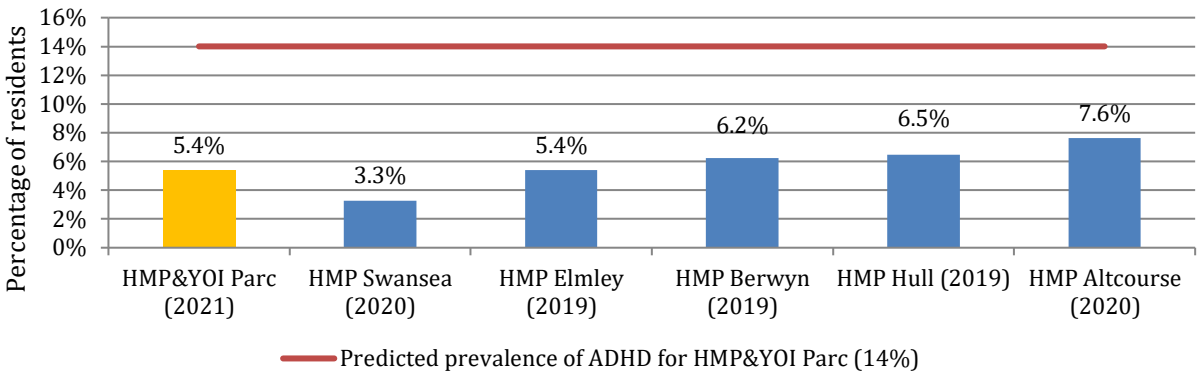
6.1.3 ADHD Prevalence

[49] See NAS website. [Accessed 11/2/21].

[50] NHS Wales (N.D.) Autism spectrum disorders. [Accessed 18/12/20].

The diagnosis rate for Attention Deficit Hyperactivity Disorder (ADHD) is low against predictions at 5.4% (n=88). However, this is similar to the average across comparators (5.8%).

Figure 62 – Identification Rate of ADHD (SystmOne data)



SystmOne prescribing data in November 2020 indicates 17 residents currently being prescribed medication for the treatment of ADHD (either lisdexamfetamine, equasym, or atomoxetine).

Note, due to the lack of psychiatry input for conditions which fall under Part 1 of the MHM, there is no mechanism to initiate diagnosis/prescribing for ADHD in the establishment. Subsequently there is currently a long list of residents with suspected ADHD with unmet need. GPs are licenced to *continue medication* (for the small number with an existing diagnosis and medication) but not to *initiate* new prescribing. There is already a recommendation for limited psychiatry input for those who fall under Part 1 of the MHM, so the recommendation is not repeated here.

6.1.4 Acquired Brain Injury

There are around 900,000 hospital admissions for head injuries each year, 10% of which are categorised as severe. Head injuries are proportionately higher among young adults and those over 75 years. Estimates state that from 31%[51] to 60%[52] of offenders have a history of traumatic brain injury. Traumatic brain injury is especially associated with offending patterns in young offenders.[53]

Head injury doubles a person's risk of going on to experience mental health problems.[54] A French study postulates a link between traumatic brain injury and the high rate of epilepsy amongst residents.[55]

Stakeholders felt there was a high level of need amongst some of the younger adults in the establishment:

[51] Waiter, L. *et al.* (2016) Prevalence of traumatic brain injury and epilepsy among residents in France: results of the Fleury TBI Study. [Accessed 8/12/20].

[52] Parsonage, M. (2016) Traumatic brain injury and offending. [Accessed 8/12/20].

[53] Williams, H. *et al.* (2010) Self-reported traumatic brain injury in male young offenders: A risk factor for re-offending, poor mental health and violence? [Accessed 8/12/20].

[54] Parsonage, M. (2016) Traumatic brain injury and offending. [Accessed 8/12/20].

[55] Waiter, L. *et al.* (2016) Prevalence of traumatic brain injury and epilepsy among residents in France: results of the Fleury TBI Study. [Accessed 8/12/20].

"We are seeing many more young men than ever before in here now with brain injuries, usually undiagnosed." (LD Nurse)

At a January 2021 snapshot, 25 residents in HMP Parc had a record of having experienced brain injury (this included those recorded as having had a cerebral infarction and those with traumatic cerebral injuries). This represented 1.5% of the population at that time.

It is noted that, due to needs in HMPs Swansea and Cardiff a dedicated Brain Injury Link Worker forms part of the team. Given the catchment area in HMP Parc there is no logic to an equivalent service provision not being available.

Recommendation Nineteen – There should be a specialist resource available in HMP Parc to meet the needs of residents with acquired brain injuries and enable access to timely diagnosis.

6.2 Service Provision

There is a distinct team of nurse-led LD practitioners within the establishment, comprising:

- One Band 7 Manager
- Two Band 6 Nurses (collectively contracted to work 40 hours per week on the LD unit)

The team sits independently on the mental health team; however, the Clinical lead for G4S has oversight of the service.

Residents with identified LD who may be deemed vulnerable in 'main accommodation' are now able to be located within the 'Cynnwys Unit' (inclusion unit). This is a further development of the two former assisted living units. There are generally 40-45 residents on this unit at any one time.

A specialist assisted living unit had opened in June 2019 to offer a supportive regime to 70 prisoners, and the prison had been awarded autism accreditation by the National Autistic Society. A team of learning disability nurses offered comprehensive assessments and management plans on the unit and throughout the prison, including X unit.[56]

HMIP described the new service in HMP Parc as *'impressive'*.[57] The prison won an RCN award for their LD work.

Referrals into Cynnwys are via a weekly Multi-Disciplinary Team meeting; this meeting also reviews residents who are on the wing. Residents do not need to have a formal diagnosis, there is a key focus on those who are vulnerable and at risk of exploitation where learning disability or cognitive impairment is the reason, thus this includes high functioning autism etc.

Stakeholders reported a high need for speech, language and communication therapy (SALT):

[56] HMIP (2020) Report of an unannounced inspection of HMP Parc by HM Chief Inspector of Prisons 11-22 November 2019. [Accessed 11/2/21].

[57] HMIP (2020) Report of an unannounced inspection of HMP Parc by HM Chief Inspector of Prisons 11-22 November 2019. [Accessed 11/2/21].

"We deal with the needs as best we can. We have had a SALT assessor in before and it was a tremendous help and made a huge difference to the individual concerned." (LD Nurse)

Recommendation Twenty – Mirroring the community model of LD services the team should have access to SALT.

The current arrangements for occupational therapy (OT) are via the wider social care pathway, which was not reported to meet the needs of individuals with LD:

"The Bridgend community team provide OT, but this is more targeted around falls prevention and disability aids. We are lacking specialisms such as sensory assessment and sometimes behavioural assessments, which, in the community, would be undertaken by a specialist OT." (LD Nurse)

Recommendation Twenty-One – There should be communication with the current OT service in Bridgend to explore options for adding specialist OT input for residents on Cynnwys.

6.3 Throughcare on Release

It was clear from stakeholder interviews that the biggest barrier to delivery of an effective LD service is the ability to access continued care for residents on release. This is particularly problematic as the majority of residents do not have a formal diagnosis thus do not meet criteria for community services. It was reported that the only available service offer was generally a referral for a mental health assessment, which was unsuitable for the majority of residents.

"Unless a patient has really severe or profound learning disabilities we can't get them into community services. We are now having to resort to raising this as safeguarding concerns for individual patients when it happens as there appears no other way." (LD Nurse)

Whilst the team can meet the needs of individuals *during their stay* at HMP Parc with or without a formal diagnosis, the problem clearly occurs on release. Given that many of these patients 'revolve' around the criminal justice system multiple times this creates a perpetual cycle of unmet need. Access to formal diagnosis would go some way to alleviating this problem.

Recommendation Twenty-Two – Mirroring the provision in community LD services, there should be access to specialist LD psychiatry and psychology as part of the provision within HMP & YOI Parc to ensure access to diagnosis in an attempt to break the revolving door cycle of vulnerability, unmet need and offending.

6.4 Chapter Summary

- The recorded identified need in HMP Parc of individuals with LD is far below predicted levels, and far below the actual evidenced need. This is being addressed by a new system which has recently been implemented. **See Recommendation.**

- There is a high prevalence of young men in the establishment with clear traits of autism, yet no provision for them to receive a formal diagnosis. **See Recommendation**.

- Unusually, despite the absence of a clear system to identify need, it is clear that the LD service in the establishment offers an excellent service to residents which (a) meets the need and (b) protects them from intimidation, exploitation and bullying in the wider prison population. Whilst the chapter includes a number of recommendations, these need to be considered in context which is that the LD service provision in HMP Parc is *by far* the most comprehensive we have seen to date and is an exemplar to other prisons.

- The award-winning Cynnwys Unit provides a comprehensive service to around 40-45 residents in the prison at any one time. When mirrored against community LD services, the team is lacking specialist (LD) psychiatry, psychology and OT input. **See Recommendation.**

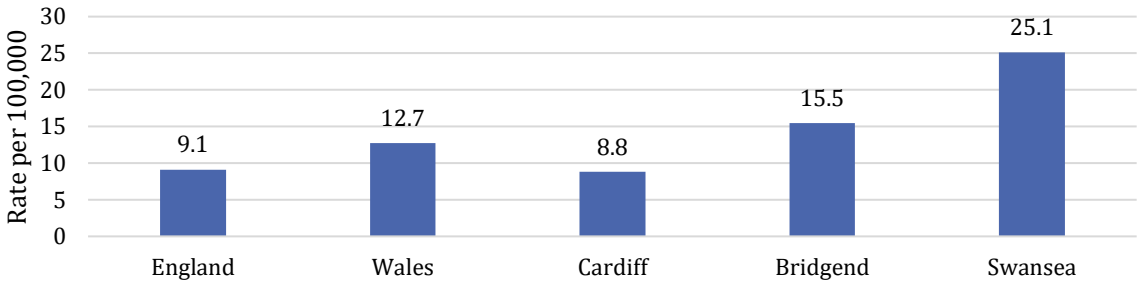
- Likely as a consequence of the lack of formal diagnosis, throughcare on release for residents with LD is particularly problematic (with the exception of those individuals who have clear and profound LD). **See Recommendation.**

Chapter Seven – Substance Misuse

7.1 Prevalence

The most recent published data on drug-related deaths (October 2020) clearly shows a far higher rate of drug related deaths in Wales than in England.

Figure 63 – Drug-Related Death Rate Comparison (males)[58]



> *Welsh drug deaths are at their highest ever levels according to a new report by Public Health Wales, with deaths from drug poisoning having increased by 78 per cent over the last 10 years.*[59]

HMIP noted:

> *more prisoners than at similar prisons saying they….had substance misuse problems.*[60]

The Drug Strategy Manager said that 80% of new admissions reported using illicit drugs in the preceding six months.

Public Health Wales estimate that rates of recent 'very heavy' binge drinking are higher in Wales (19%) than in England (14%) but lower than those in Scotland (24%). Males consistently drink more than females. As explained in Report Part B, the impact of alcohol misuse is greatest in the most deprived groups.

The Crime Survey for England and Wales (CSEW) reports on self-declared drug use amongst 16-59-year-olds and describes how, across all of Wales, overall drug use is slightly above the England/Wales average but use of Class A drugs is below the average. This is shown in the RAG-rated table below, red being where Wales is above average and green where it is below.

Figure 64 – Drug Use Prevalence Percent of Adult Population Used in Last Year (CSEW 2018/19)[61]

Substance	England and Wales total	Wales
Any drug	9.4	9.5
Any class A drug	3.7	3.1
Powder cocaine	2.9	2.4
Ecstasy	1.6	1.1
Amphetamines	0.6	0.4
Cannabis	7.6	8.1

[58] ONS (2020) Deaths related to drug poisoning by local authority England and Wales 1993-2019 (Table 4 – Males) [Accessed 21/2/21].

[59] Public Health Wales (2019) Harm reduction database Wales: drug-related mortality; annual report 2018-2019. [Accessed 18/12/20].

[60] HMIP (2020) Report of an unannounced inspection of HMP Parc by HM Chief Inspector of Prisons 11-22 November 2019. [Accessed 11/2/21].

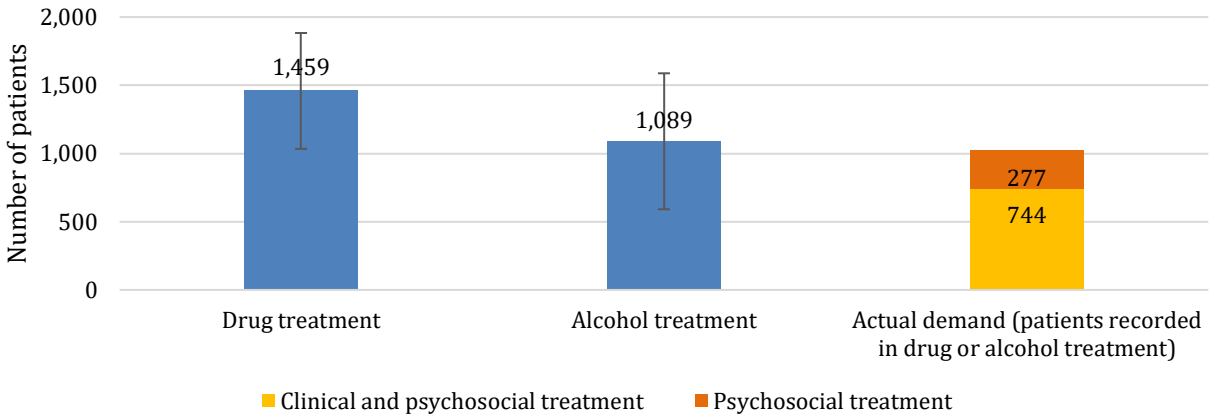
[61] ONS (2019) Crime survey England and Wales. Data Tables 3.10. [Accessed 18/12/20].

Aside from opiates, in South Wales benzodiazepines were commonly taken illicitly; this is no longer the case, the prescribed drug that was mentioned in interview was Pregabalin. 'Spice' was described as 'a major problem' not just in the prison but also in the community.

The following chart compares the expected annual incidence of substance misuse among the population of HMP Parc to the actual demand for treatment, based on the numbers of residents recorded on SystmOne as receiving any substance misuse-related intervention during the full year 2019/20.

Data analysis is limited because the psychosocial team do not record their work on SystmOne. All clinical patients also receive psychosocial support from Dyfodol.

Figure 65 – Predicted Incidence and Actual Demand (per annum)[62]



The numbers in substance misuse treatment appear to be within the range of predictions for treatment need, with 744 residents recorded on SystmOne as receiving a clinical intervention for substance misuse during 2019/20, and 1,021 reported by Dyfodol as receiving psychosocial treatment (it was not possible to determine numbers in treatment for drug vs alcohol treatment). Note that there will be overlap between those in psychosocial and clinical treatment, as it was stated that all clinical patients also receive psychosocial support, thus there will have been 277 in non-clinical treatment only, with a total of 1,021 in any treatment. There is also likely to be some overlap between the need and demand for drug treatment and alcohol treatment.

It should be noted that those in drug treatment will not only be opiate and crack cocaine users, though both substances were cited. Of residents in 2019/20 with a SystmOne record indicating a history of substance use, 22% were reported to have used opiates, and 30% had a history of cocaine misuse, though it was not clear how many were crack cocaine as opposed to powder cocaine users. Cannabis use (42%) was also common.

HMP Parc does not receive 'main' prisoners from the community but does receive vulnerable prisoners from the community; so there are alcohol dependent admissions and a need for alcohol withdrawals. During 2019/20, 11% (n=216) of new receptions to the prison had an Alcohol Use Disorders Identification Test (AUDIT) score recorded on SystmOne. Of these, 32% (n=69) had a score of twenty or above, indicative of probable dependent drinking. Note that

[62] Estimated need is based on likely prevalence among male prisoners according to literature and the estimated annual population of HMP Parc (the op cap of 1,693 as at November 2020, plus the number of new patients registered on SystmOne during the year). Clinical treatment figure taken from SystmOne 2019/20; psychosocial figure based on a reported caseload of 378 at March 2019 and 643 new allocations during 2019/20 (data supplied by Dyfodol).

Clinical Institute Withdrawal Assessment for Alcohol Revised (CIWA-Ar) is also undertaken for residents where problematic drinking is indicated.

7.2 Clinical Service

A PPO report from 2016 following a death in custody (admittedly in HMP Swansea) made a general comment about the disparity in substance misuse treatment availability in Welsh prisons in comparison to English prisons:

> *We have previously highlighted our concerns to the National Offender Management Service about the arrangements for managing drug dependent prisoners in Welsh prisons and our concern was recently echoed by Her Majesty's Inspectorate of Prisons in their thematic review of drug use in prison…I repeat my concerns.*[63]

Prisons in Wales had an approach of generally detoxing residents over a period of two months, now the approach is to allow longer term prescribing. In the past, prescribing for remand prisoners tended only to be for those who were known to community services, now the service is available for all those who test positive for opiates on reception and there is a longer term approach to prescribing, this has massively increased the numbers in treatment across the Welsh prison estate.

7.2.1 Clinical Service Provision

At the time of the most recent HMIP inspection, HMP Parc was in the throes of increasing their focus on substance misuse treatment. It is reported that the numbers engaging with clinical substance misuse treatment has risen from around 50 to some 200. The pandemic may have reduced this number. These changes mean that the SMS service for HMP Parc, in its current format is relatively new.

The clinical aspect of substance misuse provision at HMP Parc is delivered by G4S Health. Because the contact holder for GP services and prescribing for substance misuse provides the out of hours service, the service is available seven days per week, 24 hours a day.

There is nominally one GP session per week to initiate prescriptions. All prescribing reviews and follow on prescription are managed by a full time prescribing pharmacist.

Previously two nurses were assigned to the OST administrations (which have increased dramatically), now two pharmacy technicians undertake this aspect of the service. One nurse post is vacant, the other has been recruited to and the applicant is going through vetting.

There is concern that the initial assessment is too concentrated into the day of arrival and thoughts that an introduction to substance misuse treatment could be more spread-out during the induction process. Every clinical patient is reviewed within 14 to 21 days of arrival and subsequently every three to six months. In addition a resident can ask for a clinical review at any time.

The service works closely with Dyfodol, the psychosocial substance misuse service within HMP Parc, by means of weekly routine meetings and also attendance by both services in the morning clinics etc.

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[63] PPO (2016) Independent investigation into the death of Dean George at HMP Swansea on 10th of April 2016. [Accessed 18/12/20].

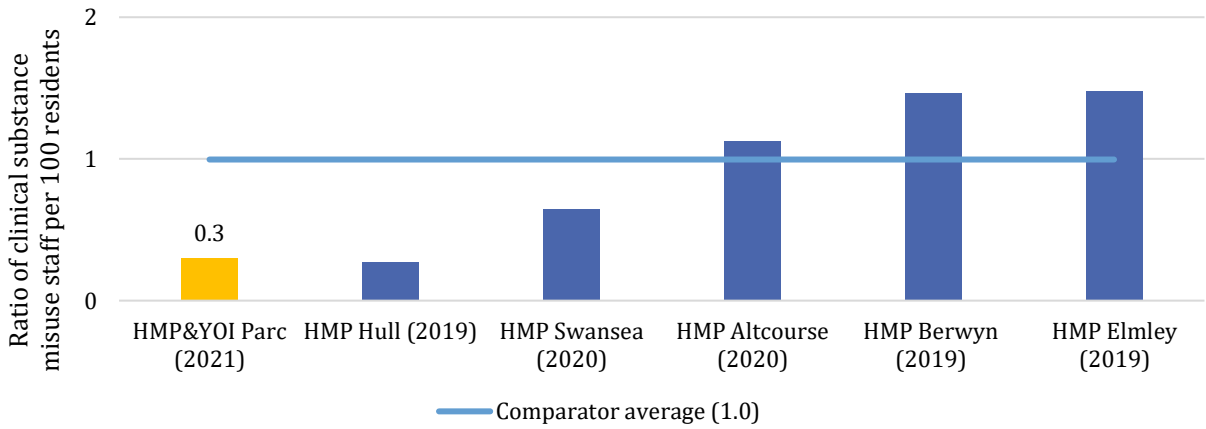
The staffing profile for the clinical substance misuse team is detailed below:

Figure 66 – Clinical Substance Misuse Team Staffing

Role	Full-time equivalents	Comments
GP	0.1	Employed by Marnell Medical Services as part of the GP contract, 1 session per week. This session is also included in the description of GP coverage in Chapter Three.
Prescribing pharmacist	1	Employed by Marnell Medical Services as part of the GP contract.
Substance Misuse Nurses	2	One post is vacant, the other has been recruited to and the applicant is undergoing vetting
Pharmacy technicians	2	Employed by G4S as part of the pharmacy complement. These posts are also included in the pharmacy staffing description in Chapter Three. Previously this was two substance misuse nurses.

The chart below illustrates that HMP Parc has a low ratio of clinical substance misuse staffing to the size of the prison population compared to similar prisons for which recent data was available.

Figure 67 – Clinical Substance Misuse Staffing Ratio (based on op cap)



7.2.2 Clinical Service Activity

In 2020 HMIP noted:

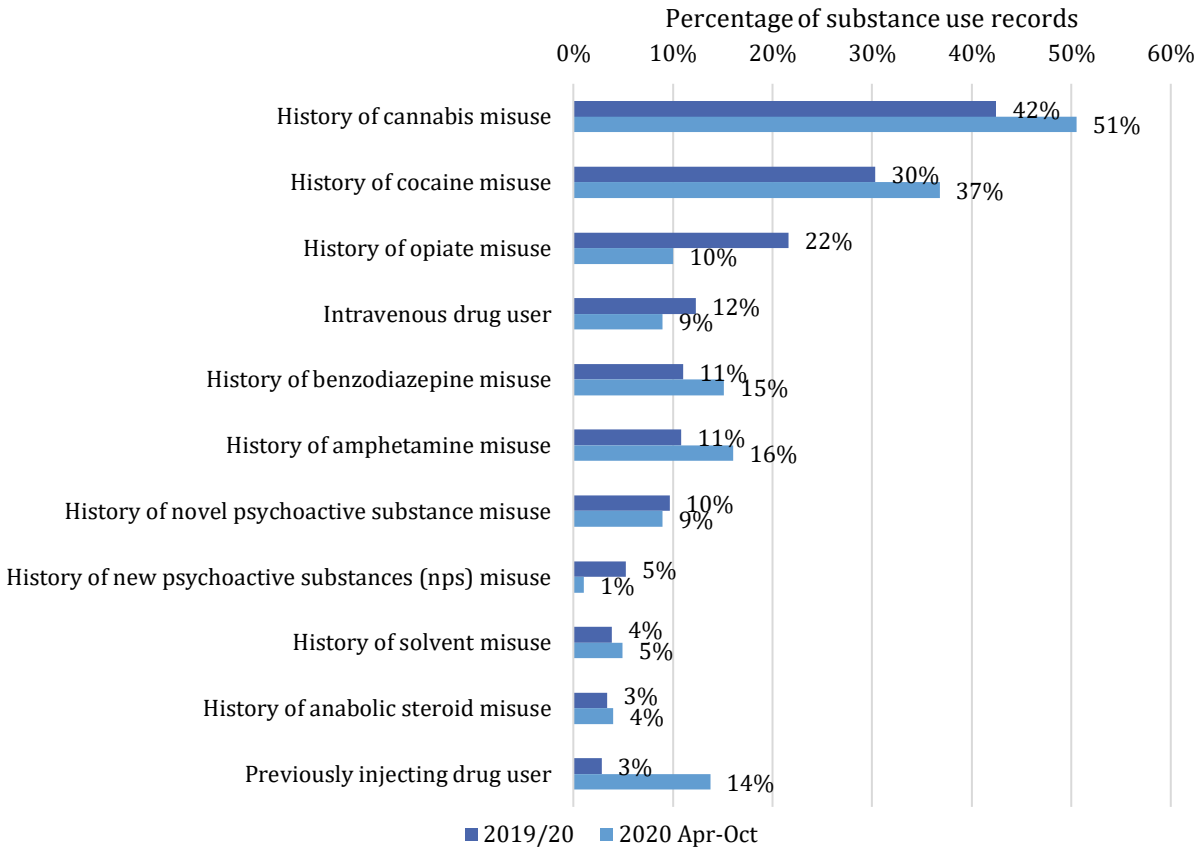
> *Demand for clinical substance misuse treatment had more than doubled since the previous inspection [in 2016] but was well managed.*[64]

The substance use history of residents at HMP Parc, as recorded on SystmOne, indicates that the most commonly reported substances used are cannabis, cocaine and opiates. The proportion of substance use records indicating cannabis or cocaine has increased in 2020/21 to date.

Note that one resident may have multiple substance use records.

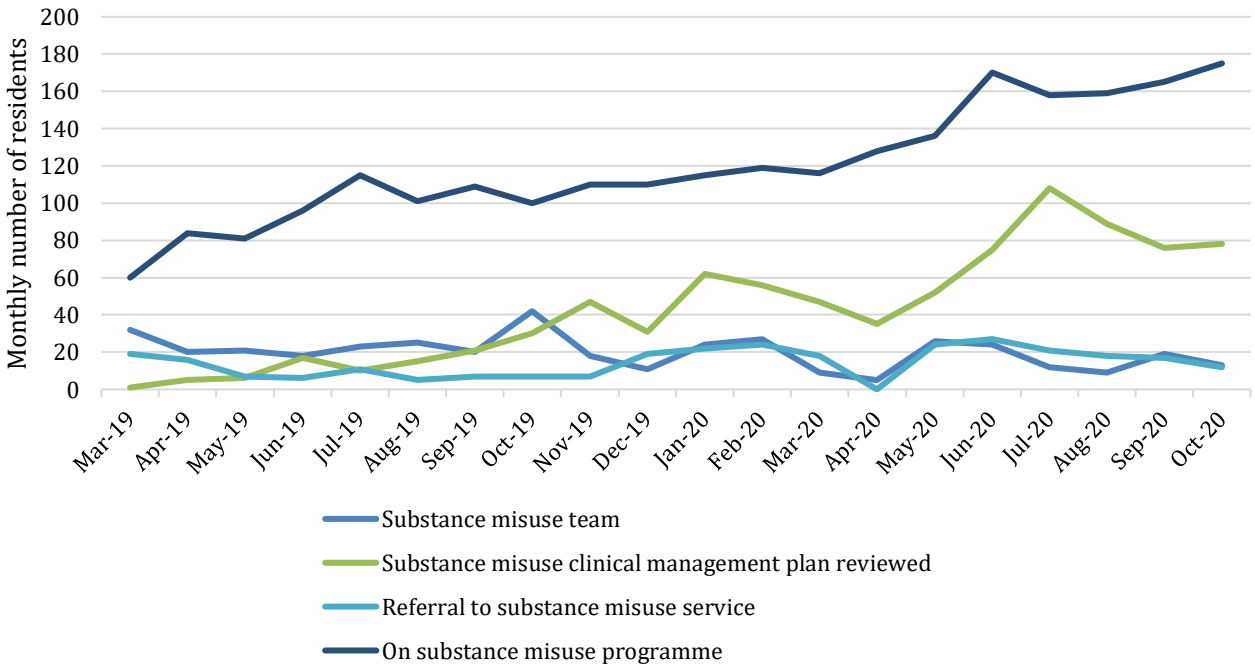
[64] HMIP (2020) Report of an unannounced inspection of HMP Parc by HM Chief Inspector of Prisons 11-22 November 2019. [Accessed 11/2/21].

Figure 68 – Substance Use Profile – Residents in Treatment (SystmOne data)



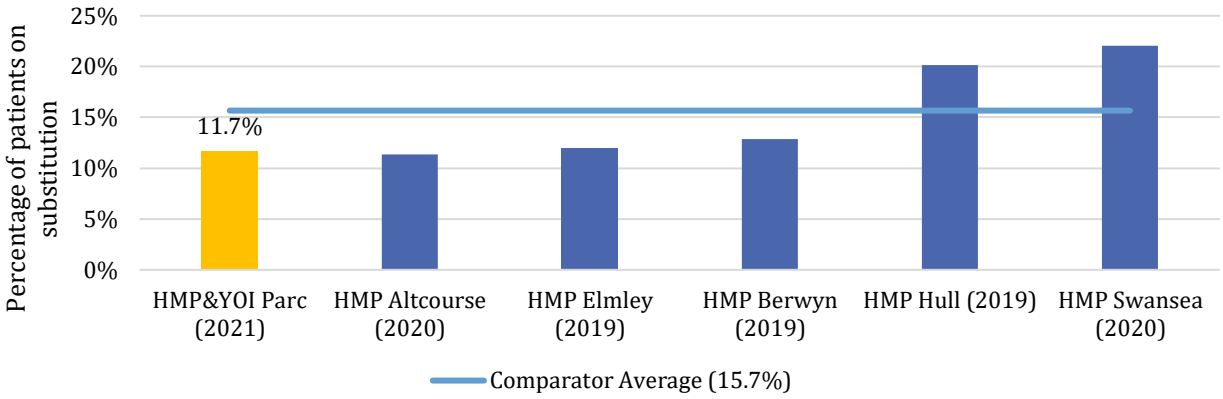
SystmOne data described an average of 105 residents per month 'on a substance misuse programme' during 2019/20. Numbers recorded have increased gradually over the last two years. There appeared to be only a slight drop in numbers in April 2020, and numbers seen have continued to increase since that time.

Figure 69 – Numbers Seen in Clinic (SystmOne data)



There are two Opiate Substitute Therapy (OST) administration points, on A Block for new arrivals and the other on D Block which is the drug treatment/recovery unit. Methadone is bottled and taken to the few (OST) residents who are not resident on these blocks. T Block is the enhanced wing, no residents in receipt of methadone are allowed to reside there, interviewees challenged this policy noting that stable residents who otherwise comply with the admission criteria should be allowed to apply. There were reported to be approximately 190 residents on OST at a December 2020 snapshot provided by G4S, equating to 11.7% of the population of HMP Parc. This is below average among comparators, although not dissimilar to three of the comparator establishments.

Figure 70 – Residents on OST Comparison (treatment service data)

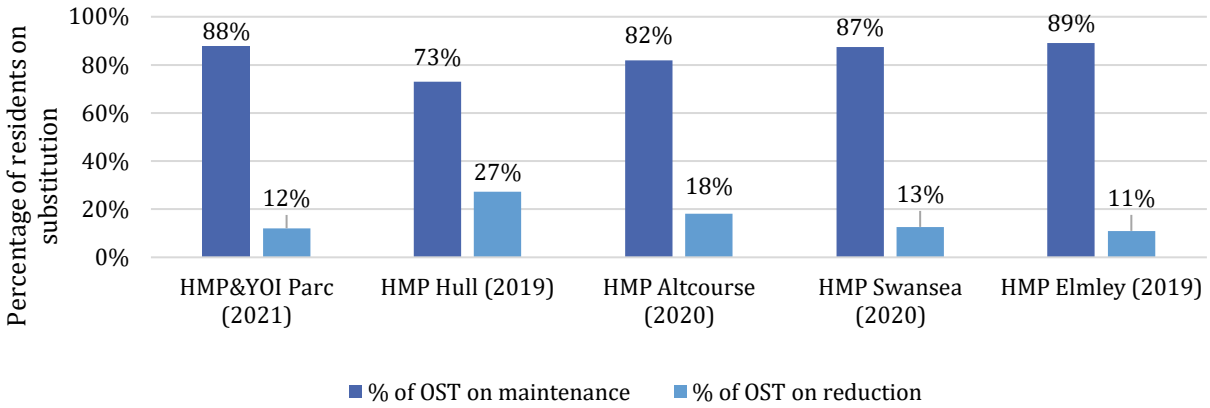


Residents continue with their prescribing treatment from the community or are generally initiated on to prescriptions in the sending prisons (HMPs Swansea and Cardiff). In these local prisons they are rapidly titrated up to 40-50 mls of methadone (or equivalent) and stabilised. In the local community the drug treatment services now allow patents up to a year to fully engage and stabilise before commencing a reduction. The prisons aim to replicate this approach working with residents rather than (as previously) imposing a rapid detoxification.

Most residents who are prescribed OST are on methadone. There is some local interest in Espranor and this is used by a number of community prescribers, it is not favoured in the prison where interviewees reported that it does not dissolve quickly, so they have found that residents can be subject to bullying and extortion. Where there are arrangements in place for continuity of prescribing in the community, on their approach to release residents can be switched to buprenorphine. Whilst Buvidal is very expensive this long acting depot treatment is occasionally used pre-release.

Of residents in receipt of OST, all were noted to also be in psychosocial treatment. In total, 182 residents were reported to be on maintenance prescribing (all on methadone) while 19 were on methadone reduction and six were on reduction programmes with different substitute medication (either Espranor or Buvidal). Given that these figures sum to more than the estimated 190 residents in total on OST, it seems evident that there is some overlap between these groups. Overall, of the reported prescriptions for OST, 88% were maintenance and 12% reduction. This is a greater proportion of maintenance than most comparators. Whilst data does not really accord with the interviewee descriptions which described an emphasis on reduction; it was noted that during the pandemic it has been felt that residents should not be under pressure to reduce.

Figure 71 – Maintenance vs. Reduction Comparison (treatment service data)



It was also reported that approximately nine residents had been prescribed Naltrexone during the past six months.

7.2.3 Alcohol Dependence

As noted above the prison receives small numbers (of VPs) from the community. The service reported that eight residents had received prescribed medication for alcohol detoxification during the six months July to December 2020. This suggests between one and two residents at any one time, equivalent to around 0.1% of the prison's population. This data was available for only two comparator establishments: 0.1% at HMP Berwyn and 8.0% at HMP Swansea.

Noting that HMP Swansea is a feeder prison, we would expect to see demand for psychosocial support from alcohol users.

7.3 Non-Clinical Service

Alpha Block includes induction and A3 is a motivation and engagement unit which prepares residents in order for them to move on to Delta. As noted in the clinical section (above) Delta Block accommodates many drug users, this has been the drug recovery wing for a number of years. This was described as quieter than general locations, with more space for group work and 1:1 meetings. As the numbers engaging in treatment have increased the need for accommodation has grown. Tango is the resettlement hub and T5 is an ISFL (Independent Substance Free Living) facility, this is somewhere that residents might aspire to and move to in the latter stages of their sentence, in general residents in the ISFL cannot be prescribed methadone, though there are a few exceptions.

All these units are part of the 'main' prison, whilst there are residents who engage with the services in the VP side, the numbers do not warrant a specialist unit.

The service is delivered by G4S Custody and Rehabilitation, it is also referred to as 'Dyfodol' which is the name used for the community substance misuse services operated by G4S in: South Wales, West Wales, Mid Wales, Gwent and the South Wales Valleys. The psychosocial workers are all G4S employees.

The nonclinical and clinical aspects of the service reported working closely together and there is a weekly Multi-Disciplinary Team meeting to discuss and review all concerning cases. The non-clinical service prioritises their work to focus on those who are engaged with the clinical

side of the service. In order to assist their clinical colleagues and to ensure frequent contact with their clients, during the pandemic the non-clinical staff have been second signers for the methadone administrations.

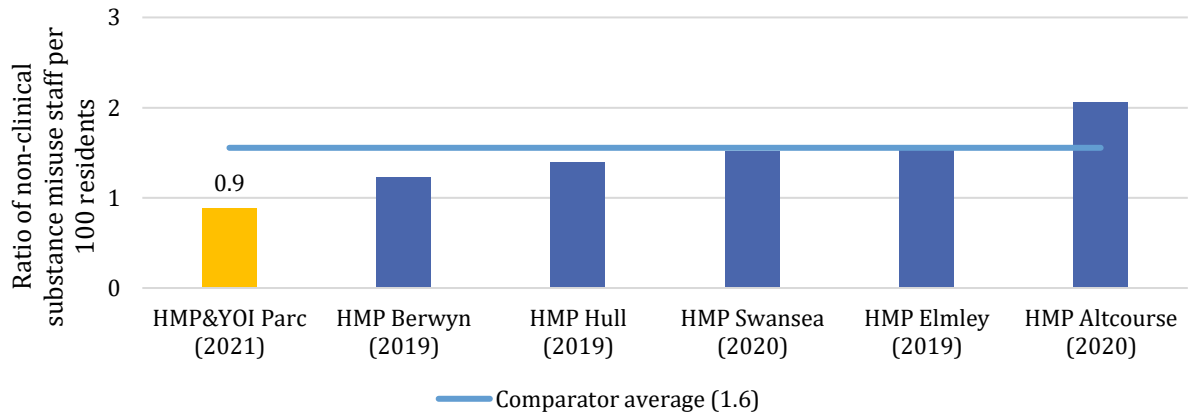
The non-clinical aspect of the substance misuse service is available Monday to Friday 8am to 5pm (with evening appointments possible on an ad hoc basis). The service has the following staffing profile:

Figure 72 – Non-Clinical Substance Misuse Team Staffing

Role	Band (or equivalent)	Full-time equivalents	Comments
Drug Strategy Manager	Service Senior Manager/Strategic Lead – E1	1	
Dyfodol Caseworker	Caseworker – F (2 bandings)	12	4 vacancies
Effective Practice Lead	Team Leader – E2	1	
Head of Rehabilitation	Functional Lead – D2	1	
Admin	Admin – F	1	1 vacancy
Performance and Data Analyst	Senior Admin – F	0.5	

The chart below illustrates that non-clinical staffing at HMP Parc is low relative to population size next to comparator establishments (note this does not include admin provision as this is often described differently between prisons).

Figure 73 – Non-Clinical Substance Misuse Staffing Ratio (based on op cap)



The psychosocial service is supported by one paid recovery champion (there are plans to add additional peer mentor roles in 2021).

The Dyfodol service sees all new receptions (on day two) and do an initial assessment (this has continued during the pandemic). The team also receives referrals from the prison as matter of routine following drug finds, suspected incidents of drug use and positive drug tests.

The interventions normally offered by Dyfodol include:

- Structured one-to-one sessions with a Dyfodol Case Worker focusing on individual's offending/substance misuse timeline, 'get to know me', building resilience, practicing gratitude, harm minimisation, relapse prevention, managing anxiety and stress, building healthy relationships, building a healthy lifestyle, coping with cravings.
- Brief intervention sessions/TMIs (ten minute interventions) with a Dyfodol Case Worker.
- In-cell intervention packs (e.g. lifestyle planning, building healthy habits) reviewed by a Dyfodol Case Worker.

- Pre-release preparation (e.g. specific structured one-to-one sessions) and Naloxone/Prenoxad training and the offer of a take home kit provided via prison pharmacy on release from custody.
- Group interventions/activities (detailed in the following table).
- Rapid Response Service (primarily focused on PS, but also fermenting liquid finds).
- Counselling for individuals with substance misuse histories, provided by New Pathways.

Figure 74 – Psychosocial Treatment Groups

Group/Programme Name	Number of Participants	Duration	Delivered by	Accredited
SMART Recovery (structured and peer-led)	8-12	Structured - 12 sessions Peer-led - weekly ongoing	Structured - Dyfodol staff Peer-led - Dyfodol staff + peers	No
ACTivate your Life	8-12	4 sessions	Dyfodol Staff	No
Building Skills for Recover	12	16 sessions	Interventions Facilitators	Yes
Yoga	4 - 10	Ongoing weekly	External Yoga Teacher	No
Mindfulness	8 - 15	Ongoing weekly	External Mindfulness Practitioner	No
Creative Writing	8-12	Ongoing weekly	Dyfodol Staff and education staff	No
Relaxation groups e.g. acupuncture	8-12	Ongoing weekly	Dyfodol Staff	No
Training for Recovery Fitness	8-12	Ongoing weekly	Dyfodol Staff	No
Diversionary and therapeutic Activities (crafts, matchbox making)	8-12	Ongoing weekly	Dyfodol Staff	No
Narcotics Anonymous and 12 step	8-12	Ongoing weekly	External Volunteers	No

During the pandemic much work has had to be delivered remotely, some individual work continues face to face. The SMS team have a 'white phone' which was described as 'invaluable'. A highly prized 'white phone' allows staff to call residents.

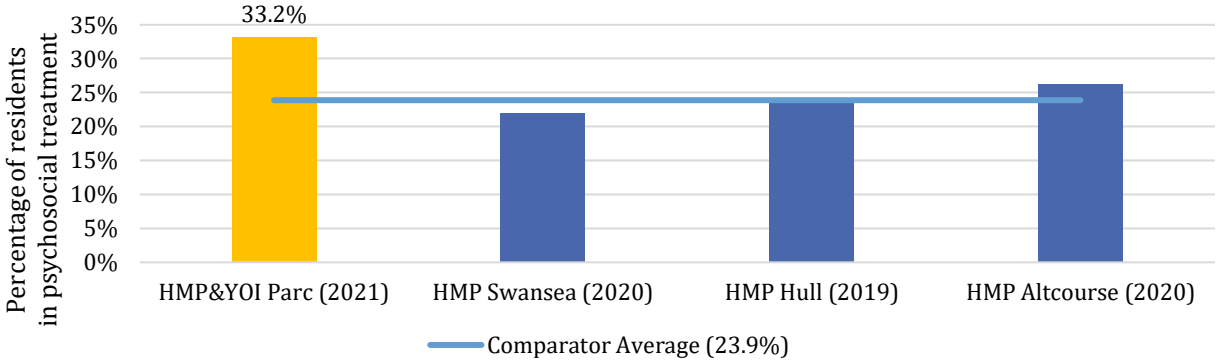
The psychosocial team do not record their work on SystmOne, rather they use the CSP (Collaborative Safety Plan) which is also used by Dyfodol in the community. They also record information on PalBase, a case management tool, utilised across the Dyfodol contract (public sector prisons, community bases and police custody suites). This will facilitate excellent communication between community and prisons within the Dyfodol contract area. However, it means that records will not travel with a resident who is transferred to another prison outside of South Wales. Looking across the vast majority of prisons, psychosocial teams now

record their work on SystmOne. SystmOne should be used for continuity of approach, to assist in joint working (and care planning) with the clinical team and to facilitate continuity of care for those who are transferred.

Recommendation Twenty-Three – The psychosocial team should record their work on SystmOne.

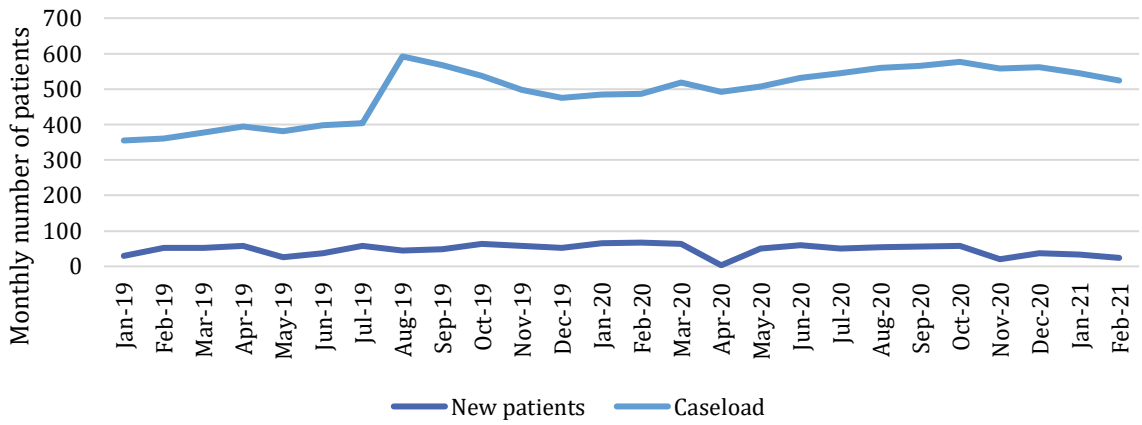
At the snapshot in December 2020, G4S reported approximately 540 residents receiving non-clinical treatment (of whom 190, or 35%, were also reported to be receiving clinical treatment). This represents 33.2% of the population at that time, higher than the average among comparators for which equivalent data was available.

Figure 75 – Residents in Psychosocial Treatment Comparison (treatment service data)



The psychosocial service reported an average of 54 new residents allocated per month in 2019/20 (with a clear drop visible in April 2020) and an average of 478 residents on the service caseload.

Figure 76 – New Psychosocial Patients and Caseload (Dyfodol data)



Whilst there were descriptions of how the clinical and psychosocial element of the service work closely together, both in terms of regular meetings and case reviews and also recently with the psychosocial workers acting as second signatory for administrations, we observe that in many other prisons these two arms have now joined into one integrated team. As evidenced there has been a recent massive increase in demand; we suggest that this is a good time to consider if, looking forward, there would be merit on integrating the two teams.

Recommendation Twenty-Four – Consider integrating the clinical and psychosocial aspects of substance misuse services into one team.

7.3.1 Accessibility and Did Not Attend (DNA) Rates

In the most recent six months available (May to October 2020), SystmOne reported an average DNA rate of 63% for substance misuse clinics. This is a major increase from the 11% DNA rate reported between October 2019 and March 2020. SystmOne reported a wait time of one working day for the substance misuse clinic at our November 2020 snapshot (though this may be an underestimate as we were not able to obtain data on residents currently awaiting appointments). Interviewees stated that the DNA rate is skewed by a Psychoactive Substance Clinic which has a very low engagement rate, so the numbers do not reflect DNAs in the majority of their clinics.

In the resident consultation, 73% of residents who responded said they knew how to access substance misuse treatment. This is similar to the average of 75% across five similar prisons (30% at HMP Elmley, 14% at HMP Hull, 26% at HMP Altcourse, and 23% at HMP Swansea).

7.3.2 Dual Diagnosis

Dual diagnosis is an imprecise term, the broad definition is used to describe anyone who has substance misuse and mental health issues. The narrow definition is anyone who mental health needs are such that they would fall under Part 2 of the MHM and have drug or alcohol dependency issues.

Taking the broad definition there is a cohort of people, where if we take their mental health issues, they fall below the threshold for Part 2, if we take their substance misuse they fall beneath the threshold for structured substance misuse interventions. However, when looking at the person as a whole they have problems.

The Dyfodol team are currently recruiting four case workers, two of who will be psychology assistants specifically to work with dual diagnosis. This report leaves Recommendation 26 (below) as these posts have yet to be appointed to and only time will tell if they meet the need.

Narrowing this a bit, the in-reach team noted that substance use is endemic amongst their caseload. Interviewees commented that in other Welsh prisons the substance misuse and mental health services work far more closely together then in HMP Parc. We note that in some prisons substance misuse and mental health teams are fully integrated. In HMP Parc different teams do not appear to work closely together, indeed they could both be working with the same with no knowledge of the other service's interventions. Co-ordinated care is hampered by use of different patient record systems.

Recommendation Twenty-Five – The two aspects of substance misuse provision and the two mental health services should find ways to work more closely and share records to provide coordinated care to those who fall under the care of both substance misuse and mental health services.

Finally, Section 5.2.6 explores the response to the narrow definition of dual diagnosis. There is one dual diagnosis nurse who is part of the in-reach team, this means that those who fall under this part of the service will meet the criteria for Part 2 of the MHM. One dual diagnosis nurse was said to not be enough. Substance misuse interviewees reported that in-reach were engaged with some residents but there it is difficult to access psychiatry.

Recommendation Twenty-Six – In order to better service the needs of residents with both substance misuse and mental health needs there should be more dual diagnosis resources.

7.4 Peer Support

Prior to the onset of covid-19 it was reported that both Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) visited the establishment and ran two highly successful groups per week; facilitated by Dyfodol. This was reported to be very popular with a number of residents. This is current suspended due to the pandemic. Groups ran on the 'main' prison and fellowship support was available in the VPU on request.

As noted in Figure 74, in normal times Dyfodol run SMART recovery groups.

The number of peer mentors has reduced during the pandemic, in February 2021 there were just three. It was reported that under normal circumstances there would be:

- Three to four 'Red Bands'. These are trusted prisoners who are allowed free movement within the prison
- Six wing based mentors , two each on – Alpha, Delta and Tango 5. Mentors will visit their peers daily to check up on and support them

7.5 Release Planning

In 2020 HMIP observed:

> *Pre-release preparation and throughcare arrangements were good.*[65]

As noted above there are a range of prescribing options and release planning commences well in advance of release to ensure continuity of care.

Whilst the substance misuse services in the community operate under different identities, the majority (Dyfodol, GDAS (Gwent Drug and Alcohol Service) and DDAS (Dyfodol Drug and Alcohol Service)) are in fact G4S services. Thus there are extremely close working relationships both between the prison services and their community counterparts and between community services. This includes use of common data systems which assists in terms of continuity of care.

Figure 77 – Community

Area	Community provider
Swansea	Dyfodol
Neath	Dyfodol
Llanelli	Community Drug and Alcohol Team (NHS)
Carmarthen	Community Drug and Alcohol Team (NHS)
Aberystwyth	Dyfodol Drug and Alcohol Service (DDAS)
Gwent	Gwent Drug & Alcohol Service (GDAS)

[65] HMIP (2020) Report of an unannounced inspection of HMP Parc by HM Chief Inspector of Prisons 11-22 November 2019. [Accessed 11/2/21].

7.6 Substance Use in the Prison

The prison holds bimonthly drug strategy meetings.

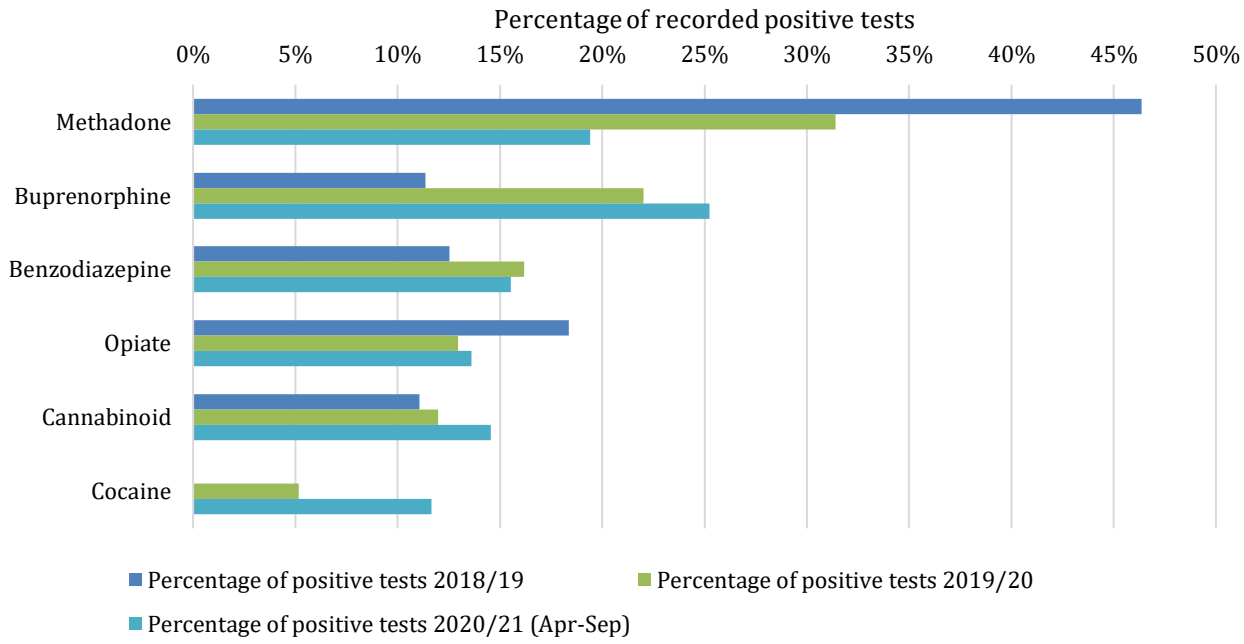
The latest HMIP report (2020) stated:

> *The random mandatory drug testing positive rate was 15.68%, which was higher than at comparable prisons and at the time of the previous inspection. The prison had a good drug supply reduction policy and action plan.*[66]

'Spice' use was described as an issue by a number of interviewees. As a result of the covid-19 pandemic, even when they have been allowed, visits are now much more tightly controlled, including no physical contact and mandatory wearing of masks. This is reported to have significantly reduced the flow of substances into the prison.

The following chart shows positive drug test results recorded on SystmOne during the past two and a half years. The most common substance residents tested positive for during 2018/19 and 2019/20 was methadone; however, this appears to have reduced in 2020/21 to date. The proportion of positive tests that indicate buprenorphine increased considerably in 2019/20 and 2020/21, as did those indicating cocaine.

Figure 78 – Drug Test Results (SystmOne data)



Note the rise in methadone is as a result of the new formulary, which was implemented around 18 months ago, before which time methadone was not prescribed within HMP Parc. It is unlikely an indication of illicit use.

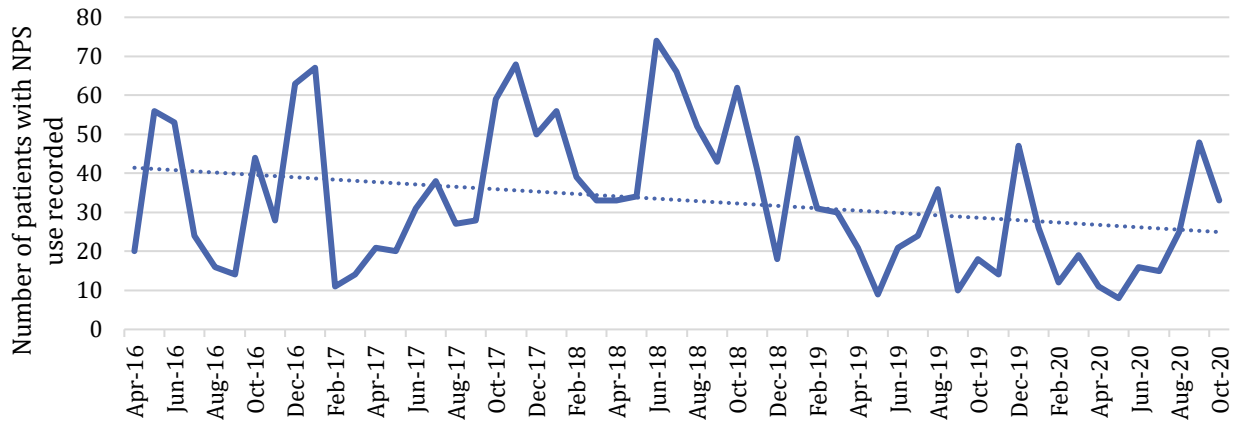
7.6.1 New Psychoactive Substances

[66] HMIP (2020) Report of an unannounced inspection of HMP Parc by HM Chief Inspector of Prisons 11-22 November 2019. [Accessed 11/2/21].

Many interviewees commented on the evident use of 'Spice' (NPS) within the establishment. Some noted the difficulty in engaging with residents, balancing an approach seeking honesty with the punishments for breaching rules.

The prevalence of NPS use appears to have declined over the past couple of years according to SystmOne records; an average of 44 residents per month were recorded on SystmOne as using novel psychoactive substances (NPS) during 2018/29, reducing to 21 per month on average in 2019/20 and 22 per month in April to October 2020. Report Part B contains much fuller information in relation to the impact of new psychoactive substances (NPS/PS) in prisons and on prison healthcare teams in general.

Figure 79 – NPS Use (SystmOne data)



The prison has a 'Psycho Active Substance Rapid Response Service' which was set up when they were experiencing a lot of issues and had a number of 'spice' related deaths.

All residents who generate a drug related 'code blue' or drug incident are seen within 24 hours. The Drug Strategy Lead described a 'real push' to work with residential staff to encourage them to be more vigilant and keep people safe. The numbers are vastly fewer than they were 18 months ago.

> *"We were seeing 60 per week, it is now around 10 per week" (Drug Strategy Lead)*

Some residents will engage others do not, the team will keep going back and will ask mentors to see those who do not engage. They cited examples of where people consistently refuse to engage until the moment is right, so it is worth their time to keep trying.

7.7 Chapter Summary

- Wales has higher prevalence of drug-related harm than seen in England. It is therefore reasonable to assume that the prevalence of need relating to substance misuse will be higher in this geographical area. There is clear evidence of high levels of need from stakeholder interviews and independent scrutiny reports.
- Nearly twelve per cent of residents in HMP Parc at our December snapshot were receiving OST. This follows a huge increase over a short period. But remains a lower rate than in most comparators.
- There are three units that house the majority of those in treatment.
- The clinical resources available to meet this need is well below that seen in comparator prisons.
- Within HMP Parc all the interviewees talked about reduction but the data describes the majority (88%) on maintenance. It was noted that the proportion on maintenance is higher than usual due to the pandemic.
- There are a small number of receptions from the community and some demand for alcohol detoxification.
- The non-clinical service is provided by Dyfodol (a G4S service who also provide non-clinical services to a range of other Welsh prisons and in the community). The service provision appears poorly resourced in comparison to similar prisons.
- Dyfodol do not record their work on SystmOne. **See Recommendation.**
- There is a well-developed peer support scheme.
- Illicit drug use (mostly 'Spice') has reduced in the last 18 months but remains an issue. The non-clinical service target offers of support to known 'spice' users.

Chapter Eight – Communicable Diseases, Screening & Immunisations

The health protection team is part of the national team, which sits underneath Public Health Wales, and has an overview of communicable diseases, screening and immunisations across all Welsh prisons, championed by a lead nurse for Health & Justice. In addition to this, there are public health teams within local authorities, specifically in Bridgend.

8.1 Blood Borne Viruses (BBV) – Screening

SystmOne data indicates that at least 15% of residents in HMP Parc during 2019/20 were known to have a history of injecting drug use. This is likely to be an underestimation of likely need.

Healthcare said this was an area that the team focussed on, the data comparing activity in HMP Parc with the average for all prisons in Wales supports this assertion. SystmOne data regarding BBV interventions shows high numbers offered and receiving screenings, though low numbers of test results appeared to have been recorded.

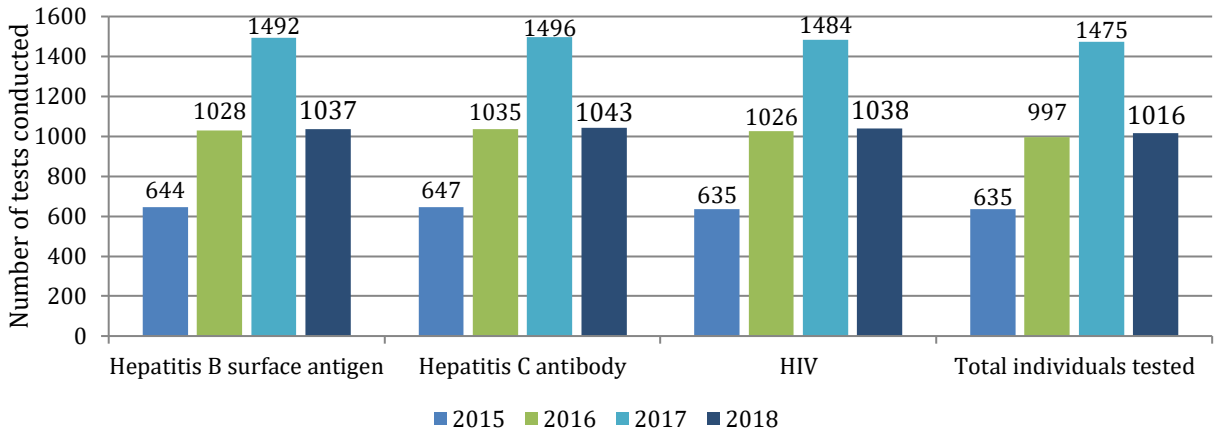
Figure 80 – Blood Borne Virus Interventions (SystmOne data)

HMP & YOI Parc	2019/20	2020/21 (April-October)
HIV		
HIV test offered	2270	885
HIV screening declined	1460	468
HIV screening test	1163	325
HIV positive	<5 (<0.4%)	<5 (<1.5%)
Hepatitis C		
Hepatitis C screening offered	2273	886
Hepatitis C screening declined	1436	463
Hepatitis C screening/test	1186	331
Hepatitis C screening positive	8 (0.7%)	0 (0.0%)
Hepatitis C antibody test	617	128
Hepatitis C antibody test positive	<5 (<0.8%)	0 (0.0%)
Hepatitis C PCR	<5	0
Hepatitis C viral ribonucleic acid PCR positive	5 (0.4%)	0 (0.0%)
Hepatitis C viral ribonucleic acid PCR negative	5	0
Hepatitis C genotype 1	6 (1.0%)	0 (0.0%)
Hepatitis C genotype 2	<5 (<0.8%)	0 (0.0%)
Hepatitis C genotype 3	5 (0.8%)	0 (0.0%)
On hepatitis C treatment plan	22	0
Hepatitis B		
Hepatitis B screening offered	2273	885
Hepatitis B screening declined	1439	464

HMP & YOI Parc	2019/20	2020/21 (April-October)
Hepatitis B screening test	1178	327
Hepatitis B screening positive	0 (0.0%)	0 (0.0%)
Hepatitis B core antibody positive	0 (0.0%)	0 (0.0%)
Hepatitis B core antibody negative	6	0
Hepatitis B immune	0	0
Hepatitis B surface antigen positive	<5 (0.4%)	0 (0.0%)
Hepatitis B surface antigen negative	102	0
Hepatitis A antibody test	0	0
Referred to hepatology service	43	<5

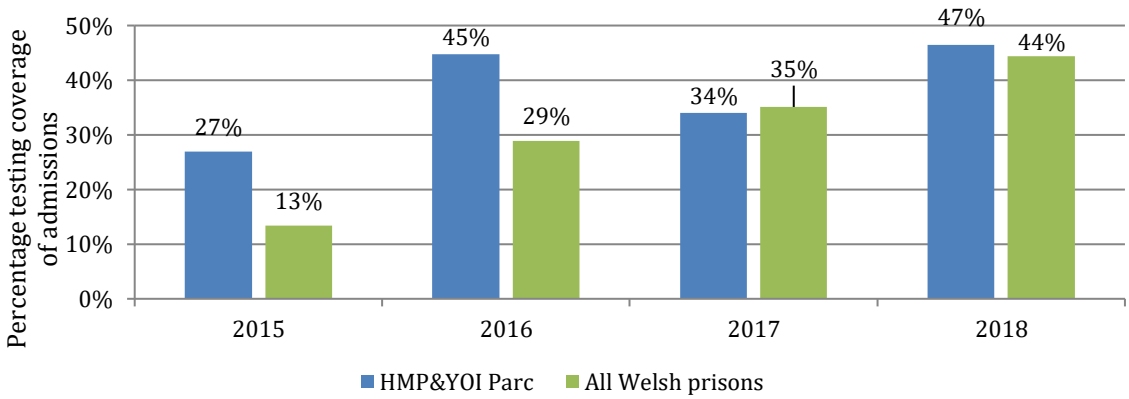
The numbers of tests reported on SystmOne for 2019/20 are broadly consistent with annual numbers reported by Public Health Wales as tested at HMP Parc, with 1,048 tests recorded (for 1,016 individuals) during 2018, the most recent year for which this data was available.[67]

Figure 81 – BBV Screening (PHW data)



Between 2015 and 2018, Public Health Wales data indicates that an increasing proportion of receptions to HMP Parc were screened for BBVs and that the prison achieved a consistently higher proportion than for Welsh prisons on average.

Figure 82 – Testing Coverage of Admissions (PHW data)



[67] PHW Communicable Disease Surveillance Centre (2019) Blood borne virus screening in prisons in Wales, 2015-2018.

As a proportion of the population of HMP Parc at a November 2020 snapshot, SystmOne data indicates that 0.4% of residents (n=6) had a record of being human immunodeficiency virus (HIV) positive, 3.1% (n=51) were identified as hepatitis C (HCV)positive (with a record of a positive polymerase chain reaction (PCR) test), and 0.7% (n=12) had a record of being hepatitis B positive. To put this in context, PHE estimates that 0.3% of the prison population is living with HIV, and 9% with HCV (as described in Report Part B),[68] so the proportion recorded as living with HIV is as expected, but the proportion living with HCV is lower than expected.

The Public Health Wales data noted above reported under 5% of tests for Hepatitis C returned a positive result in 2018 (a decrease from previous years: 7.9% of tests in 2017, 6.5% in 2016, and 8.3% in 2015 returned positive results). For Hepatitis B and HIV, none of the years had over a 5% positive rate.

8.1.1 Blood Borne Viruses – Pathway

A specialist HIV service is not provided by the Local Health Board (LHB). In view of the small numbers, G4S has independently commissioned a consultant to manage residents with HIV

Recommendation Twenty-Seven – The LHB should provide a visiting HIV service in the prison.

There is a visiting HCV service, a nurse visits weekly and can undertake onsite Fibroscan. A consultant visits as required. As with many visiting services, this has been suspended during the pandemic and is just restarting now (Feb 2021).

8.1.2 Blood Borne Viruses – Vaccinations

SystmOne data described the following numbers of residents receiving vaccinations for Hepatitis B. The covid-19 pandemic appears to have had a notable impact on these vaccinations, with a dramatic reduction in the (pro rata) numbers reported since April 2020.

Figure 83 – Hepatitis Vaccinations (SystmOne data)

Vaccination type (HMP & YOI Parc)	2019/20	2020/21 (April-October)
Hepatitis B 1	371	0
Hepatitis B 2	294	<5
Hepatitis B 3	273	5
Hepatitis B booster	91	7

8.2 Immunisation

Some data regarding vaccinations given was available from SystmOne for 2019/20 and 2020/21 to date; this is shown below. With the exception of influenza vaccinations, the numbers (pro rata) of each vaccination type appear to have decreased markedly from April 2020.

[68] PHE (2015) Blood-borne virus opt-out testing in prisons: preliminary evaluation of Pathfinder Programme. Phase 1, April to September 2014. [Accessed 18/12/20].

Figure 84 – Vaccinations (SystmOne data)

Vaccination type (HMP & YOI Parc)	2019/20	2020/21 (April-October)
Diphtheria, tetanus and poliomyelitis 1	78	25
Diphtheria, tetanus and poliomyelitis booster	14	2
Influenza 1	337	205
Meningococcal group 1	59	7
Measles, mumps and rubella (MMR) 1	0	0
Measles, mumps and rubella (MMR) Booster	0	0
Pneumococcal diseases 1	0	0

8.3 Sexual Health

As a result of a national review undertaken by the Welsh Government in 2016 of sexual health services in Wales, an inconsistency in the provision of these services to people in vulnerable groups was identified; prisoners were specifically flagged as an area for further exploration. Subsequently, a report by the health protection team in PHW is in the process of being finalised which specifically explores the sexual health provision in all the Welsh prisons.

SystmOne data on sexual health screening seems inconsistently recorded but indicates a pro rata increase in activity from April 2020 onwards compared to the previous year. Seven residents were recorded as testing positive for chlamydia during 2018/19 and fewer than five between April and October 2020.

Figure 85 – Sexual Health Screenings (SystmOne data)

HMP & YOI Parc	2019/20	2020/21 (April-October)
Chlamydia test offered	2182	898
Chlamydia screening declined	1554	461
Chlamydia diagnostic test/screen	479	148
Chlamydia test positive	7 (0.3%)	<5 (<0.6%)
Chlamydia test negative	48	0
Syphilis screening offered	1010	830
Syphilis screening declined	654	417
Syphilis serology	576	358
Syphilis infectious titre test	0	0
Syphilis titre test positive	0 (0%)	0 (0%)
Syphilis titre test negative	<5	0
Gonorrhoea screening declined	928	510
Test/screen for gonorrhoea	742	464
Gonorrhoea test positive	<5 (<0.7%)	0 (0%)
Gonorrhoea test negative	52	0
Referral to contraception and sexual health service	120	193

Data supplied by PHW illustrated the following (note this was the most up-to-date data that was available on sexual health):

Figure 86 – PHW Data on Sexual Health (Feb 2018-Feb 2019)

HMP & YOI Parc	Number screened 2018/19
Chlamydia	249
Gonorrhoea	245
HIV	1035
Hepatitis B	1035
Syphilis	5

Healthcare deliver nurse led sexual health clinics and there is a visiting GUM service. HMIP (2020) noted that a '*sexual health clinic was held, with barrier protection discreetly available on request'.*

8.4 Tuberculosis

The prevalence of tuberculosis (TB) is far lower in Wales (3.1 per 100,000 population) than it is in England (8.3 per 100,000 population), albeit these are whole estimates and as explored in Report Part B, we know TB to be more prevalent in prison settings.

Screening for TB is part of the risk-assessment on SystmOne for new receptions and there is a referral pathway where concerns are identified.

8.5 Chapter Summary

- The data recording and read coding on SystmOne of screening of communicable diseases and vaccinations in HMP Parc describes a high level of activity. Though recently this has been impacted by the pandemic.
- At least 15% of residents entering HMP Parc in the last year had a history of injecting substances, suggesting a likely high need for BBV screening and vaccinations.
- The LHB provide a visiting HCV service, but the prison currently has to procure an HIV service. **See Recommendation.**
- There is a nurse led sexual health clinic supported by visiting GUM services.
- All prisoners are routinely tested for covid-19 on reception, then again at around day five in an attempt to reduce the 14-day quarantine period on the reverse cohort unit.

Chapter Nine – Self-Harm and Self-Inflicted Deaths

9.1 Self-Harm

The latest HMIP report (2019) noted that:

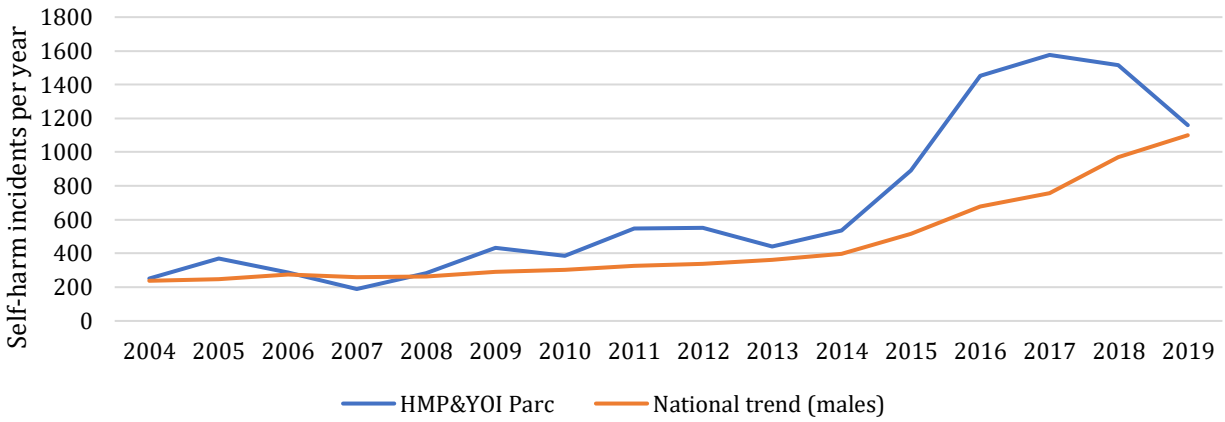
> *Although reducing over the previous year, the level of self-harm remained high and was considerably higher than at the time of the previous inspection.* [69]

The report went on to say that there were 'good initiatives' in place to tackle the issue.

9.1.1 Prevalence

The chart below considers the number of self-harm incidents in HMP Parc over time, in the context of the national trend (the national average number of incidents of self-harm per annum, standardised for a population the size of the current op cap). Self-harm incidents at HMP Parc have historically been higher than the national average whist they remain above the average, they have been decreasing since 2017.

Figure 87 – Self-Harm in HMP Parc (comparison)[70]



In some cases, high numbers of self-harm incidents may indicate several individuals engaging in these behaviours; in other circumstances a small number of prolific self-harmers may account for a large proportion of the incidents reported. MOJ data no longer includes the number of individuals recorded as having self-harmed in each prison; data provided by the prison does show this and is included below.

SystmOne data on self-harm reports only a small proportion of the numbers described by the prison, this is likely to be because healthcare staff are not routinely called to every incident of self-harm. Where an officer requests the attendance of healthcare, this should be recorded. Note that self-harm incidents frequently come through to healthcare as 'codes'. The data shows that during 2019/20, 253 individuals had an incident of self-harm recorded on SystmOne (a total of 629 incidents recorded); similar annual numbers were recorded in 2018/19 and 2017/18.

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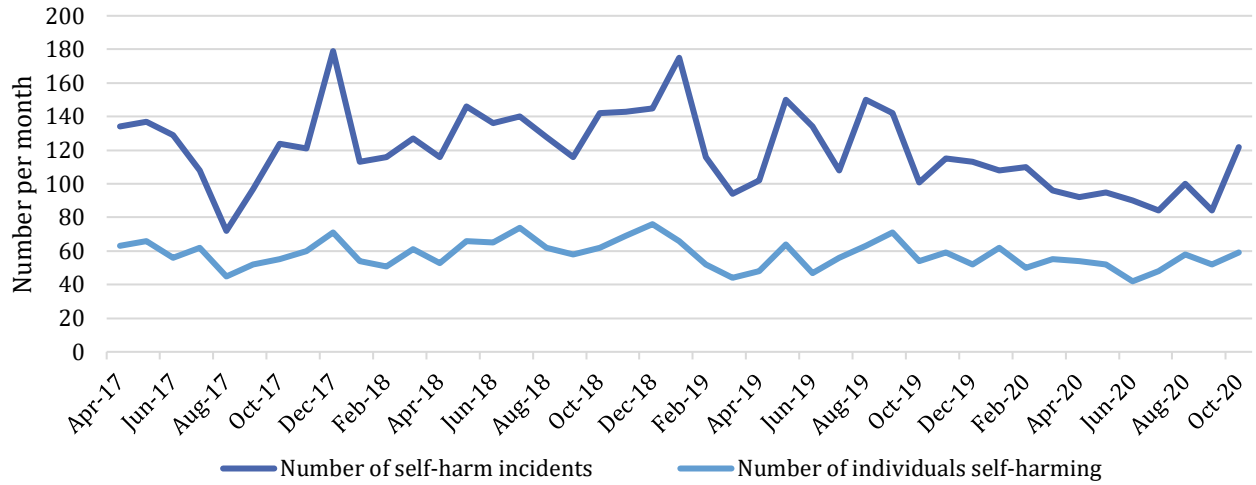
[69] HMIP (2019) HMIP (2019) Report On An Unannounced Inspection Of HMP Parc by HM Chief Inspector of Prisons. [Accessed 08/1/21].

[70] MOJ (2019) Safety in custody statistics. [Accessed 18/12/20]. Please note the national trend refers to male prisoners only and is standardised based on the op cap, so shows the number of incidents per that number of prisoners.

Recommendation Twenty-Eight – Healthcare should routinely be informed of all self-harm incidents and these should all be recorded on SystmOne.

Data provided by HMP Parc shows a fuller picture and illustrates that not all self-harm incidents are recorded on SystmOne – a total of 1,429 incidents were reported in 2019/20 (compared to the 629 indicated by SystmOne data). Note there has been a recent spike in self-harm incidents in October 2020, although this is only in comparison to the preceding few months and the monthly average is lower for 2020/21 than in recent years. The prison also supplied details of the number of individuals involved in self-harm incidents. The average number of incidents per individual has remained relatively consistent at a monthly average of 2.1 for the last three years until dropping since April 2020 to 1.9 incidents per individual.

Figure 88 – Monthly Numbers of Self-Harm Incidents and Individuals (safer custody data)

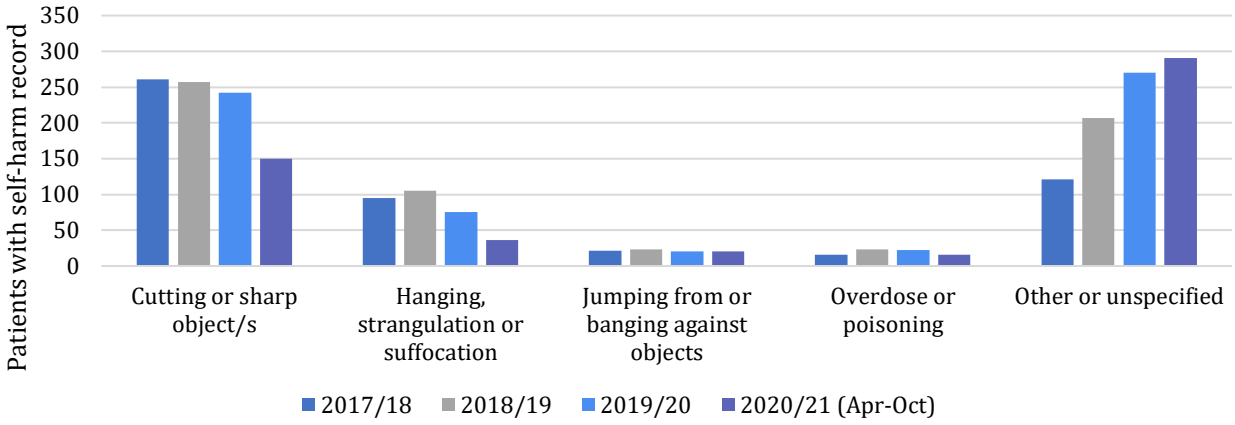


The monthly number of recorded self-harm incidents has decreased in recent years (from an average of 133 per month in 2018/19 to 97 per month in 2020/21 to date). This is a decrease since the HMIP report referenced at the start of this chapter.

Stakeholders noted that there was a clear rise in self-harm correlating to the first covid-19 lockdown period (March 2020); however, this soon levelled off and returned to previous levels by May 2020, mirroring what we have seen in other prisons.

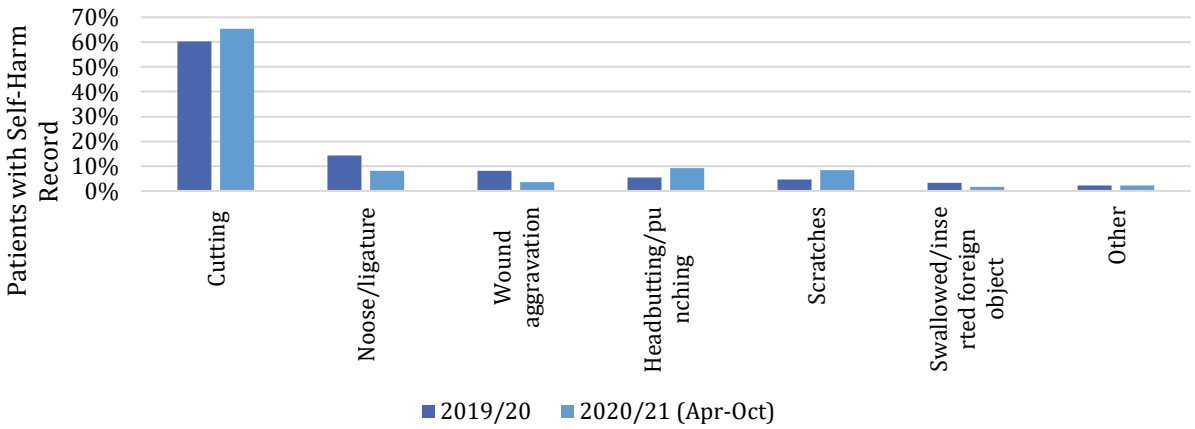
As noted, SystmOne will only offer a limited picture where the type of self-harm behaviour was recorded; the most frequent method of self-harm was cutting or self-injuring with a sharp object (38% of recorded incidents in 2019/20).

Figure 89 – Types of Self-Harm (SystmOne data)



Data supplied by the prison on the type of self-harm seemed to agree that cutting was the most frequent form.

Figure 90 – Types of Self-Harm (Prison data)



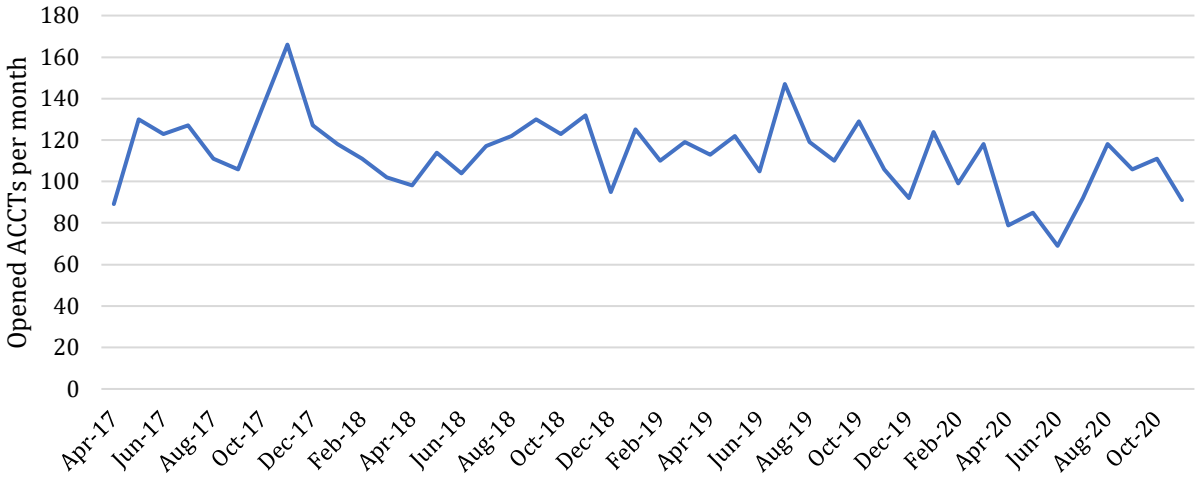
9.1.2 Responses including ACCTs

When Officers have concerns about a resident that does not warrant an ACCT (Assessment Care in Custody and Teamwork), these will be passed to healthcare. A comment from the operational line was that these issues are 'very much pushed to healthcare'.

The prison holds a weekly Clinically Vulnerable and Older Prisoners (CVOP) Multi-Disciplinary Team meeting which aims to identify those who might need assistance. There is also a weekly Multi-Disciplinary Team 'Support and Risk Meeting' chaired by healthcare to coordinate responses. Safer Custody have three Officers who will outreach and visit residents on the House Blocks. The comment from the operational side was that those at risk are more frequently identified by uniformed staff. Outside of the pandemic, healthcare delivery is focussed in the healthcare unit; with limited presence on the wings, healthcare, may be a little more distant from the residents.

Data provided by the safer custody team at HMP Parc show an average of 123 ACCTs opened per month during the full year 2017/18. This has declined gradually over time to an average of 94 per month so far in 2020/21.

Figure 91 – Opened ACCTs (safer custody data)



Healthcare staff attend all initial ACCT meetings, but do not routinely attend subsequent reviews. Nurses do; however, attend all ACCT reviews for residents in the Segregation Unit and the Safer Custody Unit. In many other prisons primary mental health will attend all ACCT reviews. In some prisons, primary mental health staff attend the first review and subsequent reviews will be attended by someone from the health and social care side who knows the resident best, this might for example be a drugs worker. Engaging in all ACCT reviews is a significant undertaking and we suggest could not be achieved within the constraints of current resources.

(The Segregation Unit has 22 cells. Whilst some mentally unwell residents inevitably end up in segregation, efforts will be made to move these residents quickly on to the Safer Custody Unit).

9.1.3 Safer Custody Unit

The 'Safer Custody Unit' is a 14 bed short-term facility for those in crisis intended to accommodate residents who are self-harming and those who are floridly mentally unwell. Many if not most of the residents on this unit will be subject to an ACCT, those who are not will have an 'Assisted Living Plan'. All cells have cameras fitted and in addition there is one constant observation cell, whilst this is not the only one in the prison it was noted in interview that the Unit would benefit from a second constant observation cell.

The Unit is available for all adult residents, both from the main and the VP sides of the establishment.

It was noted that whilst the intension is that the Unit should be a short-term option, they frequent find that residents become stuck whilst awaiting mental health transfers to hospital. An illustrative example is one resident who waited 10 months. Other services see the Unit as a 'place of safety' though it does not fall under the legal definition of this term.

The Unit is staffed 24 hours a day by a consistent group of Officers and also by primary mental health nurses.
Residents will be placed there because of presenting behaviour, not as a consequence of a diagnosis. This means some may have not have formal diagnosis; an example was given of a resident who was thought to need an ASD and LD assessment, this request was said to have 'been bounced' between departments creating unnecessary delay.

There will always be a small cohort of residents who might informally be described as 'complex primary'. They can be some of the most difficult to manage with no clear secondary diagnosis but exhibiting a range of disturbing and sometime dangerous behaviours. The description of the admission criteria for the Unit includes this group.

As long as the Unit is staffed by primary mental health nurses this appears to mean that the most unwell residents in the prison will fall under the care of the primary mental health services not secondary.

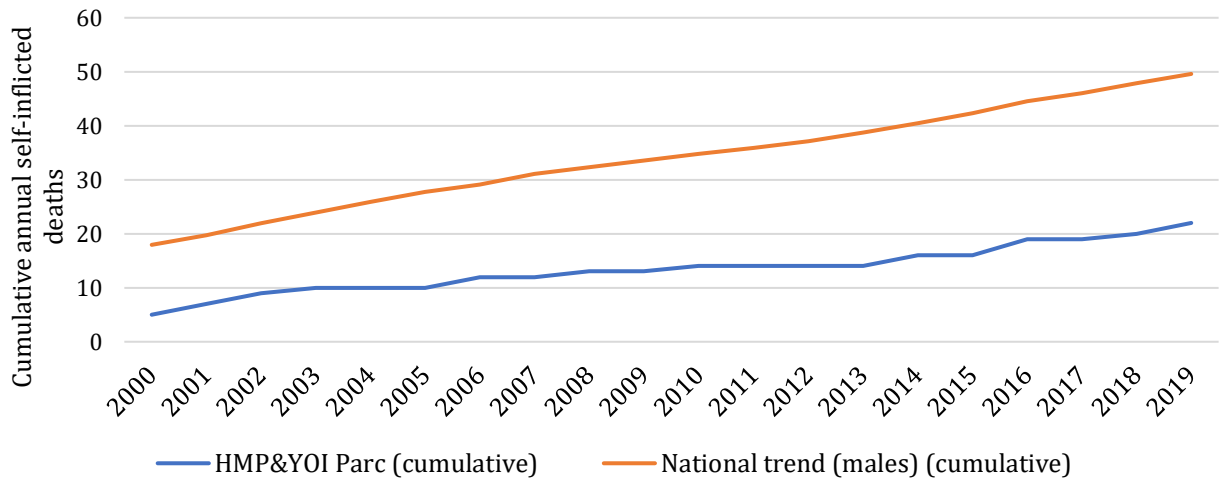
9.2 Self-Inflicted Deaths

ONS report that rates of male suicide for the whole of Wales are above those for England (ONS 2019 data: 17.2 per 100,000 in England and 21.2 in Wales).[71]

Between 2007 and 2009 there was a cluster of suicides amongst 13 to 17 year-olds in Bridgend, all except one was by hanging. Those who were teenagers at this time will now be aged between mid-twenties to early thirties. Those in HMP Parc who are from the Bridgend area will most likely have been exposed to a culture where suicide was more common than normal, some would describe this as a 'cult'. ONS report that recent rates of male suicide for the whole of Wales are above those for England (ONS 2019 data: 17.2 per 100,000 in England and 21.2 in Wales).[72]

The chart below illustrates that the number of self-inflicted deaths in HMP Parc is typically well below the national average (standardised for the size of the HMP Parc op cap). Any region in the chart where the gradient of the HMP Parc line is steeper than that of the national trend shows years where more deaths have occurred than might be expected on average. The fact that the HMP Parc line and that of the national trend are diverging shows that HMP Parc has fewer deaths in total than might be expected. The context is that the national rate has been increasing gradually since 2012.

Figure 92 – Self-Inflicted Deaths National and HMP Parc (1992-2018)[73]



[71] ONS (2020) Suicides in England and Wales. [Accessed 18/12/20].

[72] ONS (2020) Suicides in England and Wales. [Accessed 18/12/20].

[73] MOJ (2019) Safety in custody statistics. [Accessed 18/12/20]. National trend refers to male prisoners only and is standardised based on the op cap, so shows the number of incidents per that number of prisoners.

The PPO reported no self-inflicted deaths since 1st January 2017.

Deaths believed to be from natural causes are discussed in Chapter Four.

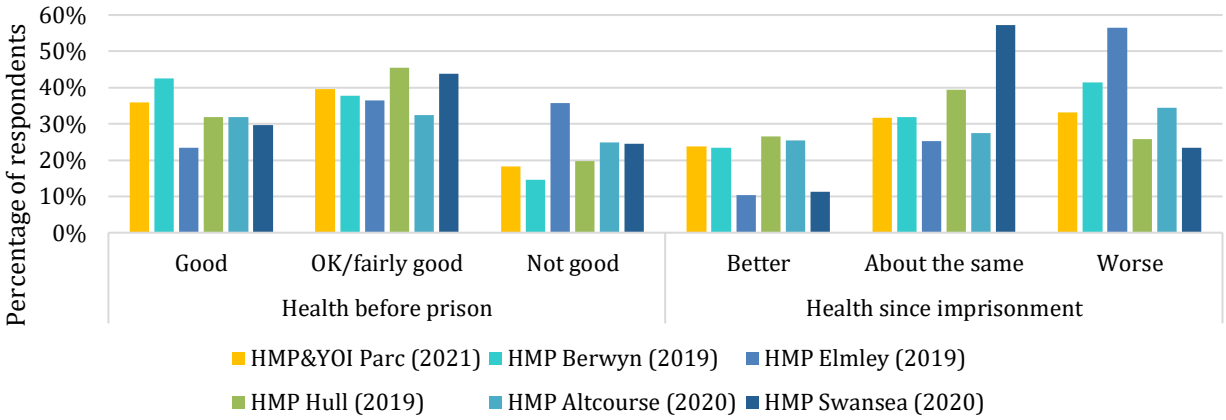
9.3 Chapter Summary

- The prevalence of self-harm in HMP Parc is higher than the national prison average.
- There is inconsistency in the recording of self-harm incidents between healthcare and the prison. Of the 1429 self-harm incidents recorded by the prison in 2019/20, only 629 were also recorded by healthcare. **See Recommendation.**
- Self-harm rates have reduced in recent years but remain a little above the national average.
- Self-harm initially increased during the first covid-19 lockdown period; however, the effects of this (coupled with the absence of the in-reach team throughout the pandemic) are likely to have been delayed.
- There is a range of interventions to identify and support residents at risk of self-harm.
- The Safer Custody Unit is a 14 bedded facility for those at greatest risk. Mental health support for these often floridly mentally unwell residents is delivered by Primary Mental Health Nurses. **See Recommendation.**
- There were no self-inflicted deaths between January 2017 and August 2020.

Chapter Ten – Wellbeing and Health Promotion

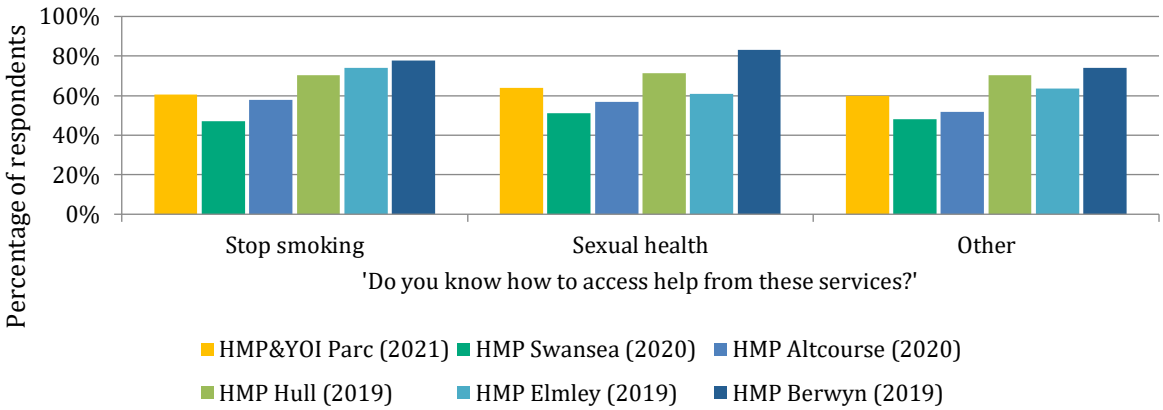
In our resident survey, respondents were asked about their health in general, before and since imprisonment. In relation to most comparator prisons we have surveyed recently, residents at HMP Parc were quite likely to report their health had been 'good' prior to imprisonment, with 75% reporting their health to have been 'Ok/Fairly Good' or 'Good'. The majority said that their health was 'about the same' or 'worse' since imprisonment.

Figure 93 – Health Before Imprisonment and Now (survey data)



Residents were asked if they knew how to access health promotion services such as smoking cessation and sexual health, as well as 'other' services such as healthy living and weight management. Residents at HMP Parc were no more or less likely than those at other similar prisons (on average) to say they were confident in accessing these services. We have expected to see a decrease in these numbers during the pandemic as residents will often learn about or develop trust in services by talking with their peers and in HMP Parc this is a key role for the Health Champions, described below.

Figure 94 – Accessibility of Health Promotion Services (survey data)



10.1 Generic Health Promotion & Wellbeing

HMIP (2020)

> *The prison had a coherent approach to health promotion. The health care team utilised a calendar of events reflecting national programmes, and health promotional information was displayed throughout the prison.*

There is a PLL who works closely with a team of 16 Healthcare Champions. This PLL used to cover health promotion with the Champions, as the PLL role has expanded, other HCAs now work with the Champions to deliver generic health promotion. they follow the national health promotion calendar and adapt these for the custodial environment.

The Champions take the message to each house block putting up posters and distributing leaflets.

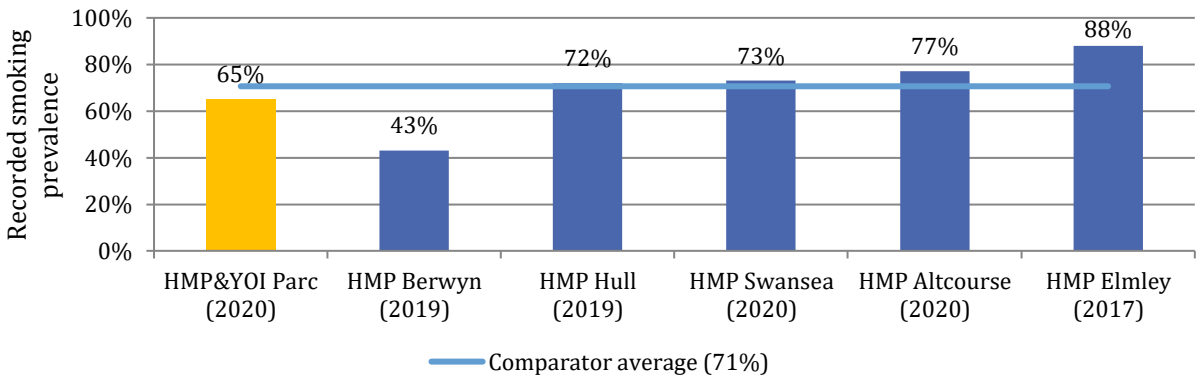
The PLL will check on the most vulnerable residents where they are not in receipt of other support. This might, for example, include food refusers or residents who decline secondary care appointments.

10.2 Smoking

ONS states that the age-standardised rate of smoking for those over 18 years in Wales is 15.5% which is above that of England (13.9%).[74] The report notes that smoking rates are highly correlated with deprivation, with those from the lowest socio-economic group twice as likely to smoke as those in the highest.

SystmOne data indicates that 65% of the prison population at an November 2020 snapshot were recorded as being smokers. This percentage is below the comparator average of 71%. It should be noted that this may include residents with a record of having smoked in the past, who have since quit.

Figure 95 – Smoking Comparison (SystmOne snapshot data)



In our resident survey, 50% (n=127) of respondents reported they had smoked before entering the prison (lower than the average of 51% across the five comparators), and 66% (n=168) said they currently used a vape or electronic cigarette (higher than the comparator average of 56%).

[74] ONS (2020) Adult smoking habits in the UK: 2019. [Accessed 18/12/20].

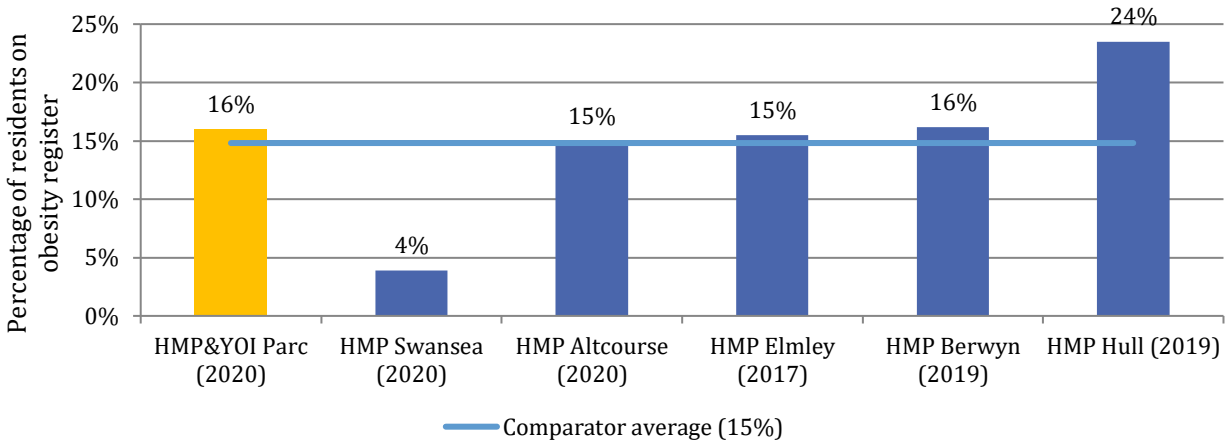
10.3 Weight Management

A recent report from Public Health Wales Observatory states that 60% of adults are overweight and, of these, 24% are obese. This figure is projected to increase a little to 64% overweight by 2030.[75] Being overweight is correlated with deprivation: the more deprived, the more overweight. As noted in Chapter Two, residents are predominantly from lower socio-economic groups.

There are typically two systems where weight is recorded. SystmOne body mass index (BMI). records should report the height-to-weight ratio as taken at reception or subsequently updated, and QOF should record any residents where obesity is considered an issue. In theory, these two measures should match, though it is usual for SystmOne BMI data to indicate a slightly higher proportion of obese residents compared to the QOF register.

In HMP Parc, the number of men on the QOF obesity register is about average relative to recent data from comparators (260 men, or 16%, next to an average of 15% across similar prisons). Whilst the relatively younger age profile of residents combined with a number of opiate users in HMP Parc may be an indicator of less obesity, the likely need is still higher than is currently being identified (and subsequently met).

Figure 96 – QOF Register Obesity



SystmOne data reported a higher rate of obesity with 25% of residents with a BMI record of 30 or above. A further 35% of those with a record were recorded as being overweight. Only 3% of records indicate a resident who was underweight.

Findings from the prisoner survey included suggestions that residents have access to scales to they can monitor their own weight.

10.4 Transgender

As noted in Chapter Two, the establishment currently holds six transgender residents (26th February) this is within a range that generally fluctuates between five and eight. The residents can be serving all different types and length of sentence.

Interviewees described a dedicated support pathway which is based on HMPPS guidance.

[75] Public Health Wales Observatory (2019) Obesity in Wales. [Accessed 18/12/20].

Until some 18 months ago all transgender residents were initially placed on the VP wing for their own protection, now they have individual needs assessments which includes consideration of health needs and risks before being allocated accommodation. This assessment informs an individual care plan which is reviewed every six to eight weeks by the Transgender Board. A number of residential staff have received transgender training and Key Workers will be selected from this group.

A challenge for the prison is that only the enhanced and VP wings have integral showers. If their behaviour allows, those on the main will be fast tracked to the enhanced wing.

There is a separate canteen list which includes items that the transgender group might need.

Report Part B describes the health needs of transgender residents and the likely health inequalities and includes further references to guidance documents.

10.5 Resident Engagement

HMIP (2020)

> *Consultation with prisoners on health issues was strong. It was led by an enthusiastic and committed member of staff who provided support during induction, as well as a valuable patient advice and liaison service which enabled prisoners to resolve individual concerns constructively.*

There are normally 16 Health Champions, this is paid role; there is a Champion in each house block. In addition to health promotion (described above) their role is to act as a conduit between healthcare and their patients. They deal with low level queries from residents, in normal times they represent residents' views via monthly meetings. Every month the PLL sends out questionnaires, 10 for each Champion to distribute and collect back in. The Champions help other residents to learn about and access healthcare.

The PLL role includes managing all queries and complaints, most complaints are about medication. She responds to all queries, if they are 'big issues' she will visit the resident. An example of a query might be asking about the outcome of a hospital appointment. For all complaints, she will contact the resident (in normal times visits).

Many Champions are also engaged in peer support which is covered in the following chapter; however, restrictions imposed by the pandemic and limitations of the telephone system combine to mean that Champions cannot current deliver their full role.

IMB note that the rate of formal complaints they receive that relate to healthcare are low and attribute this, in no small part to the work of the PLL.[76] This was reiterated in interview where the Chair of the IMB observed that the Board receive relatively few complaints about healthcare. Figure

[76] IMB (2019) Annual Report of the Independent Monitoring Board at HMP & YOI Parc for the reporting year 1 March 2018 to 28 February 2019. [Accessed 11/2/21].

10.6 Chapter Summary

- The findings from our prisoner survey suggest that the overall health of residents in HMP Parc immediately prior to imprisonment was poorer than we see in comparator prisons, likely reflecting the poorer health in the communities from which residents are drawn. Reports of health since imprisonment are average.

- Against comparator prisons, residents in HMP Parc were less likely to rate the health promotion services available to them in the establishment as accessible. This is in a context where, due to the pandemic we expected to see poor results.

- HCAs work with Health Champions to deliver generic health promotion messages.

- Prevalence of smokers amongst residents arriving into HMP Parc is a little below the average seen in comparator prisons. With few residents arriving from the community, there is little demand for smoking cessation.

- There is a very comprehensive approach to resident engagement, with a PLL who works with a team of health champions.

Chapter Eleven – Social Care

11.1 Overview

The 2014 Social Services and Wellbeing (Wales) Act has a wide focus and the interpretation of the meaning of 'social care' is broader than is evident in England. Wellbeing not only forms part of the title of the Act in Wales but is at the heart of the whole document. Note the definition of wellbeing includes:

- Physical and mental health, and emotional wellbeing
- Protection from abuse and neglect
- Education, training and recreation
- Domestic, family and personal relationships
- Being able to participate and contribute to society
- Respecting and securing rights and entitlements
- Achieving social and economic wellbeing
- Having suitable living accommodation

The wellbeing duty, as set out in Section 5 of the Act, requires any person exercising functions under the Act to seek to promote the wellbeing of people who need care and support.

There is a Memorandum of Understanding between the prison and Bridgend County Borough Council, to acknowledge the council's responsibility to deliver care to those eligible. Social care provision was recognised as commencing in the prison in 2016; prior to that residents had been cared for by nursing staff and it had been difficult for staff to separate out social care provision from general healthcare.

The registered manager for domiciliary care is a member of the healthcare team and packages of care are delivered by HCAs.

Noting that the age profile in HMP Parc is lower than the national prison average, with a lower proportion of residents over 50 years, we would expect the need and subsequent demand for social care to be much lower than in comparator prisons. However, as evidenced in the data the delivery of care is far greater than seen elsewhere. This is in part a consequence of acknowledgement of the social care needs of residents with cognitive impairment who are frequently overlooked elsewhere.

The prison has two assisted living units where many of those with the greatest social care needs tend to live:

- One for the 'main' prison with up to 16 beds. At any one time 12 to 14 beds tend to be occupied mostly by residents with neurological issues including learning disability, ADHD and Asperger's. One cell has a hospital bed.
- One for the VPU with 23 ground floor cells, again one has a hospital bed. These cells tend to be occupied by the frail elderly including residents with dementia.

Separate to both of these is a palliative care suite and the Safer Custody Unit; both are described in an earlier chapters.

All the cells on X Block (the VPU) are level access with grab rails and showers, all showers have seats. If cells need adapting, the OT will advise the prison on suitable adaptations. The prison only has three cells that are large enough to accommodate hospital beds, this was said to be inadequate to meet the needs.

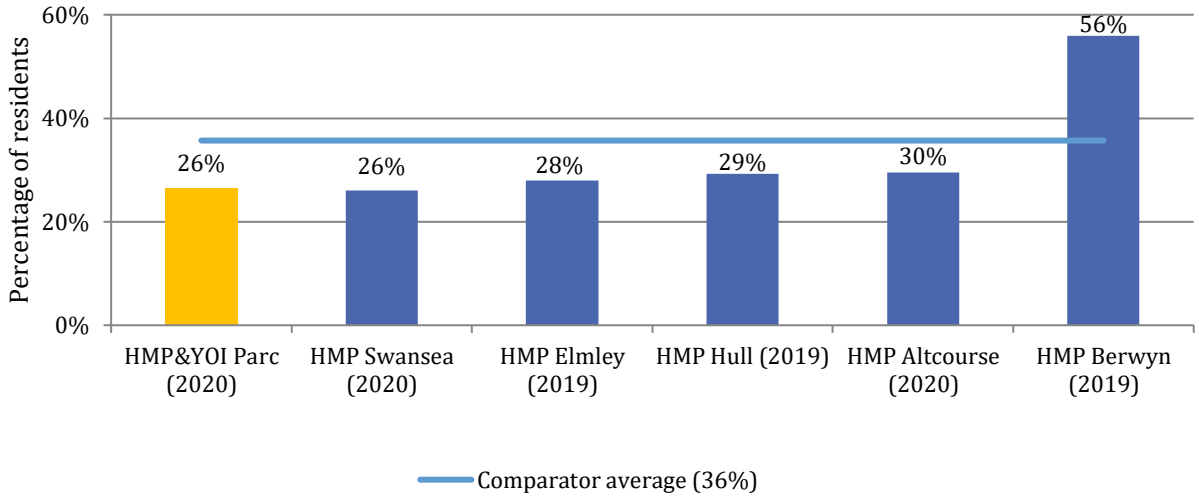
11.2 Social Care Needs – Daily Living

As a consequence of multiple read codes for broadly similar needs, SystmOne is poor at detailing social care needs in the population; this national issue outside of local control means that comparisons informed by SystmOne in this section should be treated with caution.

At December 2020, data provided by the prison describe 510 individuals (31% of the population) with any disability, which was a little below average for comparator prisons.

Data provided by healthcare indicate that 26% of residents had some form of disability recorded on SystmOne. This is lower than the average of 34% with any disability recorded on SystmOne across comparators.

Figure 97 – Disability Comparison (SystmOne data)



The table below shows the numbers of records on SystmOne of disability, mobility problems, or use of mobility aids (only those affecting five or more residents are included). As explained above the categories overlap and we have no way of knowing if one resident is entered once or multiple times.

Figure 98 – Disability and Mobility Problems (SystmOne data)

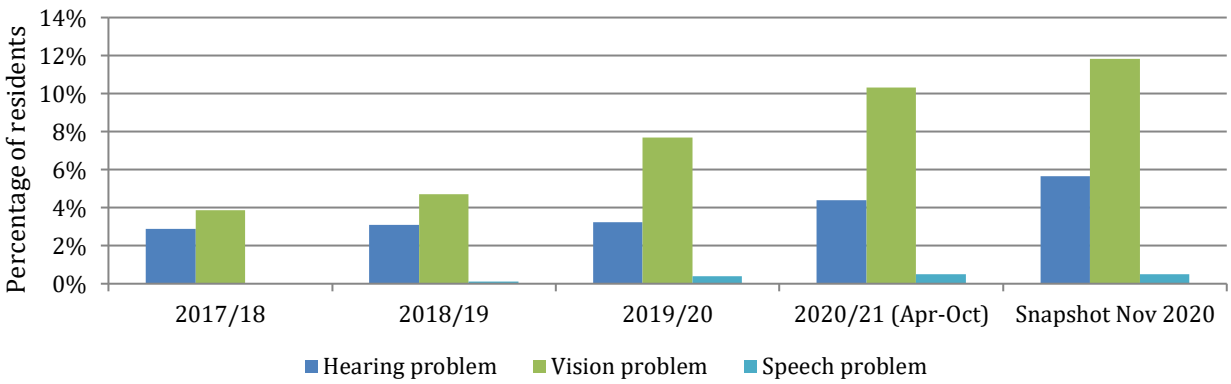
HMP & YOI Parc	Snapshot November 2020
Reduced/impaired mobility	130 (8%)
Difficulty mobilising	24 (1%)
Does not manage stairs	23 (1%)
Difficulty managing steps and stairs	17 (1%)
Physical disability	23 (1%)
Disabled	22 (1%)
Disability No Other Symptoms	21 (1%)
Walks independently with stick	22 (1%)
Uses walking stick	5 (0%)
Needs walking aid in home	20 (1%)
Uses wheelchair outdoors	10 (1%)
Mobile outside with aid	10 (1%)
Uses wheelchair indoors	9 (1%)
Registered disabled	8 (0%)
Confined to chair	7 (0%)

In our resident survey, 17% (n=43) of respondents self-reported having a physical disability or mobility problem. This is lower than the average of 24% across comparators (35% at HMP Elmley, 21% at HMP Hull, 20% at HMP Altcourse, and 21% at HMP Swansea).

The chart below outlines the percentage of residents recorded on SystmOne with sensory impairments, in recent years and at a recent snapshot. The data describes increasing proportions of residents with hearing or vision problems.

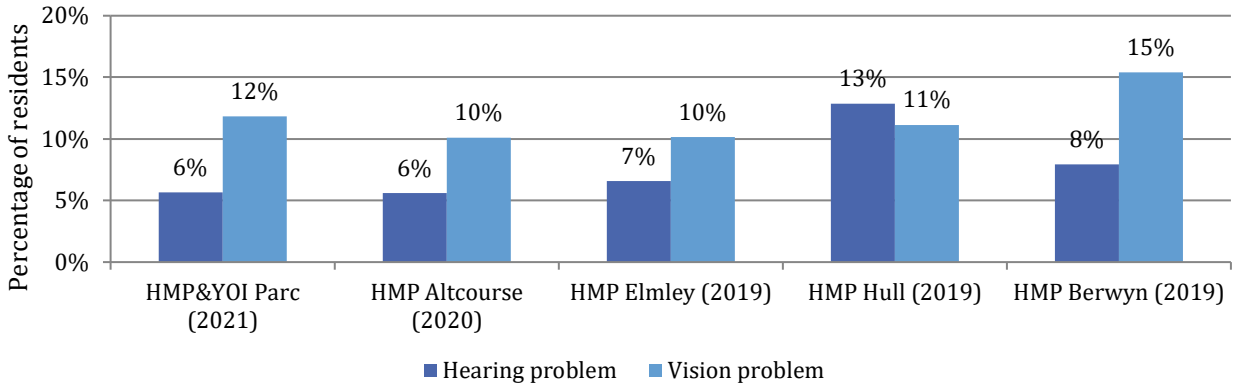
At the snapshot, there were eight residents (0.5%) with a recorded speech problem.

Figure 99 – Sensory Impairment (SystmOne data)



As a benchmark, the 5.7% (n=92) at snapshot with a recorded hearing problem was low next to comparators, while the 11.8% (n=192) of residents with vision problems was average.

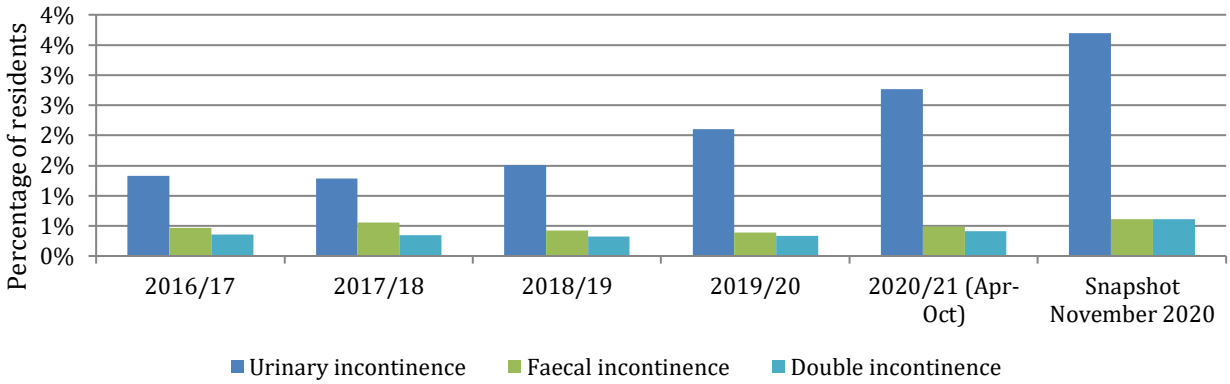
Figure 100 – Sensory Impairments Comparison (SystmOne data)



In our resident survey, 16% (n=40) of residents said they had a hearing or sight problem. This is lower than the average of 25% across comparators (31% at HMP Elmley, 20% at HMP Hull, 26% at HMP Altcourse, and 20% at HMP Swansea).

SystmOne data showed an increasing proportion of residents with any recorded continence problems at HMP Parc over the last five years; these records were mainly for urinary incontinence, though there were 10 men recorded with faecal and double incontinence at the November snapshot. At the time of the snapshot there were 60 residents (3.7% of the population) with any incontinence problems recorded, higher than the average of 2.1% across comparators. Residents can access secondary care specialists, this will be via an escort as this service does not visit the prison.

Figure 101 – Incontinence (SystmOne Data)



The table below summarises self-care problems (affecting five or more prisoners) recorded on SystmOne at a recent snapshot. There were a number of self-care problems recorded on SystmOne (read coded), the most common being the 1.7% (n=42) of residents 'unable to manage medication'.

Figure 102 – Self-Care Problems (SystmOne data)

HMP & YOI Parc	Snapshot November 2020
Unable to manage medication	42 (1.7%)
Difficulty writing	40 (1.6%)
Unable to perform personal care activity	35 (1.4%)
Unable to prepare food for eating	20 (0.8%)
Unable to clean room	16 (0.6%)
Unable to make bed	11 (0.4%)
Unable to write	10 (0.4%)
Unable to bath self	8 (0.3%)
Difficulty getting on and off toilet	7 (0.3%)
Unable to perform nail care activities	7 (0.3%)
Needs assistance with medication concordance	7 (0.3%)
Unable to perform laundry activities	6 (0.2%)
Unable to shower self	6 (0.2%)
Resident requires medication to be administered	5 (0.2%)
Unable to dress	5 (0.2%)

11.3 Social Care Needs – Wellbeing

In terms of wider wellbeing, it can be argued that there is an almost limitless need and potential for limitless service demand amongst residents in HMP Parc given the risk factors amongst the majority of residents.

Section 2.4.6 describes that 13.5% of residents in HMP Parc have been homelessness. Section 2.4.9 also indicates that around half of residents in HMP Parc are parents of children under 18 years, though this does not mean they are carers.

The Substance Misuse chapter describes an increasing recognition of the proportion of the population in HMP Parc experiencing problems related to substance misuse and increasing numbers engaging in clinical treatment.

The Mental Health chapter describes a massive likely need for mental health care, alongside scare resources.

11.4 Service Provision

The referral pathway is that that applications are all channelled to the registered manager who collates the information and forwards applications to the Council. The prison noted that all referrals are accepted, the council perspective was that healthcare staff are very good at identifying those with needs; however, they also receive referrals from other sources including self-referrals and not all of these are accepted. Where they believe there to be a need, G4S will support the resident while the council formally decide about a package of care. This is not a contracted service, elsewhere we have found that councils will allocate a nominal sum each year to contribute to these interim arrangements.

Whilst the social workers are security cleared and carry keys, in common with other interviewees they noted that vetting does take a long time and delays hinder their ability to deliver care.

The prison chairs a weekly Clinically Vulnerable and Older Prisoners (CVOP) meeting which is also attended by the Council and aims to identify those who might need assistance and is a source of social care referrals. This meeting will identify residents who would be better suited to living on one of the two 'Assisted Living Units' or in some cases the Safer Custody Unit. Adult social care noted that nearly all commissioned packages of care are delivered to residents living in these specialist units. Recent examples of cases discussed at the meeting included men with dementia or incontinence. In addition to these units, the main prison benefits from a unit for residents with learning disability or mental health issues – those who are not coping in general location. Adult social care noted that there are a range of focussed Multi-Disciplinary Team meetings where social care needs could be raised, they participate in a number, including the 'High Risk Meeting'.

For various reasons, some people decline offers of care; in these cases lead nurses will visit the resident and endeavour to encourage them to accept help.

G4S employ 'several' HCAs, interviewees were unable to quantify this further. The HCAs form part of the wider complement of eight HCAs described in Chapter Three, social care provision demands will flex according to how many hours of care are being commissioned at any one time. When social care services were first implemented the average was 35 to 45 hours of care per week in total and the hours never exceeded 50. In the last 12 months the packages of care have totalled 120 to 130 hours per week. One way of thinking about the staffing resource is to say that at best an HCA might manage some 30 hours per week client facing time, provision is equivalent to at least four FTE staff, this is twice the allocation described by healthcare interviewees. If there is an under recognition of the work, it will mean that the draw from other aspects of HCA work in healthcare is not acknowledged.

When an HCA is not available a nurse can deliver the package of care, the cross charge is always at a rate appropriate for HCA cover.

Prison interviewees noted that there is currently no occupational therapy provision and this is a gap in a comprehensive provision. The Council explained that whilst there has been a gap a new appointment is currently going through vetting. The OT supports residents and can assess for aids and adaptations.

There is potential to meet more needs via telecare, in other words falls monitors and the like. This is something which is in place in other prisons. There are three issues to consider: first is finding technology that will work in the prison, second is who pays for the purchase and upkeep. Finally, how is the equipment monitored 24 hours a day? (It may be appropriate to be monitored in the wing office during core hours but if this is not staffed overnight monitoring will need to take place elsewhere).

11.5 Buddy and Mentor Scheme

There is a two tier arrangement of peer support schemes, this is more sophisticated than seen in most other prisons.

In essence, buddies help with practical support and mentors offer social support; this was summed up as '*buddies might make another resident a cup of tea, mentors might sit and chat with him while he drank it'*.

Mentors are all trained by education and hold certificates. They talk, perhaps play chess and so on, offering social support to their peers. Either buddies or mentors might accompany a fellow resident to an appointment or adjudication to support them.

The residents run support service called Ralph. At present the peer mentors and Healthcare Champions cannot visit other prisoners so due to the pandemic, some mentors have their telephones adapted so that they can call between cells to support their peers on the telephone, this is an especially important means of tackling isolation during the covid-19 pandemic. However, the capacity is limited because many of those who could do a mentor role do not have a suitable telephone. The observation was that in the absence of effective peer support this role will fall to hard pressed operational staff.

The local adult social care team do not currently offer mentors training or support, this could benefit and further enhance the programme. For example the new OT would be able to offer useful advice and insight.

11.6 Care Leavers

The Social Services and Wellbeing (Wales) Act 2014 places an enduring responsibility to support young adults leaving care. This specifically applies to 18-25 year-olds. The issue for the prison is identifying these people and linking them to the responsible authority.

In our resident survey, 18% (n=45) of residents said they had previously been in care. This is a little higher than the average of comparators (14% at HMP Elmley, 14% at HMP Hull, 13% at HMP Altcourse, and 22% at HMP Swansea). When filtering the results for HMP Parc to identify those who are over 18 and under 25; there were 29 responses, of whom three had been in care, small numbers will create large fluctuations in percentages.

Care leavers are identified as part of the induction process which takes place for every new reception. It is now a question routinely asked and recorded. This is welcome and in the context of the wider prison estate, very unusual. The prison has a care leaver co-ordinator, but as yet there is no systematic approach to ensure those eligible for leaving care support are linked to their home leaving care team. The adult social care team will respond to requests to make these links.

Recommendation Twenty-Nine – Nearly all the pieces are in place to systematically link those eligible for leaving care support with their home leaving care teams. A short, focussed piece of work to ensure there is a consistent pathway from identification to referral should ensure this becomes a routine practice.

11.7 Release Planning

Interviewees explained that when there is a known date and the resident is in HMP Parc, the release planning process commences six months prior to any planned release, this includes reviewing if there will be any support needs on release. Adult social care said that planning

was a big part of their work in the prison. The example was given of a resident with LD, the prison staff will contact the LD team in Bridgend so that any interagency communication with the home area is LD team to LD team. They will also explore what links and potential informal support can be available from family/friends/carers in the community.

Adult social care observed that the prison environment can provide stability which may not exist in the community, they were very clear that there will be residents who whilst they cope well in prison will struggle in the community. They noted that a number of residents have complex needs which do not fit neatly into diagnostic categories. An illustration was a resident transferred in on an open ACCT with a short time left to serve. The resident had help from a drugs worker. He had emotionally unstable personality disorder so did not fit well into the in-reach team's brief, but they did support him and linked him with his home Community Mental Health Team, adult social care linked him with his home social care services. Having given this as an example of a case which worked well, a wider observation is that it can often be difficult to get in-reach involved with a resident. Many need psychology input both for support and to make a diagnosis. It is far more difficult to access services for support on release without a diagnosis. Unlike some other secondary care mental health teams, in-reach does not include a social worker, this post would affect a bridge between the two services.

There is a large element of prison life which potentially masks social care needs, in that many day-to-day living tasks are actually done for residents. Residents in HMP Parc may have been in prison for a number of years; social care needs which they may face in the community can be difficult to identify in the prison environment.

11.8 Chapter Summary

- As with every prison, SystmOne READ coding is confused making it difficult to identify needs relating to physical disability or frailty. This is largely outside the control of the prison.

- The age profile of residents in HMP Parc is predominantly young, thus we would have expected that demand for social care in terms of physical support needs is more limited than we see in other prisons. However, the broad interpretation of social care needs under Welsh legislation means support is offered to a number of residents.

- There is an elderly population, predominantly in the VPU, who have high levels of social care needs.

- There is clearly close and effective inter agency working between the prison, healthcare and the local council which is underpinned by a Memorandum of Understanding.

- The number of hours of care delivered has increased dramatically.

- There is a very comprehensive scheme of peer support available.

- There is good identification of care leavers which, given the young age profile of residents in HMP Parc, is welcome. The identification is followed by an established pathway to link young residents with their home local authority leaving care teams, where possible. **See Recommendation.**

- There is a comprehensive and structured approach to release planning.

Chapter Twelve – Findings and Recommendations

This report focusses on the adult population, there will be a separate report describing the needs of the under 18 year old population.

12.1 Conclusions

Health 'needs' are complex. As explained in Chapter One (and Part B), the health system responds to demands which are, in part, informed by need. Healthcare in HMP & YOI Parc is no exception to this.

Need is defined by morbidity (illness). The *general population* served by HMP Parc is a little less healthy than the combined England and Wales average. The *actual population* within HMP Parc is, like in any prison, an extreme subset of the general population, with the evidence and proxy indicators used in this HSCNA (Part B) showing that prisoners have far more health inequalities than their counterparts in the general population. Health needs are highly age correlated; as we age, we need more healthcare. Whilst the overall data does not clearly evidence an aging population in HMP Parc, there is a small, but growing, number of frail elderly residents who require a disproportionate health and social care input. Each additional individual in this group forms a small proportion of the overall population in the prison but adds considerably to the health and social care need. Nationally, it is suggested that the health spend for an average 85 year old is 5.6 times that for an average 30 year old.[77] Many interviewees talked about the large number of sex offenders and the large elderly population; placed in wider context neither is especially large. The prison's VPU tripled in size a number of years ago (we were told 2016); it appears the interviewees are still noticing this change. In common with many other prisons interviewees noted that a number of first time residents are receiving very long sentences (typically for historic sex crimes) at an old age.

Resident expectation is a strong driver for demand. If we take dental care as an example; a quarter of a century ago, when the prison was built and the PFI contract commenced, most 75 year olds had few, if any, standing teeth; now many residents seek out dental care in order to retain standing teeth into old age – society's expectation has changed.

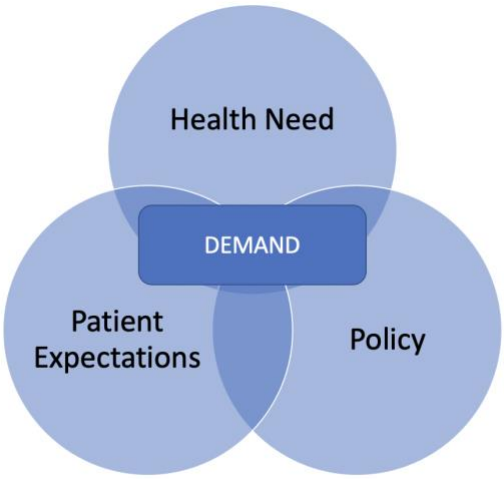
The final consideration is **policy**. By way of example the numbers engaged in clinical substance misuse treatment has quadrupled in a short period of time, yet there are probably no more opiate dependent people in the community served.[78] What has happened is that policy changed and treatment has been made more accessible. A further example is that following the Care Act, Adult Social Care have been visiting the prison and assessing social care needs, their work has helped healthcare focus on both health and social care needs of the elderly, this has identified more needs.

This is summarised in the illustration below:

[77] Full Fact website quoting Institute for Fiscal Studies data. [Accessed 19/2/21].

[78] NHS digital website describes a small recent increase in Class A drug use but says this is likely to be cocaine and Ecstasy. [Accessed 19/2/21].

Figure 103 – Drivers for demand



Noting the above, we can conclude, without a shadow of doubt, that health demand has changed dramatically since HMP Parc opened. This report articulates how changing need has played a part in this.

12.2 Summary of Findings

Many interviewees were rightly keen to describe the numerous awards that healthcare and the prison have received for different aspects of their health and social care work. If one aspect of healthcare stands out in contrast to other prisons, this is the approach to learning disabilities which is extraordinarily comprehensive. By comparison if one part of the service were to be singled out for improvement it would be mental health (particularly the under resourced in-reach service) which, as widely acknowledged in interviews, HMIP reports etc, is woefully under-resourced.

The sections below consider highly a few of the wider findings/observations that arose during the HSCNA process.

12.2.1 Primary Healthcare Resourcing

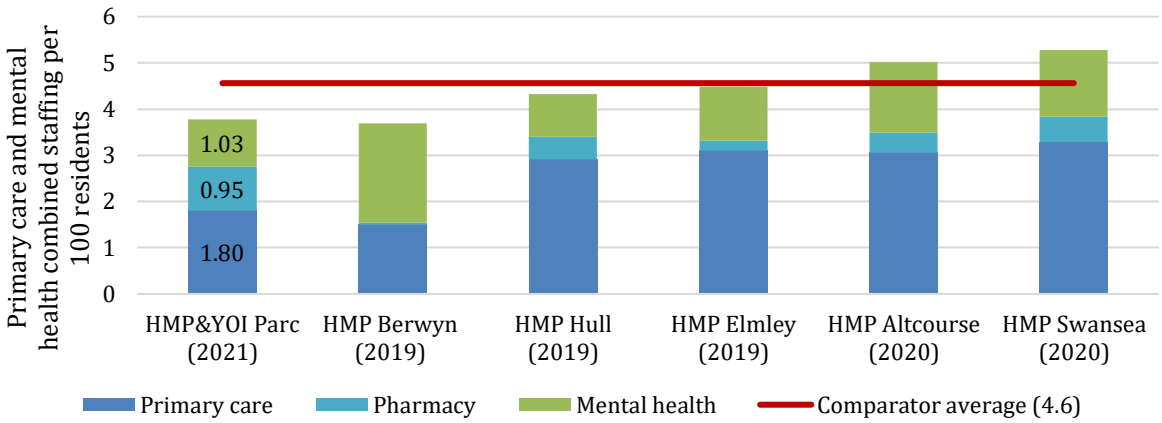
A question which we kept revisiting during this project was: if faced with finite resources and you choose to concentrate investment in a number of specialist areas of provision; does this detract from the core and what is left to deliver the everyday 'bread and butter' core services? To illustrate this question – on any one day it would appear the numbers of staff in what (for want of a better description) we will call the primary mental health role is below average for the size of prison. Further investigation identifies that five RMNs are specifically allocated to the Safer Custody Unit and to Cynnwys Unit which together serve about 2% of all residents. This then leaves remarkably few for the remaining 98% of the population.

We received many slightly different descriptions of the core nursing staffing numbers and specifically different descriptions of the staffing roles. This means some conclusions are a touch tentative. We are confident in stating that the total physical and primary mental health nursing resources collectively are relatively low. This is explored in detail in Chapter Three.

For a complete overview, the chart below includes pharmacy resources. These are relatively high because this includes staffing for a dispensing pharmacy, by contrast, for example, HMP

Swansea has off-site dispensing, so needs relatively fewer pharmacy staff on site. In HMP Parc pharmacy technicians deliver about ¾ of all administrations, this relieves nursing staff of this burden but increases the number of pharmacy technicians needed, each establishment makes different decisions about weighting, there is no right or wrong approach.

Figure 104 – Primary Care Staffing both Physical and Mental Health also including Pharmacy



The chart above illustrates that amongst comparators HMP Parc has the second lowest rate of staffing per 100 residents, at 3.78 this is considerably below the average (4.6). Just to bring staffing up to this average would require some 14 FTE additional posts.

Healthcare needs and benefits from a range of specialist nursing skills. Some of these exist within the team, for example a diabetes nurse, but there are also gaps. Where nurses have specialist skills we gained an impression that this was more by luck than judgement. Applicants came with specialist skills, rather than healthcare taking a systematic skills audit identifying gaps and undertaking targeted recruitment to fill gaps. A recurrent theme in interview was a reluctance to invest in nurse training, a number of interviewees said this contributed to staff turnover and created skills deficits within the teams.

The demand on escorts is unusually high. Whilst the reason is likely to be largely that services which could be delivered on site are only available off site, there will be many factors that influence this. Allied to the paragraph above, if specialist skills exist in the core team, then this can reduce demand for secondary care. Chapter Three describes a range of initiatives which have been trialled elsewhere and shown to reduce the demand for escorts.

12.2.3 Mental Health provision

We suggest that the mental health provision would benefit from a fundamental review, with a view to an integrated all age adult service.

Under Part 1 of the MHM, we found a primary mental health service that, in the absence of talking therapy resource, was over dependent upon prescribing. There was a gap in trauma informed therapy. At this level, there was a lack of capacity for diagnosis and we had concerns for those who might be described as 'complex primary', in other words challenging residents who do not meet the threshold for Part 2 of the MHM.

Under Part 2 of the MHM, the in-reach team is clearly very stretched and throughout the pandemic has been largely absent from the establishment offering a remote service.

The in-reach team describe their remit as being for working age adults. We heard various descriptions of what might be available for older residents. It is clear that the older persons' mental health service does not visit and expects residents to be escorted to a secondary care setting. Examples include to the Memory Clinic which is the setting for diagnosis of dementia. There needs to be onsite provision of Part 2 mental health services for older residents.

12.2.4 Substance Misuse

Recent changes in policy have dramatically increased demand for these services. The numbers in receipt of OST have more than doubled in a short period. This has had a knock on impact upon the psychosocial service as (appropriately) those in receipt of a prescription are also expected to engage with the psychosocial element of the service. In light of these recent changes, the report recommends a review of the services with a view to an integrated team.

12.2.5 Social Care

The scope and range of social care provision is impressive and greatly exceeds that seen in most other prisons.

12.2.6 Access to Facilities

Space is clearly at a premium. The opening comments in this chapter explain how demand has increased and with this increase there will be more healthcare activity. Prior to the onset of covid-19 there was already pressure on space; post covid-19 there will, in all likelihood be additional pressures resulting from 'social distancing' requirements.

'Social distancing' will likely mean the holding room is inadequate, either there will need to be a larger room, or more likely rooms. Alternatively there will need to be a fundamental rethink about healthcare delivery and a move to wing based services. The latter would demand clinical rooms in each houseblock.

'Social distancing' means each member of staff in an office needs more space. If, as seems likely, healthcare staff continue, or (hopefully) expand the number of telephone consultations there will need to be confidential space to make these calls from. This is both about staff being able to hear the resident and also medical confidentiality.

The dental suite operates every weekday morning and afternoon. Prior to the onset of covid-19 the service was struggling to meet demand. Now there is the additional pressure of a huge pent up demand. If there is to be any additional capacity there are two choices. Either delivery has to extend into the evenings and weekends, or there needs to be a second suite.

Lastly and probably simplest, healthcare staff need far more 'white phones'. Healthcare can efficiently deliver a proportion of their service remotely via the telephone. To do so they need to be able to call residents, not just wait for residents to call them. The current process where healthcare is dependent on a resident calling them is ridiculously inefficient.

12.3 Impact of Covid-19

Covid-19 has impacted residents of the prison and healthcare for nearly a year. This HSCNA endeavours to report on 'normal' need whilst also acknowledging the impact of covid-19. Whilst there may be, an as yet unknown impact of 'long-covid', the assumption is that in the future need will return to something akin to what was seen previously. The recovery process will be lengthy and complex; HMP Parc has a number of long-term residents, so pent up demand will not be transferred or released and will need to be addressed in the prison. There will be pressure across all aspects of wider health provision probably for years. Examples will include a backlog of secondary care appointments, including the impact of late or missed diagnosis. Visiting clinics and dentistry could, in theory, put on additional sessions if the limited space allowed; but the professionals will be under pressure to deliver additional work in all the settings they work in.

Recommendation Thirty – There will need to be a comprehensive covid recovery plan taking into account all aspects of healthcare. Any proposals for additional sessions/clinics etc will need to be costed and devised in consultation with the services delivering them.

Covid-19 has demanded many new working practices, such as no longer relying on face to face contact for all interactions with residents and moving to some telephone consultations. Some will hopefully be retained and improve services in the long-term. Covid-19 also presents some opportunities for innovation, for example secondary care providers are generally more amenable to the idea of telemedicine than previously as they endeavour to reduce footfall.

A feature of interviews were descriptions of innovations that were either paused due to covid-19 or planned for when restrictions are lifted. We can only comment on what we find, many of the ideas sounded positive, but the benefit will only be felt once they are implemented. They must not be lost.

12.4 Summary of Recommendations

Finding	Recommendation
The prison and healthcare data described numbers with disabilities differently.	**Recommendation One –** All data on disabilities (including learning disabilities) collated by the prison should routinely be shared with healthcare, the operational and healthcare side would benefit from a common understanding of need.
During the pandemic, healthcare has moved to telephone consultations. This approach is likely to be retained after restrictions ease. There is a chronic lack of telephones.	**Recommendation Two –** Healthcare need more telephones, especially 'white phones'.[79]
The prison generates an unusually high demand for escorts.	**Recommendation Three –** Explore opportunities to reduce the volume of escorts. This includes alternative means of healthcare delivery such as visiting diagnostic trucks and telemedicine.
Pharmacy facilities are inadequate.	**Recommendation Four –** The pharmacy need space to store medication and equipment. Both the pharmacy room and the store should have air-

[79] 'White phone' is enabled for calls to be made to patients in their cells.

Finding	Recommendation
	conditioning as many medications should be stored within prescribed temperature ranges.
Data described a smaller than expected number with respiratory conditions. Interviewees identified some gaps in nurse training.	**Recommendation Five –** Healthcare should prioritise the identification of respiratory conditions to ensure likely need is met. This should include ensuring that at least one nurse is trained in spirometry and able to use the equipment in the prison.
	Recommendation Six – There should be a nurse lead for each LTC.
	Recommendation Seven – Train some nurses to undertake diabetic foot checks.
Retinal screening services visit annually. This means that some residents will have to wait over a year between tests. In most other prisons, visits are twice yearly.	**Recommendation Eight –** Increase the frequency of retinal screening service visits to be once every six months.
With a lack of talking therapies, the primary mental health response is over dependent on pharmacological responses.	**Recommendation Nine –** The primary mental health provision needs an alternative to medication. It should include talking therapies – we recommend psychological wellbeing practitioners skilled in interventions such as CBT.
There is a lack of trauma informed therapy.	**Recommendation Ten –** There needs to be trauma informed interventions. We suggest EMDR.
There is a gap in capacity to diagnose residents, to initiate prescribing and to address needs of those with complex needs. (if you adopt the recommendation of psychological informed interventions for this cohort, there will also be supervision needs).	**Recommendation Eleven –** There needs to be both clinical psychologist and psychiatrist input for residents under Part 1 of the MHM. (Both may only need to be quite limited.)
There is a lack of provision for those whose needs fall under Part 2 of the MHM.	**Recommendation Twelve –** There needs to be a review of resourcing, with a view to substantially increasing the resourcing of services for those receiving care under Part 2 of the MHM.
The in-reach team would be more accessible and integrated with other health provision and the prison if based on site	**Recommendation Thirteen –** Services for those receiving care under Part 2 of the MHM should be based in the prison, rather than reaching in.
Gaps in provision would be addressed via a fully integrated mental health response.	**Recommendation Fourteen –** Services for those who fall under Part 1 and Part 2 of the MHM should be integrated.
There is no service for those with personality disorder.	**Recommendation Fifteen –** There needs to be a service for residents with personality disorder.
There is very limited access to mental health care for older residents.	**Recommendation Sixteen –** An older person's mental health pathway (which includes a response for dementia) should be reviewed to ensure (a) that there is appropriate recognition of need (b) that 'in house' support is available to support cognitive functioning and (c) that there is access to an Older Persons Specialist from the community service where needed.

Finding	Recommendation
Whilst the response to LD is excellent there are anomalies in the data. A repeated issue raised in interview was the lack of ability to make diagnosis; this is especially important for accessing services on release.	**Recommendation Seventeen –** Review the identified prevalence of LD in the establishment once the new recording system has been embedded to ensure there is a clear picture of likely need.
	Recommendation Eighteen – Training and skill development should be offered to ensure that the team have the qualifications necessary to do ASD diagnosis in the future. This should be regularly reviewed to ensure staff turnover does not result in this facility being 'lost' in the future. This could be achieved with specialist LD Psychiatry input, specialist training for current nurses, or, ideally, a combination of both.
There is a lack of specialist provision for those with acquired brain injury.	**Recommendation Nineteen –** There should be a specialist resource available in HMP Parc to meet the needs of residents with acquired brain injuries and enable access to timely diagnosis.
There is no access to SALT services.	**Recommendation Twenty –** Mirroring the community model of LD services the team should have access to SALT.
The OT services should be more accessible to those with cognitive impairment.	**Recommendation Twenty-One –** There should be communication with the current OT service in Bridgend to explore options for adding specialist OT input for residents on Cynnwys.
As noted above, a repeated issue raised in interview was the lack of ability to make diagnosis; this is especially important for accessing services on release.	**Recommendation Twenty-Two –** Mirroring the provision in community LD services, there should be access to specialist LD psychiatry and psychology as part of the provision within HMP & YOI Parc to ensure access to diagnosis in an attempt to break the revolving door cycle of vulnerability, unmet need and offending.
The psychosocial team do not record their work on SystmOne.	**Recommendation Twenty-Three –** The psychosocial team should record their work on SystmOne
The substance misuse service has seen a recent and massive increase in demand. This is now a good time to explore restructuring the response.	**Recommendation Twenty-Four –** Consider integrating the clinical and psychosocial aspects of substance misuse services into one team.
Many residents receive care from one or both of the substance misuse services (clinical/psycho-social) and also from one of the two parts of the mental health provision (primary/in-reach). At present there appears to be very limited care co-ordination and communication.	**Recommendation Twenty-Five –** The two aspects of substance misuse provision and the two mental health services should find ways to work more closely and share records to provide coordinated care to those who fall under the care of both substance misuse and mental health services.
There is only one dual diagnosis nurse and the needs are increasing.	**Recommendation Twenty-Six –** In order to better service the needs of residents with both substance misuse and mental health needs there should be more dual diagnosis resources.
A visiting specialist HIV service is not provided by the LHB.	**Recommendation Twenty-Seven –** The LHB should provide a visiting HIV service in the prison.
Data indicates that healthcare are not aware of all self-harm incidents.	**Recommendation Twenty-Eight –** Healthcare should routinely be informed of all self-harm

Finding	Recommendation
	incidents and these should all be recorded on SystmOne.
The identification of and response for care leavers is far better than seen in most other prisons. It would benefit from systems being formalised.	**Recommendation Twenty-Nine –** Nearly all the pieces are in place to systematically link those eligible for leaving care support with their home leaving care teams. A short, focused piece of work to ensure there is a consistent pathway from identification to referral should ensure this becomes a routine practice.
We were concerned that some descriptions of recovery plans for covid-19 did not take full account of the constraints that will be imposed by competing demands upon limited time professional have and the facilities available from which to deliver care in the prison.	**Recommendation Thirty –** There will need to be a comprehensive covid recovery plan taking into account all aspects of healthcare. Any proposals for additional sessions/clinics etc will need to be costed and devised in consultation with the services delivering them.

Appendix A – List of Interviewees

Name	Role	Organisation
Janet Walsgrove	Director	G4S
Clare Frost	Head of Healthcare	G4S Medical
Dr Rose Marnell	GP	Marnell Medical Services
Lynne Davies	Patient Liaison Lead	G4S Medical
Laura Mc Cloy	Nurse	G4S Medical
Kirsten Mallins	Pharmacy Manager	G4S Medical
Nicola Horn	Practice Manager	G4S Medical
Chloe Slater	Lead Nurse (Primary Care)	G4S Medical
Morwenna Schokkenbroek	Lead Nurse (Primary Care)	G4S Medical
Sarah New	Clinical Lead Registered Manager Domiciliary Care	G4S Medical
Lowri Jones	Pharmacist, Clinical SMS Lead	G4S Medical
Arianwen Selway	Learning Disability Nurse	G4S Medical
Kelvin Hughes	Chair	IMB
Carly Rees	Safer Custody Senior Operational Manager	G4S
Daniel Srivastava	Lead Dentist	Time for Teeth
Terri Warrilow	Team Manager	Adult Social Care Bridgend Council
Joy Griffiths	Senior Social Worker	Adult Social Care Bridgend Council
Feroz Peerbaccus	Mental Health in-reach Team Manager	Swansea Bay University health Board
Rhianna Jones	Clinical Lead (Primary Mental health)	G4S Medical
Scott Threadgood	Head of Residence	G4S

In addition 253 residents contributed their views view a survey.

Appendix B – Long-Term Condition Management

Figure 105 – Full Data for Selected QOF Indictors

Condition	Indicator	Percentage of eligible complete	Complete	Eligible
Asthma	Review in previous 12 months	1%	<5	70
COPD	Review/assessment in last 12 months	0%	0	24
	Influenza immunisation in last winter	92%	24	26
Cancer	Review within 6m of diagnosis	100%	<5	<5
Diabetes	Blood pressure checked + in optimal range	55%	28	51
	Foot examination in last 12 months	16%	10	62
	IFCC-HbA1c checked + in optimal range	50%	27	54
	Treated with a statin	72%	42	58
	Influenza immunisation in last winter	89%	55	62
CHD	Blood pressure checked + in optimal range	71%	24	34
	CHD therapy in last 12 months	76%	34	45
	Influenza immunisation in last winter	92%	35	38

Appendix C – Predicted Substance Use Incidence Calculations

Figure 106 – Calculation of Predicted Need

Drug treatment	HMP & YOI Parc
Population in a year (op cap + turnover)	3,693
Prevalence estimate (low)	28%
Prevalence estimate (high)	51%
Expected incidence (low)	1,034
Expected incidence (high)	1,883
Expected incidence (mid-point)	1,459
Alcohol treatment	HMP & YOI Parc
Population in a year (op cap + turnover)	3,693
Prevalence estimate (low)	16%
Prevalence estimate (high)	43%
Expected incidence (low)	591
Expected incidence (high)	1,588
Expected incidence (mid-point)	1,089