A Twelve-Month Study of Prison Healthcare Escorts and Bedwatches

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Description	This report presents the findings of a comprehensive study to identify accurate costings and clinical reasons for healthcare escorts and bedwatches in order to inform a decision on their future management. All recommendations will now be put forward for consideration within the Department of Health and the Home Office
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Contents

1. Executive Summary

1. In April 2003, budgetary responsibility for prison health services in English and Welsh public sector prisons transferred from the Home Office to the Department of Health. At that time, responsibility and funding for the security costs associated with healthcare escorts and bedwatches were excluded from the transfer, pending further investigation.

2. This report presents the findings of a comprehensive study that Prison Health and Her Majesty's Prison Service (HMPS) have carried out to identify accurate costings and clinical reasons for escorts and bedwatches in order to inform a decision on their future management.

3. Prison Health carried out an audit of all escort and bedwatch events for 142 prisons over a period of twelve months, including information on the number of escorting staff, duration of the episode and the clinical reason. Data were collected on a total of 47,857 episodes.

4. In parallel to the audit, three options for future funding and management of escorts and bedwatches were piloted in shadow form for a six-month period at a number of establishments.

5. A costing and budgetary analysis exercise was conducted, drawing on information from both the audit and the pilots.

6. Current data collected by HMPS accounting systems are not adequate to financially monitor escorts and bedwatches activity. As a result, all pilot sites significantly underestimated their shadow budgets.

7. The vast majority of episodes involve the use of two escorting officers at any one time. The exceptions to this are in the high secure estate, where the average number of escorting officers is three, and the open prisons, where the majority of episodes are unaccompanied.

8. The majority of escort episodes are completed within four hours, from the prisoner leaving the establishment to his or her return. The majority of bedwatch episodes are completed within four days.

9. The average weighted cost per escort episode has been calculated (including mental health transfers) at £140. The average weighted cost per bedwatch episode is £3,731.

10. It is recommended that funding and responsibility should transfer to Primary Care Trust (PCT) to help meet the requirement that decisions to provide treatment outside of the prison should be based on clinical imperatives.

11. The audit has provided sufficient information to use a combination of zero-based and indicative budgeting to allocate the funding. This would facilitate local verification of current activity and expenditure and would incentivise PCT/prison partnership boards to discuss future needs and potential changes to the service provided.

12. Necessary data requirements should be incorporated into HMPS accounting systems and the clinical prison health IT project being taken forward via NHS Connecting for Health to enable improved management of the budget.

13. The following areas of potential service redesign have been identified:

- addressing the area of injury and other trauma, which is the most common clinical reason for escort and bedwatch episodes. A reduction in unnecessary visits to A&E could have a marked effect on high levels of escorts and bedwatches activity;
- providing within the prison a wider range of the treatments and procedures normally provided by a GP practice in the community;
- providing specific clinics within the prison to provide a more cost effective service within these specialties.

14. Legal advice states that the Secretary of State for Health may legally exercise the function of making decisions about removing prisoners to hospitals under section 22 of the Prison Act 1952. Therefore, further legislation would not be necessary for a transfer to take place.

2. Introduction and Background

In April 2003, budgetary responsibility for prison health services in English public sector prisons transferred from the Home Office (HO) to the Department of Health (DH). By April 2006, Primary Care Trusts (PCTs) had assumed responsibility for commissioning primary care based services in all publicly managed prison establishments in England. At the time of the initial transfer, it was decided to exclude responsibility and funding for the security costs associated with escorts and bedwatches pending further investigation.

An escort is an episode where a prisoner is escorted by security staff to attend hospital. This includes the transfer of prisoners to NHS mental health facilities. A bedwatch is a hospital admission of at least one night in length, during which the prisoner requires constant observation for security purposes.

Her Majesty's Prison Service (HMPS) currently collects budgetary information relating to bedwatches only in the form of ex gratia payments to staff.

Prison Health and HMPS have therefore carried out a comprehensive study to identify accurate costings and clinical reasons for care being offered outside the prison. The overall aim was to identify the most cost effective option for future management of the escorts and bedwatches budget for recommendation to DH and HMPS senior management.

This final report brings together the findings from the various strands of work carried out under the aegis of the escorts and bedwatches project. It includes a review of the possible methods for setting a budget for escorts and bedwatches activity and an appraisal of the options for future management of this budget.

The report concludes with a series of recommendations.

2.1 Project Initiation

The escorts and bedwatches project involved three major strands of work: a full audit of escorts and bedwatches activity, a set of pilots and a costing and budgetary analysis exercise.

The audit exercise was carried out over a twelve-month period in all English and Welsh public sector and contracted out prisons in order to gain a realistic picture of activity levels, taking into account any irregularities in the data due to seasonal, regime or other factors.

Running in parallel to this exercise, three options for the future funding and management of escorts and bedwatches activity were piloted in shadow form at a number of prison establishments. These options were as follows:

- budget remains with HMPS
- budget transfers to the PCT
- a shared budget, with joint responsibility

A costing and budgetary analysis exercise was conducted, drawing on the data generated by both the audit and the pilots.

An Escorts and Bedwatches Steering Group was established to oversee the project, comprising the following members:

Julie Dhuny	Durham & Chester Le Street PCT (Chair)
Jeanne Bryant	HMPS Security
Sue Russell	Regional Development Lead, NW Development Team
Georgina Lacey	Healthcare Manager, Isle of Wight Cluster
Helen Coombes	Healthcare Manager, HMP Nottingham
Paul Follett	DH Statistics
Jenny Bywaters	DH/CSIP Public Health Advisor
Malcolm Pearce	DH Prison Health
Tom Bolger	Healthcare Manager, HMP Wandsworth
Claire Watson	Melton, Rutland and Harborough PCT
Sandra Peck	Healthcare Manager, HMP Morton Hall
Richard Wilkinson	Security & Operations Governor, HMP Morton Hall
Wendy Hardicker	Southern Norfolk PCT
Mike Shann	Governing Governor, HMP Birmingham
Henry Potts	CHIME, University College London
Bob Steele	Health Economist, Medicon Associates
Susan Wishart	HMPS Business Change Support Team
Steven Henderson	DH Prison Health
Andrew Hardy	DH Prison Health
Fiona Pearson	DH Prison Health

The main responsibilities of this group were to i) support the central team and advise on the implications of escorts and bedwatches for both prisons and PCT; ii) support the pilot sites and ensure information collected was of the required quality and content and; iii) review all papers and advise on the content of all reports.

Prison Health carried out a literature review to determine the current state of research in the areas of prison health escorts and bedwatches and the provision of secondary care to prisoners. This was updated regularly during the project and is documented in Annex J: Literature Review.

2.2 Communications

Prison Health staff attended all area managers' meetings at least once, to ensure that all governing governors and area managers had been briefed about the project, and subsequently returned to four of these to present local data. HMPS Business Change Management Team was also briefed at their meeting in June 2006.

Fourteen healthcare manager/PCT regional meetings were attended to ensure widespread dissemination of the project and a regional nurses' meeting for the London region was briefed in May 2006.

The Prison Officers Association and Royal College of Nursing were briefed at two of their joint meetings in May 2005 and March 2006.

The project team led a work stream discussion on escorts and bedwatches at the 'Sharing Good Practice' conference in May 2006.

2.2.1 Themed event

Prison Health held an all-day themed event on 'Escorts and Bedwatches: Developing National Policy and Local Practice' at the Botanical Gardens in Birmingham on 3 May 2006. Around sixty participants attended and, while the largest group of attendees were heads of prison healthcare, PCT prison health leads and prison governors among others were also present. The day was facilitated by the Prison Health Development Network at the Health Services Management Centre (HSMC), The University of Birmingham.

The objectives of the event were to:

- share the results of the escorts and bedwatches audit;
- discuss the key issues resulting from the potential transfer of the budget from HO to DH;
- explore innovative approaches to delivering healthcare within prisons which may reduce the need for escorts and bedwatches.

For notes of the event and copies of the presentations, visit the HSMC website at the following URL: http://www.hsmc.bham.ac.uk/prisonhealth/Events.htm

3. Escorts and Bedwatches Audit

3.1 Method

Prison Health produced a questionnaire in consultation with colleagues in HMPS, DH, the wider NHS, the contracted prisons sector and external research consultants. The questionnaire was designed to provide the data necessary to address the following issues:

- How consistent is the demand for escorts and bedwatches within each prison?
- For what clinical purposes are escorts and bedwatches taking place?
- How many person-hours of staff time are involved?
- What examples of good practice can be identified from the field and shared around the estate?
- What resources should be transferred if responsibility for escorts and bedwatches moves to the NHS?
- How many episodes take place outside of normal business hours for prisons with and without 24-hour healthcare provision?

Prior to the full implementation of the audit, the questionnaire was piloted in eight prisons for a period of two weeks in March 2005. The final version produced was the seventh iteration, taking account of the pilot and the consultation exercise.

Text replies were kept to a minimum with tick boxes where possible, ensuring the questionnaire was easily understandable and not time-consuming to complete. The age categories used tally with those used by the Office for National Statistics (ONS) in order to allow cross-referencing with data collected on secondary care services provided in the general population. The categories of presenting complaint correlate with those used in the World Health Organisation's International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10), for the same reason.

For a copy of the questionnaire, see Annex A.

For the purposes of the audit, escorts and bedwatches were defined as follows:

Escort means either:

a) the prisoner was taken by prison staff for external healthcare treatment and was returned to the establishment on the same day,

b) a late night visit to A&E in which the prisoner was not admitted to hospital (but technically returned to the establishment the following day), or

c) transfer of the prisoner to a secure NHS mental health facility.

Bedwatch means that the prisoner was admitted to hospital and spent at least one night outside of the establishment, requiring constant observation for security purposes.

The full data collection began on 18 April 2005 and extended to all visits to external healthcare service providers, including those where an escort was not used, in order to give a complete picture of activity in this area. Mental health transfers were also collected, being included in the above definition of 'escort'.

Consignments of the printed questionnaires were sent by post to all establishments, along with a covering letter, guidance for completion of the questionnaire and a timetable for returns.

Returns were initially collected on a weekly basis in order to allow speedy identification of any data collection difficulties. This was followed by a phased move to monthly collection from July 2005.

Prison Health staff used an Excel spreadsheet to monitor receipt of the questionnaires, showing totals received from each establishment and the percentage of establishments having returned in each reporting period.

Questionnaire returns were input centrally for statistical analysis onto SPSS, a software package used for conducting statistical analyses, manipulating data, and generating tables and graphs that summarize data. Where the data appeared to be anomalous or otherwise remarkable, Prison Health contacted the relevant establishment directly in order to determine the reason.

Two interim reports were produced in September 2005 and February 2006, overseen by the Escorts and Bedwatches Steering group. These presented analyses of the national audit data by prisoner demographics, type of episode, clinical reasons for episode and cost in staff-hours. Annexed to these reports were aggregate totals derived from each individual prison's audit returns. The interim reports therefore allowed prisons and PCTs to view their own returns in the light of the overall picture and to identify areas that they might wish to examine more closely.

The audit period concluded on 21 April 2006 and the final dataset for analysis was produced on 14 July 2006, the data having been 'cleaned' in SPSS to remove any inputting errors and systematic coding errors.

3.2 Validation

On completion of the data collection and input stage of the audit, a file was produced detailing the total number of escorts, bedwatches and unaccompanied hospital visits reported by each establishment on a month-by-month basis. This was sent to each establishment with a covering letter requesting that they check these totals against locally held records and confirm that their activity had been reported accurately. It was stated in the letter that nil responses would be taken as confirmation that the given establishment was content.

For further information, see Annex E.

3.3 Data Collection Issues

The commencement of the audit was moved back from the originally scheduled date of 01 April 2005 in order to allow full incorporation of the findings from the pilot and consultation exercises.

Although the majority of the original consignments of questionnaires were delivered and signed for at the prison gate, a large number of them failed to arrive at the health care manager's office, delaying the commencement of the data collection in a number of establishments. Some of these were reluctant to provide the data retrospectively, resulting in incomplete returns for the opening weeks of the audit.

The initial guidance sent with the questionnaires explained the use of ONS and ICD-10 categories and drew attention to sections of the form where further clarification was felt to be required, based on the outcomes of the pilot and consultation exercise.

On 21 June 2005, an updated guidance document was circulated to all health care managers, addressing the mistakes most frequently found in the completion of the questionnaires during the first two months of the audit. The most common errors were:

- presenting complaint for fractures being coded as 'Musculoskeletal system and connective tissue' instead of the correct 'Injury, poisoning and other consequences of external causes'
- presenting complaint for sexually transmitted diseases being coded as 'Genitourinary system' instead of the correct 'Infectious (transmittable) and parasitic diseases'

A further set of guidance, addressing specific points regarding the questionnaire and the audit as a whole, was circulated with the first interim report in September 2005. In both cases, there appears to have been a reduction in these mistakes following the circulation of the guidance. Another relatively frequent error was subsequently found to be:

- presenting complaint for cuts, burns and similar injuries being coded as 'Skin and subcutaneous tissue' instead of the correct 'Injury, poisoning and other consequences of external causes'.

A subsequent comparison of the bedwatches data with national hospital admissions data showed roughly similar proportions of episodes in the 'Musculoskeletal system and connective tissue', 'Genitourinary system' and 'Skin and subcutaneous tissue' categories, suggesting that the recoding had been successful.

For comparison with national admissions data, see Annex G.

A fourth guidance document was circulated with the second interim report in February 2006. This reiterated the points raised in the previous guidance, stressed the need for all data items to be completed and specifically addressed the requirement for data to be captured on out-of-hours emergency episodes.

Some establishments experienced problems in collecting data due to a lack of communication between the security staff, who have responsibility for escorting the prisoners, and the health care centre. In these cases, when a prisoner leaves the establishment in the evening or at the weekend, it has been difficult to retrieve the necessary information from security staff.

In addition, the movement of prisoners' medical records as part of transfer between prisons caused some difficulties for establishments when retrospectively completing questionnaires for escorts and bedwatches involving prisoners no longer resident at that establishment. Some cases of missing data are therefore due to the information no longer being available to the staff completing the questionnaire.

It is important to note that the data collected on tests did not capture the totality of this activity. Some establishments have informed us that the escorting officers have not always reported all the tests undergone by the escorted patient. The health care centre have only become aware of these tests when the results have arrived, some time after completion and return of the questionnaire to Prison Health.

3.4 Summary of Returns

The data collected represent 47,857 episodes, of which 45,324 were either escorts or unaccompanied hospital visits and 2,533 were bedwatches. These cover a period of 369 days (18 April 2005 to 21 April 2006).

Returns were required from all 142 private and public prisons in England and Wales. This figure was reduced to 141 following the closure of The Weare in July 2005. Despite having shared health care services, Grendon/Spring Hill and Usk/Prescoed are each treated as two separate establishments, as they fall into different prison types. All but one of the prisons submitted returns for all or most of the activity within this period. The exception was Buckley Hall, which re-roled from a women's prison to a male category C prison in September 2005. Missing returns have been identified via the validation exercise and accounted for within budgetary calculations.

For a full discussion of underreporting, see Section 12.1 and Annex E.

The 142 prisons have been categorised into six types:

Prison type	Number with 24 hour hospital cover	Number without 24 hour cover	TOTALS
Trainer/Other	9	39	48
Local	34	0	34
Female	8	9	17
Open	0	14	14
YOI/Juvenile	12	9	21
High Secure	8	0	8
TOTALS:	**71**	**71**	**142**

The category 'Trainer/Other' captures the Category B and C Trainer prisons and all other male establishments which do not fit any of the other categories.

For a breakdown of the returns by prison (grouped into prison type), see Annex D.

For statistical analysis of the audit dataset, see Annex B.

For a discussion of the main audit findings, see Section 8.

4. Pilots

4.1 Method

The following three options for the future funding and management of escorts and bedwatches activity were piloted in shadow form at a number of prison establishments:

- budget remains with HMPS
- budget transfers to the PCT
- a shared budget, with joint responsibility

Prison Health canvassed the estate for volunteer sites by attending meetings aimed at area managers, healthcare managers and PCT representatives and also the Prison Health 'Sharing Good Practice' conference, held in May 2005. Meetings were held with each prospective pilot site to discuss the planned piloting arrangements and agree which option would be piloted. The sites were agreed as follows:

PCT	Prison(s)
Option 1: Budget remains with Prison	
Melton, Rutland and Harborough	Ashwell, Gartree and Stocken
Ashton, Leigh and Wigan	Hindley
Option 2: Budget moves to PCT	
Durham and Chester le Street	Frankland
Norwich	Wayland
Bedford	Bedford
Option 3: Shared Budget between PCT & Prison	
Nottingham City	Nottingham
Preston	Preston
East Cheshire	Styal

Prison Health produced Terms of Reference, to be formally signed off upon initiation of the pilot, for each of the three options. These were approved by the Escorts and Bedwatches Steering group, and required that each site:

- appoint a pilot site lead who would be responsible for co-ordinating activities for the duration of the pilot

- appoint a management team, with accountability to the Escorts and Bedwatches Steering Group, to meet with a minimum frequency of once per month. The management team was to include appropriate representation from finance, commissioning and healthcare and would be chaired by the pilot site lead;
- agree a shadow budget based on healthcare escorts and bedwatches expenditure for 2004/05 plus a 5% uplift, then proceed to provide accurate costings against this budget for the length of the pilot. This exercise had to include an examination of the most cost effective means of managing the escorts and bedwatches budget. Pilots were not required to consider transport costs, preparation time and other 'hidden' costs although several sites did;
- submit regular progress reports to Prison Health detailing costings, risks, and any identified issues. These reports would contribute to a final pilot closure report containing an evaluation of the pilot and any recommendations arising;
- contribute to a project-wide lessons learned log upon project closure.

The pilots commenced on 1 October 2005 and ran until 31 March 2006, capturing six months of activity. A workshop for all sites was held on 10 March 2006 to encourage discussion and sharing of experiences.

4.1.1 Profiles

As an additional exercise designed to identify the hidden costs associated with escort and bedwatch events (e.g. preparation time), each pilot site was asked to construct a profile of what constitutes a standard 'escort' or 'bedwatch' episode in their establishment, distinguishing between planned, emergency, in hours and out of hours episodes. All activities associated with an event from start to finish were identified, including the type and number of staff involved, and the average time taken to complete the activity. The returns were compared by the central team to identify a single general profile of each type of event to be used to cost the associated preparation overhead.

For standard profiles, see Annex F.

For results of costing exercise, see Section 5.

4.1.2 Budgets

The budgets identified by the pilot sites for the six-month activity ranged from £7,500 to £25,000 and all proved to be underestimated, with an average shortfall of £48,000. This is largely due to the fact that historically, escort costs have not been separately identified within HMPS accounting systems. Some pilot sites therefore based their budgets on historical costs for staff hours on bedwatches only. Although a certain amount of variation is inevitable as costs are controlled by medical need, this highlights the inadequacy of the current data available to monitor financially escorts and bedwatches activity.

All sites appointed a representative(s) from other prison or PCT finance, as required by their chosen option, to monitor expenditure against the shadow budget.

For budgetary findings, see Section 6.

4.2 Issues Identified

A number of issues affecting the provision and management of escorts and bedwatches activity were identified via the pilot exercise. These have been summarised in the following table:

Issue/Risk	Description
Inability to Forecast Need and Manage Risk	Unknown healthcare needs (e.g. patients entering custody arrangements who require frequent dialysis treatment) present a risk to planning for care and expenditure and pilot activities clearly demonstrated that a single long-term hospitalised patient can put an immense burden on the escort budget. This is linked to the issue of 'health tourism' detailed overleaf.
Staff Skills	Some pilot sites reported that a lack of training has lead to additional escorting activity, particularly in areas such as blood taking and suturing. It was also reported that healthcare centres frequently find it difficult to release staff for education/training due to staff shortages, or run largely on agency staff who are not with the prison long enough to necessitate training. Training in the medical terminology used in accessing secondary care would also increase the efficiency of administrative staff.
Burden on Administration Staff	Prison healthcare administration staff spend a large part of their working time organising and rescheduling hospital appointments in order that more urgent appointments can be accommodated on any given day. They may also be asked to prioritise appointments if all cannot be accommodated, despite their lack of clinical training.
Cancellations	**By Hospitals** Pilot site data indicates that a significant number of appointments are cancelled by the NHS Acute Trusts, often at very short notice and sometimes after the escort had left the prison establishment. It is likely that the hospital does not appreciate the financial and staffing implications of such an action. **By the Prison** The most common cause of cancelled appointments is a shortage of escorting staff, usually resulting from staff having to prioritise an emergency appointment. Cancellations sometimes also result from security risks (e.g. prisoner inadvertently receiving the hospital appointment, concerns about the prisoner's motives for attending hospital). Prisoners are also commonly transferred to other establishments as a population management mechanism, usually at short notice to the healthcare staff. More stringent use of protection against transfer whilst on medical hold could be useful here, although this is not always adhered to.

Issue/Risk	Description
Cancellations	**By the Prisoner** Cancellations by the prisoner are sometimes due to refusal to attend but mainly occur as a result of the impact of their sentence on their access to secondary care. If given a choice of a prison transfer or accessing secondary care, a prisoner will most commonly choose the transfer. At present there are no mechanics for transferring the prisoner onto a consultant's waiting list in another hospital, in another area, which means that prisoners' health suffers as a result of progressing through their sentence. Prisoners may also choose to cancel their appointment upon release into the community.
Number of Escorting Officers	Prison policies regarding the number of escorting officers, which must accompany a prisoner are often inflexible. However, in certain cases it would make sense for the number of escorts to be reduced. For example, the number of officers guarding a terminally ill patient on long-term bedwatch may be reduced if risk assessment indicates that the risk of escape is low. In some prisons, the number of escorting slots available (typically two officers per day) has not been updated to reflect changes in population and prison type.
Preoperative Assessments	Although the smaller community and district hospitals are happy for prison healthcare staff to undertake preoperative assessments within the prison, the larger teaching hospitals tend to insist on the patients attending the hospital for these procedures. This is sometimes due to the fact that the teaching hospital is providing a service for a more complex healthcare need which requires more assessment than the prison has the equipment to undertake (e.g. cardiology tests). However, this is not true in all cases. There is no financial gain for the hospitals undertaking this additional episode of patient contact, which is included in the overall price for an operation. The extra escorting charge that impacts upon the prisons' budget only.
Poor Communication	**Between prison healthcare and security staff** Healthcare staff are often not informed of out-of-hours emergency episodes, even when the patient was still in hospital. Timely transfer of treatment details to healthcare staff upon return to the establishment following an escort event is also not always evident. **Between secondary care and prison healthcare** Hospital staff often pass details of follow-up appointments direct to prisoner, or send them to the prisoners home address. This presents a security risk.
Health 'Tourism'	Prisons may be prone to transferring 'problem' prisoners if they do not feel they have sufficient healthcare capacity, or it is felt that the prisoner poses a security risk.

Issue/Risk	Description
Cleanliness of healthcare centre	A surprisingly commonly reported issue relates to the uncleanliness of the healthcare centre, leading to prison healthcare staff feeling unable to carry out certain procedures within the prison. To overcome this problem, some prisons have employed external cleaners or have taken measures to ensure that prison cleaners are trained to a sufficient standard. Consideration is needed as to whether this option is viable with prisons which have a high turnover rate.
Litigation	The risk of litigation is increased if a prisoner's healthcare needs are not met due to an inability to meet escorting requirements

For recommendations arising from these issues, see Section 9.

5. Costing

5.1 Method

The current information on escorts and bedwatches activity within HMPS accounts is insufficient on which to base a budget or sum of money to be transferred. One of the main objectives of the Escorts and Bedwatches project was therefore to identify the cost of escorts and bedwatches to a level of accuracy sufficient to allow the possible transfer of a sum of money from one organisation and to another, such as not to disadvantage either side (i.e. the total sum identified should not lead to financial problems for HMPS and should be sufficient for the NHS to continue to commission a similar level of service were a future transfer to take place).

It was decided to use a pragmatic mix of ingredient and profile approaches to cost this activity:

- Data on all escort and bedwatch events for 142 prisons was collected over a period of 12 months, including information on the number of escorting staff and activity duration. This provides an accurate estimate of the overall levels of activity for escorts and bedwatches and associated direct labour inputs and allows the costing of the labour input involved in carrying out escort and bedwatch events, excluding preparation overheads. Levels of under-reporting were identified and an adjustment made as part of the costing process.

  For discussion on under-reporting, see Section 12.1, and Annex E.

- Estimated activities for other resources are available from standard profiles collected by the pilot sites; this allowed the costing of the staff overhead associated with each type of event.

  For standard profiles, see Annex F.

- A standard staff rate is to be used to cost the above, in the form of:

  i) an average Full Time Equivalent (FTE) hourly staff rate for the prison officer grade to be applied to preparation activities, escort events and in-hour bedwatch events. This will take account of all standard staff allowances (national insurance, superannuation, skills and responsibility and general allowances).

  ii) the Bedwatch ex gratia hourly allowance plus 9.3% national insurance to be applied to out-of-hours bedwatch events,

The following items will remain a prison responsibility and are therefore excluded from the calculations:

- For bedwatches, the cost of governor visits
- Inmate daily hospital allowance (60p per day)

The cost of providing healthcare staff, including admin support, has also been excluded as it is already included within the general prison health allocations.

5.2 Cost of Escort and Bedwatch Activity

The weighted average cost of providing a escort or bedwatch episode has been calculated as follows:

Weighted average cost per episode

Bedwatch	£3,731
Escort (inc. Mental Health Transfers)	£140

In the event of a transfer to the NHS, additional allowances would need to be added to cover travel and subsistence, transport and locality pay/London weighting.

6. Future Budgetary Options

These costings facilitate the consideration of future options for the management of the budget.

6.1 Options for setting the budget

A budget should be a plan of action matched by resources required to implement the plan, and is normally divided into revenue and capital. Regular examination of budgets should be undertaken to ensure that budget levels continue to reflect need and are a realistic financial base for the service. Activity levels should be reconciled as part of the budget setting process. There is often a tendency for financial data to be verified and included without any attempt to do the same with the service activity data. The result can be that budgets do not match activity at the very start of the budget management process, undermining budget management accountabilities and leading to inaccurate unit cost information.

There should be links to key performance indicators to consider how cost effective past budget allocations have been and decide whether any immediate changes to base allocations would be appropriate.

There are three realistic options to setting future budgets for escorts and bedwatches:

OPTION 1
Do Nothing/Current Accounts/Incremental Budgeting System (IBS)

This approach adjusts the current year's results for changes in activity levels and cost increases due to price inflation. If taken forward, there would be no change to the current situation: information would continue in the current form and budgets would increase incrementally to meet inflation and increased total activity.

Advantages

- No additional implementation costs
- No impact on health or prison staff
- No disruption to current situation
- Easy to implement
- Adequate cost control

Disadvantages

- Continuation of lack of good management information on costs and activities
- No direct link to health needs
- Past inefficiencies would be maintained year on year
- Emphasis on cost control rather than efficiency and effectiveness
- Prevents a critical look at, and fresh approach to, expenditure
- May create a perverse incentive to maintain high activity levels

Risks

- Variation in practices between prisons would remain high
- Inefficient decisions would continue
- System will remain accountancy/cost control led
- Traditional culture and practice difficult to change

Summary

Line–item budgets are part of operational requirements for cost control. However, these budgets do not reflect the true cost of providing escorts and bedwatches and insufficient information on activity and costs on which to set and manage a budget efficiently. Sums identified within individual prison accounts are unlikely to be acceptable to either party as a measure of the sums required to provide an escort and bedwatch service.

OPTION 2
Zero-Based Budgeting

In this approach, current levels of activity and resources are reviewed in order to either change or verify them. All budget headings are therefore given a value of zero at the beginning of the budget development process, and each item of expenditure should be justified in terms of what will happen if it were excluded from the plan. This enables the allocation of available resources in a more effective and efficient manner.

Advantages

- Thorough assessment of current patterns of resource use
- Both provider and commissioner have the opportunity to change and agree activity to get a better resource allocation
- Decisions can be made on priorities based on factual information
- Clear links between budgets and objectives
- Promotes innovation, effectiveness and efficiency
- More likely to have unnecessary expenditure excluded
- Focus on value for money

Disadvantages

- Can be expensive and time consuming unless supported by good IT
- May sometimes be overkill if done too frequently
- May be difficulties in identifying suitable performance measures and decision criteria
- Questioning current practice can be seen as threatening
- May be lack of information on costs and outputs of options other than current practice

Risks

- Progress may be impeded through challenges to the dataset. However, all establishments had an opportunity to verify total returns as part of the validation process (Annex E: Results of Validation Exercise)

Summary

The audit exercise has provided sufficient information on which to base discussions on the levels of activity, the need for these activities and their cost. In effect, the audit has allowed the prison and health services to conduct a one-off zero-based budget for these areas. This could then be compared to the levels within current accounts and/or as verification against nominal budgets.

OPTION 3
Indicative (Formula) Budgeting

Formulae have been extensively used within the NHS and would normally contain a small number of key measures to calculate an appropriate distribution of resources (e.g. a formula to allocate resources to health authorities on the basis of the differing healthcare needs of their respective populations would contain measures of population served by each authority amongst others). Budgets could be set on the basis of the funding level commensurate to groups being identified for each prison where the activity and average cost would be adjusted for a number of factors thought to affect the costs of providing escorts and bed watches. These might include security status, gender, age mix and any other factor found to be significant from the statistical analysis. The arguments for taking this approach would be:

- To level out differences in cost efficiency through applying a single tariff to all prisons in the group. Those whose real costs were below the tariff would make a profit and those above would have an incentive to reduce costs and;
- Activity levels would be standardised by applying an expected level of activity per head of population. This would identify prisons not achieving expected levels of activity.

Advantages

- Budgets are seen as 'fair' if participants accept that the formula reflects all of the key factors affecting cost and activity
- Indicative budgets try to reflect where prisons lie relative to the group average and can help identify or level out differences between similar prisons in terms of both activity and cost
- Cheaper than zero-based budgeting and slightly more expensive than incremental budgets

Disadvantages

- Centrally driven system
- Non-commercial approach
- Key variables can be difficult to identify
- Agreement is often difficult

Risks

- The dataset does not identify significant variables for the formula to be acceptable
- There are extensive inequalities identified between current budgets and those identified from the formula leading to significant readjustments

Summary

The audit should provide sufficient information from which to derive a formula to allow indicative budgets to be created and this approach has many attractions in a situation where there appear to be large variations in practices and historical investments. However, considerable more work would need to be done to verify any formula produced and the approach may now be regarded as a slightly out of date methodology in the NHS. Formulae and the audit data could still be used for performance management purposes producing a number of key group indicators.

6.2 Who should hold the Budget?

Having considered the various options for setting the budget for escorts and bedwatches, it is necessary to identify the best organisation to hold the budget. This will allow improved planning, coordination and control of associated activity.

Three options were piloted in shadow form at a number of prison establishments (see Section 4) in order to highlight the advantages and disadvantages of each method, including the problems of managing the security aspects of prison healthcare related to escorts and bedwatches. Findings were as follows:

Option 1
Do Nothing

Status quo continues and the budget remains with HMPS. Budgetary responsibility for prison health and the security aspects of bedwatches and escorts remain in different organisations.

Advantages

- There would be no additional costs incurred
- No additional burden is placed on PCTs
- No impact on clinical or administrative staff

Disadvantages

- Current problems within the system would remain
- Security availability would still drive health need rather than security being a requirement of health need
- Incentives for health to change the patterns of health care delivery with respect to outside prison appointments and bedwatches would remain low
- Incentives to implement best practice would remain low
- Incentives to invest in facilities would not be improved
- Unable to calculate the whole cost of the episode
- Unable to support longer-term strategic initiatives
- May not link to clinical processes, e.g. referral and discharge

Risks

- Current inefficiencies identified by the audit likely to remain
- Miss opportunity to strengthen working relationship between prison and PCT

Summary

Taking this option forward is unlikely to solve any of the problems identified from the audit. Health need in relation to escorts and bedwatches would not be proactively managed nor traditional culture and practice changed.

Option 2
Shared Budget

The budget is held jointly between HMPS and the PCT.

Advantages

- Prisons and PCTs would gain a better understanding of each other's problems and perspectives
- Issues should be addressed more quickly
- Compromises should be available from both partners
- Could be used to support the transitional transfer of responsibility and the budget
- Encourages joint partnership working that could act as a lever

Disadvantages

- Agreement is often difficult and the status quo becomes the fall-back position inhibiting change
- Compromise can impede efficiency and effectiveness
- Joint management is most difficult when there are significant cultural differences between the organisations involved. Shared visions can be difficult to obtain
- Decision-making processes can be difficult and convoluted beyond the importance of the actual decision itself. May lead to bureaucratic processes
- The budget at an organisational level may be too small to be of interest
- Future requirements and growth can be difficult to agree especially where core funding comes through different departments (HO and DH)
- May lead to difficulties in accountability and owning risk
- Difficult to ring fence the budget
- There would be additional budget setting and budget management costs in terms of time and personnel

Risks

- Neither partner would be really in charge and lead change
- Poor relations would cause real problems
- The 'do nothing' scenario would prevail

Summary

There is a difference between working in partnership and joint budgets. This option addresses the strengths and weaknesses of joint budgets. The level of budgets, their rules (e.g. treatment of variances), management arrangements, audit, etc. need to be clear and unambiguous. Managing joint budgets between prison and health is likely to be difficult for a number of reasons and past experience of this approach in the public sector is not encouraging.

Option 3
Budget transfers to PCT

The budget is transferred to PCTs.

Advantages

- The same organisation would be responsible for commissioning both health and security elements
- There would be a greater likelihood of health led decisions and healthcare can be based around the patient not the organisation
- Incentives should be higher to improve efficiency and effectiveness in the need for outpatient (escorts) and bedwatch care
- Allows the whole cost of the episode to be calculated and the completion of all aspects of baseline healthcare funding
- Potential for savings which could be reinvested in healthcare
- Development and implementation of care pathways
- Supports better planning of healthcare

Disadvantages

- Any transfer of responsibilities will cause short-term problems and anxiety for both parties
- Additional work and risks for PCTs
- There is a danger that PCTs will simply hand the funding back to prisons and no change will occur
- PCTs may be reluctant to take on 'security services'
- Governors still controlling (in reality) access to secondary services
- Might be more expensive than the status quo because less flexibility within total labour budget of prisons. Alternatively, greater efficiencies might be possible through better decision making

Risks

- New PCTs are unable or unwilling to take on new responsibilities
- Very difficult without management information derived from a clinical IT system
- Funding may be bundled into Strategic Health Authority allocations with no ring fencing possible, hence no savings being identified to reinvest

Summary

This option is the most likely solution. It gives a health-oriented organisation the lead in what should be health led decisions. Prisons would always remain responsible for individual prisoner risk assessment and, for the time being at least, the provision of the required security resource. There are likely to be higher levels of innovation and change. The transfer could be introduced by a phased handover over an agreed period of time.

7. Legal Advice

Advice on the legality of a possible transfer of responsibility of escort and bedwatches activity from the Home Office to the Department of Health was obtained in November 2003 and March 2004. Confirmation that this advice is still relevant was received in August 2006.

Under section 22 of the Prison Act 1952, the Secretary of State may direct that a person detained in custody be taken to a hospital or other suitable place for the purpose of medical investigation, observation or treatment; and unless the Secretary of State otherwise directs, the person shall be kept in custody while being so taken, while at that place, and while being taken back to the prison. Under section 80 of the Criminal Justice Act, the Secretary of State may make arrangements for the delivery of prisoners between prisons and hospitals, and for the custody of prisoners while they are outside prison for temporary purposes. The arrangements are to be performed by prison custody officers, and the arrangements made by the Secretary of State may include entering into contracts with other persons for the provision by them of prisoner custody officers.

Under the Interpretation Act 1978, "the Secretary of State" is defined to mean "one of Her Majesty's Principal Secretaries of State", unless the contrary intention appears. The Secretary of State for Health is therefore able to exercise functions under the above provisions.

The provision of escorts and bedwatches can not be seen to fall within the Secretary of State's powers under the National Health Service Act 1977 as these are provided for the purposes of ensuring security and would not necessarily be calculated to facilitate or be conducive or incidental to the discharge of the Secretary of State's functions under the 1977 Act.

The prisoner is deemed to be in the custody of the governor and this should remain the case if the Secretary of State for Health exercises the function of making decisions about removing prisoners to hospitals under section 22 of the Prison Act 1952.

8. Discussion

8.1 Main Findings

This report deals with a far larger audit dataset than either of the interim reports and additionally presents findings from the pilot sites and the costing and budgetary analysis exercise. However, most of the main findings from previous reports still stand.

As can be expected, the median number of staff involved in escort and bedwatch episodes is higher for high secure prisons (3 escorts) than for other prison types (2 escorts). The median length of an escort episode is two hours and mean staff cost is 5.57 person-hours. The median length of a bedwatch episode is 50 hours and the mean staff cost is 212 person-hours.

The most common reason for an escort event across most prison categories is 'Injury, poisoning and other consequences of external causes'. The only exception to this is for Open prisons, where 'Musculoskeletal system and connective tissue' is the most common reason. For bedwatch episodes, 'Injury, poisoning etc.' again accounts for the largest number in most prison categories. The exceptions here are Female prisons, for which 'Pregnancy, childbirth and the puerperium' is the most common category of presenting complaint, and Open prisons, for which it is 'Circulatory system'.

The majority of events are completed within a 1-4 hour period for escorts and a 1-4 day period for bedwatches.

The analysis of the time series data in Section 12.1 shows no evident seasonal variation in the volume of escort and bedwatch activity across the estate. However, there is a weekly variation, with episodes being much less frequent at weekends.

8.2 Trauma

A striking feature of the audit dataset is the high number of episodes resulting from trauma such as lacerations, cuts and fractures, as noted above. The comparison with the general population (see Annex G: Comparison with National Admissions Data) shows that trauma accounts for a higher proportion of non-day case admissions (i.e. bedwatches) among the prison population for all age and gender groups studied apart from men aged 65 and over. Trauma is the reason for nearly 50% of out-of-hours escorts and unaccompanied visits and 70% of emergency escorts. Furthermore, around 25% of planned outpatient appointments are visits to the fracture clinic, orthopaedic/hand clinic or X-Ray, which can be largely assumed to be follow-up appointments subsequent to a visit to A&E.

It can be inferred that high levels of assault and self-harm are causing this inflated level of activity. Among bedwatches resulting from trauma, the highest proportion (36%) are due to intentional self-harm. With the exception of mental health interventions, this is not something that PCT commissioning can influence.

8.3 Tests Performed outside of the Establishment

From the analysis of tests performed in Section 11.3.3, it would appear that a number of treatments that could be done in the healthcare centre are carried out externally. Blood tests, for example, are fairly simple procedures and the decision to send a prisoner out for this when healthcare facilities exist in a prison is questionable. This would suggest that there is a training gap amongst prison healthcare staff in this area.

Prisoners are also sent out for injections (including flu jabs and vaccinations), suturing (inserting and removing), to have dressings changed and for urine tests. There may be valid reasons for some of these incidents, but in the main these basic procedures should be carried out in the prison healthcare centre. It has been suggested by several sites that the uncleanliness of the clinical rooms causes the patients to be sent out. One PCT has solved this by employing civilian cleaning staff, rather than using prisoners. However, it would not seem unreasonable to train the prisoners involved in cleaning the healthcare centre to maintain agreed standards of cleanliness.

A number of treatments can only be carried out in a general hospital setting, such as chemotherapy, MRI and DVT scans and colposcopy. However, taking prisoners out for some forms of physiotherapy and occupational therapy, counselling, podiatry and a number of minor surgical procedures, may not be cost effective. PCTs may also wish to consider the possibility of obtaining specialist equipment, probably on a temporary basis, for use within the prison (e.g. obtaining a home dialysis machine if the patient is deemed suitable).

To examine this further, the project team consulted a GP practice[1] to determine which procedures from the list resulting from the audit should generally be offered within primary care. These were given as follows: acupuncture, skin biopsy, blood pressure, changing dressings, coil fitting, counselling, cyst removal, ear syringing, ECG, eye test, eye lash removal, vaccinations (inc. flu, tetanus), spirometry, minor surgery, nasal obstruction, physiotherapy, podiatrist, speech therapy, stitches, urine test. It is that noted that secondary care treatment may still be required when specialist intervention is needed (e.g. facial lacerations and other areas where scarring can affect a person's psychological wellbeing).

1. Hadley Practice, Broadstone, Dorset.

8.4 Prison Healthcare Centre Survey

The analysis of the relationship between the rate of escorts and bedwatches and the availability of healthcare services within the prison (see Section 12.2) shows that the variety of clinics offered is not a good predictor of rate of episodes. Simply providing more clinics in the healthcare centre is therefore not likely to make a sizeable impact on the overall scale of escorts and bedwatches activity from a given prison. The reason for this appears to be the predominance of trauma as a reason for taking prisoners out to hospital.

However, the analysis of the relationship between provision of specific clinics (e.g. GUM, dentist, physiotherapy, optician, X-Ray) and the rate of visits to the relevant outpatient department does indicate that services could be provided more cost effectively within these clinical specialties.

8.5 Emergency and Out-of-Hours Survey

Although prisons with 24-hour cover have significantly lower rates of escorts and bedwatches overall than those without it, a significantly higher proportion of these episodes take place outside office hours (defined as Monday to Friday 9 – 5).

Emergency escorts from prisons with 24-hour cover are more likely to be due to instances of trauma or pregnancy than those from prisons without. Prisons without 24-hour cover are more likely to send out emergency escorts for complaints relating to the circulatory system, respiratory system, digestive system and musculoskeletal system. This implies that a number of episodes treated as requiring an emergency escort could have been handled in-house if more hours of healthcare cover were provided in the prison.

In total, over 10% of escorts and unaccompanied visits result from emergencies. Within the YOI/Juvenile estate, this rises to around 25% of all escorts episodes dropping back down to a maximum of 13% for all other prison types. By contrast, almost two thirds of bedwatch episodes arise from emergencies. The female estate has the greatest proportion of emergency episodes (75%), followed by the YOI/Juvenile, Local, Trainer/other and Open estates. Less than 50% of bedwatch episodes in the High Secure estate result from emergencies. This would seem to support the findings of the Safer Custody Group, who reported in their newsletter dated September/October 2005 that, proportionally, women accounted for 53% of all self-harm incidents, and men just 42%. This is in spite of the fact that women form only 6% of the prison population.

However, one prison/PCT partnership has recently begun to address the level of episodes treated as emergencies, using an innovative approach. Eastern Hull PCT have seconded an emergency care practitioner to address the number of unnecessary visits to A&E. This person is working with the PCT and Acute Trust highlighting training and experience

needs, looking at ways to facilitate rotations, as well as developing in-house clinics using existing teams, specialists and domiciliary arrangements for visiting consultants. Wing staff now have a single point of contact with healthcare to discuss injuries. At the time of writing, it is too early to assess the impact of these developments on the rate of emergency escorts.

8.6 Rates Analysis

Since prison category alone is the strongest predictor of an establishment's rate of escorts and bedwatches activity, we can conclude that variance within categories is relatively low. Despite this, there are outliers at both the low and high ends of the scale.

The calculated rate of episodes per operational capacity place per year for each establishment are listed within prison categories in Section 12.2. These are for information only and should not be regarded as 'league tables', since the many variables affecting rate of escorts and bedwatches do not apply uniformly to all the establishments within a prison type.

8.7 Information and Communication

An unintended outcome of this study has been to draw attention to the need for improved lines of communication both within prison establishments and between prison and PCT partners. Linked to this is the ongoing need for a clinical IT system in prison healthcare centres.

Problems of poor communication between wing staff and prison healthcare staff caused some difficulties with the audit data collection. For example, healthcare staff were sometimes not informed of out-of-hours emergencies. Information from the hospital could sometimes fail to get back to prison healthcare staff, such as details of tests and procedures undergone by the escorted patient. This led to under-reporting of these types of activity in the audit. Transfer of prisoners between establishments often led to cancelled appointments, especially when healthcare staff were not forewarned by staff with responsibility for population management. This is wasteful of NHS resources and also has a negative impact on the patients' care, as their places in the waiting lists are usually lost.

On the other hand, some NHS trusts have demonstrated poor awareness of the needs of the prison, for example by sending details of follow-up appointments directly to the prisoner concerned with no account taken of the security implications.

Such poor communication within the system currently presents an impediment to improved management of the healthcare escorts and bedwatches service.

The pilot exercise showed that existing financial data on escorts and bedwatches were inadequate for budget setting, as all of the pilot sites underestimated their shadow budget.

8.8 Budgets

The requirement for escorts and bedwatches is a direct result of the need for a healthcare intervention for a prisoner and the meeting of that need is a clinical decision both in urgency and location. The audit indicates widespread variation between prisons in access to care and in the ways it is delivered. There is evidence of differing priorities between prisons and health in their agenda, different visions, and processes.

Improving or changing healthcare practice requires skilled resources from an organisation whose primacy is healthcare rather than security. Current practice would appear to see a number of occasions where the requirements of the prison service take precedent over the health care needs of prisoners (e.g. the unavailability of escort staff).

There may be a reduced likelihood of this happening where the budget for commissioning escorts and bedwatches is held and managed by the same organisation responsible for defining the health need.

9. Recommendations

General recommendations

1. The most efficient location for the management of this resource is the organisation responsible for generating and managing its demand: the National Health Service in the form of Primary Care Trusts. Therefore the funding and associated responsibility should be transferred. This is consistent with the requirement that the decision to provide treatment outside of the prison be based on clinical imperatives and not on security considerations. Under this arrangement, the prison's governing governor must retain his or her current responsibility for determining the degree of security required.

2. Using the audit data as a negotiating baseline, a combination of zero-based and indicative budgeting should be used to allocate the global sum agreed to PCTs. This offers a unique opportunity to verify current activity and expenditure levels and patterns and would incentivise PCTs and their local prisons to discuss current patterns, future needs and potential changes.

3. The outcome of the deliberations of PCT/prison partnership boards should be to provide sufficient information to form a Service Level Agreement (SLA) for providing escort and bedwatch activity. This would reduce the risk of either party, PCTs as commissioners and prisons or others as suppliers, from misunderstanding exactly what is expected in terms of both service provision, and financial terms. Key clauses in this SLA should include:

    i. service definition
    ii. performance tracking
    iii. managing risk
    iv. problem management
    v. fees and expenses
    vi. customer duties
    vii. warranties and remedies
    viii. legal compliance
    ix. termination

4. Escorts and bedwatches should be included in the normal business of PCT and prison discussions at partnership boards and strong partnership working encouraged.

5. PCT/prison partnerships must work with local secondary care providers to increase their awareness of security procedures when treating prisoners.

6. Examples of good practice from around the estate should be shared between all PCT/prison partnerships.

7. Necessary data requirements should be incorporated into HMPS accounting systems and the Prison Health IT project being taken forward via NHS Connecting for Health.

Recommendations for PCTs

8. More robust commissioning discussion should be encouraged around secondary care services. PCTs should investigate commissioning the most frequently accessed specialties to come into prisons and work in partnership to develop innovative alternative solutions to prisoners being escorted to hospitals.

9. Acute trusts need to be aware of the levels of healthcare available within the prison, so enabling prisoner in-patients to be discharged appropriately and pre-operative assessments etc. to be carried out in-house where appropriate.

10. Administration staff should have an allocated contact in each secondary care setting with whom to deal with appointments and/or cancellations.

11. Further work should be undertaken on scrutinising the number, reason and cost implications of cancellations.

12. PCTs should ensure that staff skills analyses of prison healthcare staff are undertaken, underpinned with a clear training and education strategy.

Recommendations for HMPS

13. The Prison Service should review its procedure for the number of escorting officers accompanying low risk prisoners on lengthy inpatient stays.

14. Prisons should review the number of escorting slots available to ensure they are sufficient to meet need, particularly when in the context of changing population or prison type.

15. Policies and procedures for improving information exchange between prison security and healthcare staff should be developed nationally.

16. Prisons should ensure that, where prisoners are employed to clean clinical areas, they have been trained to a sufficient standard.

Recommendations for DH

17. National clinical management guidelines should be produced to ensure consistency of provision.

18. Work should be taken forward to resolve the issue of prisoners being disadvantaged by not being transferred to an equivalent place on the waiting list when moving to a different prison.

10. Annex A: Audit Questionnaire

HM PRISON SERVICE

DH Department of Health

Prison Healthcare escorts and bedwatches audit 2005/2006

Please complete this form on the prisoner's return to the establishment and use a separate copy of the form for every healthcare escort, bedwatch or unaccompanied hospital visit.

For the purposes of this audit:

Escort means either:
a) the prisoner was taken by prison staff for external healthcare treatment and was returned to the establishment on the same day,
b) a late night visit to A & E in which the prisoner was **not** admitted to hospital, or
c) transfer of the prisoner to a secure NHS mental health facility.

Bedwatch means that the prisoner was admitted to hospital and spent at least one night outside of the establishment, requiring constant observation for security purposes.

SECTION A General Information

A1: Establishment name _____

A2: Date (dd/mm/yy) ____ /____ /____
For escorted and unaccompanied hospital visits enter date of visit; for bedwatches enter date prisoner left the establishment.

A3: Did patient leave establishment during office hours? (i.e., Mon – Fri 0900 – 1700)
During office hours ☐ Outside office hours ☐

A4: Gender of patient M ☐ F ☐

A5: Age: 0-15 ☐ 16-17 ☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65+ ☐

A6: Prisoner No. _____

A7: Number of staff involved
Please indicate how many staff were involved with the escort / bedwatch at any one time.
None ☐ 1 ☐ 2 ☐ 3 or more ☐

If 3 or more please specify how many _____

For escorts and unaccompanied hospital visits please complete section B.
For bedwatches please complete section C.

SECTION B Escorts and unaccompanied hospital visits

For unaccompanied visits, please go straight to B2

B1: Length of episode in hours _____
Enter full duration of episode, from when patient left the establishment to when s/he returned, to the nearest whole number

B2: Nature of episode:

Planned outpatient appointment	☐ Answer B3 to B5
Emergency visit to A & E / other emergency facility	☐ Answer B3 to B5
Mental health transfer	☐ Questionnaire completed

B3: Which outpatient department? _____
(e.g., orthopaedic, maternity, dermatology etc.)

and / or,

B4: Which, if any, of the following tests / treatments?

Blood test ☐	Colposcopy ☐	CT scan ☐	Cystoscopy ☐
Day surgery ☐	Dentist* ☐	ECG ☐	EEG ☐
Endoscopy ☐	MRI ☐	OT ☐	Physio ☐
Ultrasound ☐	X-ray ☐		

Other tests (please specifiy): _____

** Completion of B5 not needed*

B5: Category of presenting complaint:
*Indicate category of **initial** clinical reason for hospital visit*

- Infectious (transmittable) and parasitic diseases ☐
  *e.g., TB, HIV, **sexually transmitted diseases**, viral hepatitis*
- ALL cancers and benign tumours ☐
- Blood and blood-forming organs ☐
  e.g., anaemia
- Endocrine, nutritional and metabolic diseases ☐
  e.g., diabetes, disorders of thyroid gland
- Mental and behavioural disorders ☐
- Nervous system ☐
  e.g., cerebral palsy, inflammatory diseases of central nervous system, extrapyramidal and movement disorders, degenerative neurological conditions (Alzheimer's, Parkinson's, etc.)
- Eye and ear ☐
- Circulatory system ☐
  e.g., hypertension, ischaemic heart diseases, pulmonary heart disease
- Respiratory system ☐
  e.g., acute upper respiratory infections, influenza and pneumonia, tonsilitis
- Digestive system ☐
  e.g., hernia, appendicitis, liver disease, colitis
- Skin and subcutaneous tissue ☐
  e.g., infections of the skin, dermatitis, eczema
- Musculoskeletal system and connective tissue ☐
  e.g., arthropathies, osteopathies, muscle disorders, infections of musculoskeletal system
- Genitourinary system ☐
  *e.g., renal failure, kidney and urinary diseases, diseases of the male and female genital organs (**not sexually transmitted diseases**)*
- Pregnancy, childbirth and the puerperium ☐
  e.g., delivery, abortion, disorders in pregnancy
- Injury, poisoning and other consequences of external causes ☐
  e.g., overdoses, fractures, lacerations, stabbing, hanging and other trauma

  Caused by: Accident ☐
  Intentional self-harm ☐
  Assault ☐

SECTION C Bedwatches

C1: Length of bedwatch in whole days and extra hours ___ days ___ hrs
Enter duration of entire bedwatch episode (including length of admission and travel to and from NHS premises) in complete days plus any additional hours to the nearest hour (e.g., 3 days 6 hrs)

C2: Planned or emergency?
Planned inpatient stay ☐
Emergency hospital admission ☐

C3: Name of hospital _____

C4: Which inpatient ward? _____
(e.g., medical, surgical, IC, CCU, maternity, etc.)

SECTION C Bedwatches *(continued)*

C5: Category of presenting complaint:
*Indicate category of **initial** clinical reason for hospital visit*

Infectious (transmittable) and parasitic diseases ☐
*e.g., TB, HIV, **sexually transmitted diseases**, viral hepatitis*

ALL cancers and benign tumours ☐

Blood and blood-forming organs ☐
e.g., anaemia

Endocrine, nutritional and metabolic diseases ☐
e.g., diabetes, disorders of thyroid gland

Mental and behavioural disorders ☐

Nervous system ☐
e.g., cerebral palsy, inflammatory diseases of central nervous system, extrapyramidal and movement disorders, degenerative neurological conditions (Alzheimer's, Parkinson's, etc.)

Eye and ear ☐

Circulatory system ☐
e.g., hypertension, ischaemic heart diseases, pulmonary heart disease

Respiratory system ☐
e.g., acute upper respiratory infections, influenza and pneumonia, tonsilitis

Digestive system ☐
e.g., hernia, appendicitis, liver disease, colitis

Skin and subcutaneous tissue ☐
e.g., infections of the skin, dermatitis, eczema

Musculoskeletal system and connective tissue ☐
e.g., arthropathies, osteopathies, muscle disorders, infections of musculoskeletal system

Genitourinary system ☐
*e.g., renal failure, kidney and urinary diseases, diseases of the male and female genital organs (**not sexually transmitted diseases**)*

Pregnancy, childbirth and the puerperium ☐
e.g., delivery, abortion, disorders in pregnancy

Injury, poisoning and other consequences of external causes ☐
e.g., overdoses, fractures, lacerations, stabbing, hanging and other trauma

Caused by: Accident ☐
Intentional self-harm ☐
Assault ☐

HM PRISON SERVICE

DH Department of Health

11. Annex B: Analysis of Audit Data by Episode

11.1 Prisoner Demographics

11.1.1 Gender

As expected, the majority of episodes involved male prisoners in establishments of the types Local and Trainer/Other. These figures are absolute numbers of episodes reported. Please refer to section 12.2 for the analysis of activity levels weighted by operational capacity.

Prisoner Gender: Number of Episodes (Escorts & Bedwatches)

Prison type	Male	Female	TOTAL
Trainer/Other	15,952	0	15,952
Local	14,772	156*	14,928
Female	0	5,912	5,912
Open	5,187	0	5,187
YOI/Juvenile	3,785	0	3,785
High Secure	2,093	0	2,093
TOTAL:	**41,789**	**6,068**	**47,857**

11.1.2 Age

As expected, the age group 25 to 34 is the category containing the highest number of prisoners involved in escorts, bedwatches and unaccompanied hospital visits. The higher figure in the 35 to 44 category from Open prisons reflects the fact that these establishments hold large numbers of prisoners nearing the end of long-term sentences. Data on age of prisoner were missing for 1,226 cases, which have been excluded from the following analysis.

Age of Prisoner: Number of Episodes (Escorts & Bedwatches)

Prison Type	0-15	16-17	18-24	25-34	35-44	45-54	55-64	65+	TOTAL
Trainer/ Other	0	0	1,851	5,883	4,283	1,972	1,185	668	15,842
Local	0	5	2,475	5,080	3,777	1,355	631	570	13,893
Female	1**	42**	1,352	2,147	1,389	800	146	15	5,892
Open	0	0	394	1,635	1,640	982	401	105	5,157
YOI/ Juvenile	80	913	2,619	100***	47***	5***	3***	0	3,767
High Secure	0	0	226	549	523	468	220	94	2,080
TOTAL	**81**	**960**	**8,917**	**15,394**	**11,659**	**5,582**	**2,586**	**1,452**	**46,631**

11.1.3 Number of Staff and Time Involved

Number of Episodes: By Number of Staff Involved per Episode (Escorts and Bedwatches)

Prison Type	0	1	2	3	4	5	6	7	TOTAL
Trainer/ Other	267	181	14,557	925	22	0	0	0	15,952
Local	16	115	13,752	860	170	14	1	0	14,928
Female	1,322	356	4,150	69	13	2	0	0	5,912
Open	4,162	982	36	6	1	0	0	0	5,187
YOI/ Juvenile	61	65	3,488	157	13	1	0	0	3,785
High Secure	0	7	886	565	474	80	75	6	2,093
TOTAL	**5,828**[2]	**1,706**	**36,869**	**2,582**	**693**	**97**	**76**	**6**	**47,857**

* The female patients in a local prison are from Peterborough (152 cases), the only establishment built to house both men and women, and from Durham (4 cases), which for a short period retained a very small female unit.

** These are from Bullwood Hall, New Hall, Downview and/or Eastwood Park, all of which have some accommodation for juveniles.

*** These are from Swinfen Hall and/or Onley. HMYOI Swinfen Hall is a 'Young Adult Offender Institution', holding prisoners aged 18-25. HMP & YOI Onley is a Category C adult prison and YOI. This means that it could have been coded either as 'YOI/Juvenile' or as 'Trainer/Other'. We have chosen to place it in the former category.

2 This figure includes 1,666 events for prisoners who will have been released on temporary licence or housed in semi-open conditions in addition to the 4,162 events for prisoners housed in full open conditions.

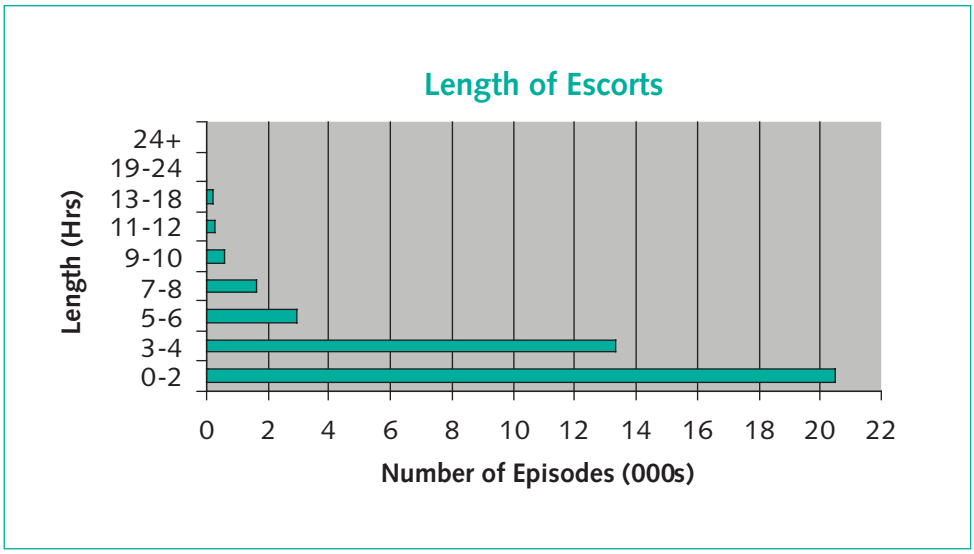
As would be expected, the variation in number of staff involved per event according to prison type was highly statistically significant.[3] This is demonstrated by the following table:

Prison Type	Median Number of Escorts
High Secure	3
Other	2
Open	0

11.1.4 Length of Episodes: Escorts and Unaccompanied Visits

The reported length of escort episodes varied from 1 to 28 hours, showing a highly skewed distribution, as illustrated by the bar chart below. 85% of escort episodes were of short duration (equal to or less than 4 hours). Episodes reported as escorts of more than 24 hours duration have been recoded as bedwatches, with the exception of one very long mental health transfer (28 hours).

The length of episodes was not recorded for the 5,777 cases when no escorts were used and data were missing in 30 accompanied cases. These have been excluded from the following analysis.



The median length of escort, which indicates the length of a typical episode, was 2 hours[4] and the interquartile range was 2 to 3 hours.

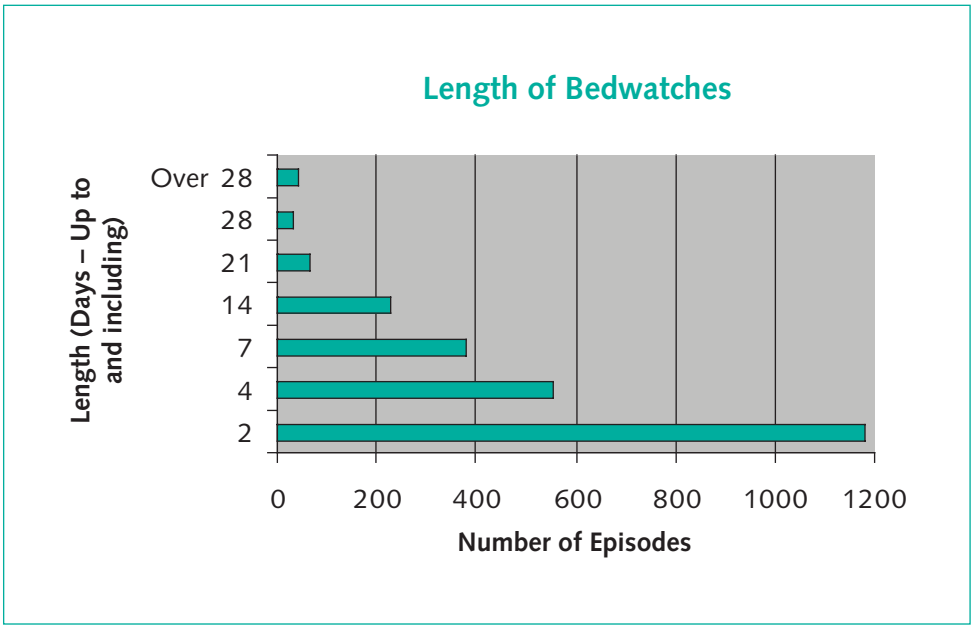
3 Kruskal-Wallis $X^2(5) = 27{,}834$, $p < 0.0001$.

4 Bootstrapped 95% confidence interval lies entirely within the response of 2 hours.

11.1.5 Length of Episodes: Bedwatches

The reported length of bedwatch episodes varied from 7 hours to 85 days, again showing a highly skewed distribution. Episodes reported as bedwatches of less than 12 hours duration have been recoded as escorts, with the exception of one emergency visit to a high dependency unit (reported as 7 hours) and one episode of 11 hours for which further data were not available.

The following analysis excludes 40 unaccompanied episodes.



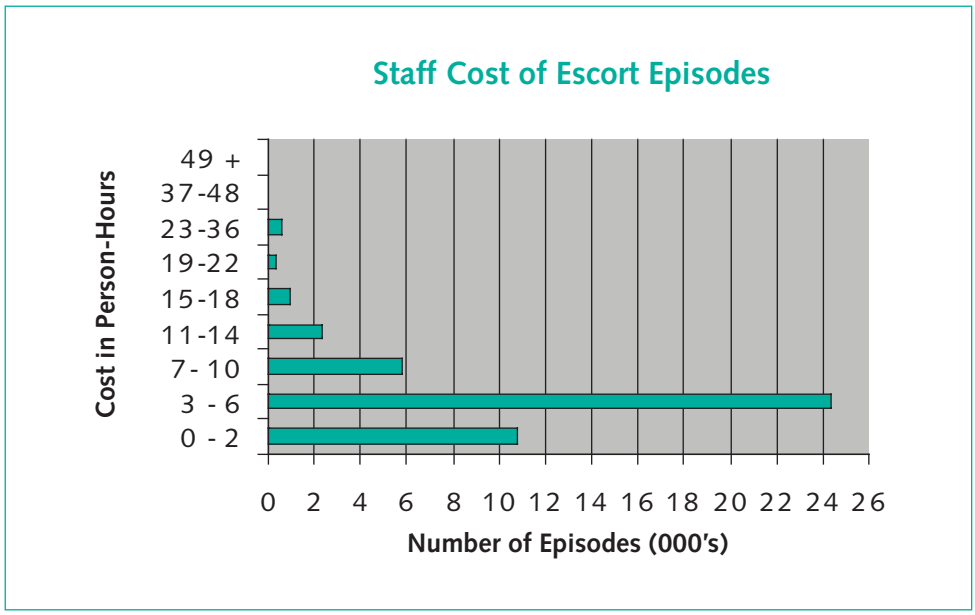
The median length of bedwatch, giving the length of a typical episode, was 50 hours[5] (2 days and 2 hours) with an interquartile range of 28 to 120 hours.

11.1.6 Staff Cost in Person Hours: Escorts

From the data collected on the number of staff involved and the length of episodes, a measure of the cost in person-hours was calculated as illustrated in the diagram overleaf.

5. Bootstrapped 95% confidence interval: 49-52 hours.

In terms of person-hours, the distribution of escorts is again highly skewed:

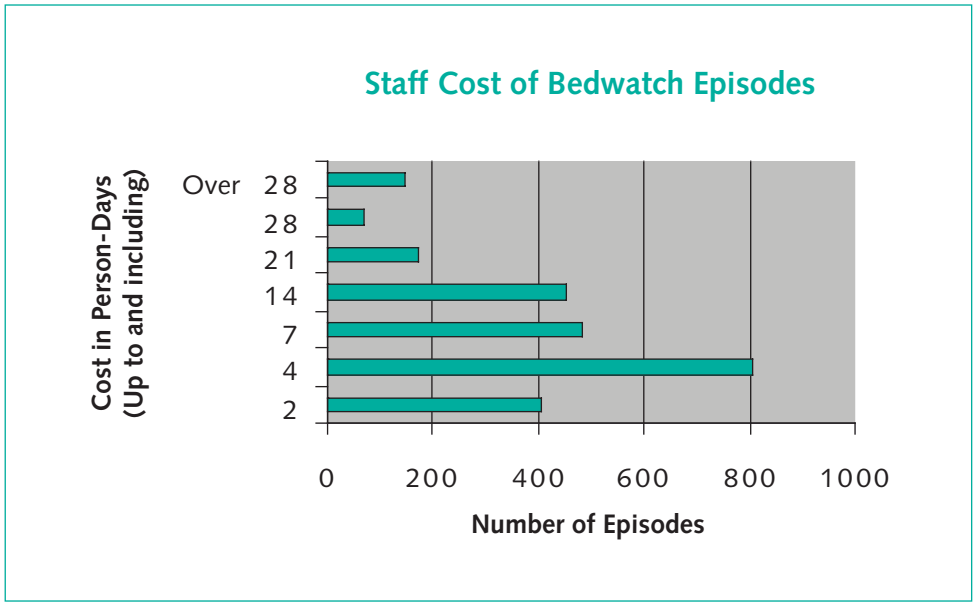


The median here was 4 person-hours[6] with an interquartile range of 3 to 6 person-hours.

The mean is also useful here as it gives us the expected cost: 5.57 person-hours.[7]

11.1.7 Staff Cost in Person-Hours: Bedwatches

In terms of staff costs in person-hours, the distribution of bedwatches is again highly skewed:



6 Bootstrapped 95% confidence interval is entirely within 4 hours.

7 Bootstrapped 95% confidence interval: 5.52 to 5.62 person-hours.

The median here was 100 person-hours[8] with an interquartile range of 56 to 240 person-hours.

The mean is also useful here as it gives the expected cost: 212 person-hours,[9] *i.e.* slightly under 9 person-days.

11.2 Nature of Episodes

11.2.1 Escorts and Unaccompanied Visits: Planned, Emergency, Mental Health Transfer

The overwhelming majority of escorted and unaccompanied hospital visits were for planned outpatient appointments. These data were missing for 120 cases, which have been excluded from the following analysis.

Nature of Episode	Escort Episodes	% of Total	95% Confidence Interval
Planned Outpatient Appointment	39,539	87.5	87.2-87.8
Emergency	5,119	11.3	11.0-11.6
Mental Health Transfer	546	1.2	1.1-1.3
TOTAL	**45,204**	**100.0**	

Escorts and Unaccompanied Visits: Nature of Episode

	Planned Outpatient Appointment		Emergency		Mental Health Transfer		
Prison type	Number of Episodes	% per Prison Type	Number of Episodes	% per Prison Type	Number of Episodes	% per Prison Type	TOTAL
Trainer/Other	13,884	91.2	1,310	8.6	28	0.2	15,222
Local	11,652	84.3	1,785	12.9	390	2.8	13,827
Female	4,853	86.7	716	12.8	28	0.5	5,597
Open	4,849	94.3	288	5.6	3	0.1	5,140
YOI/ Juvenile	2,587	73.8	893	25.5	25	0.7	3,505
High Secure	1,714	89.6	127	6.6	72	3.8	1,913
TOTAL	**39,539**	**87.5**	**5,119**	**11.3**	**546**	**1.2**	**45,204**

8 Bootstrapped 95% confidence interval: 98 to 106 person-hours.

9 Bootstrapped 95% confidence interval: 201 to 226 person-hours.

Disregarding mental health transfers, the proportion of emergency versus planned episodes varies significantly according to prison type.[10] A far greater proportion of emergency episodes occur in YOI/Juvenile prisons, more in Local and Female prisons and fewer in Open, High Secure and Trainer/Other.

Escort and Unaccompanied Visits: Proportion of Emergencies

Prison type	Planned Outpatient Appointment	Emergency	Emergency episodes as% (excluding mental health transfers)	95% Confidence Interval	TOTAL
Trainer/Other	13,884	1,310	8.6	8.2-9.1	15,194
Local	11,652	1,785	13.3	12.7-13.9	13,437
Female	4,853	716	12.9	12.0-13.8	5,569
Open	4,849	288	5.6	5.0-6.3	5,137
YOI/Juvenile	2,587	893	25.7	24.2-27.1	3,480
High Secure	1,714	127	6.9	5.8-8.1	1,841
TOTAL	**39,539**	**5,119**	**11.5**	**11.2-11.8**	**44,658**

The rate of mental health transfers also varies significantly according to prison type.[11] There are far more mental health transfers from High Secure and Local prisons and far fewer from Open and Trainer/Other.

Escort and Unaccompanied Visits: Proportion of MH Transfers

Prison type	Planned Inpatient Stay	Emergency	Emergency episodes as %	95% Confidence Interval	TOTAL
Trainer/Other	28	15,194	0.18	0.12-0.26	15,222
Local	390	13,437	2.82	2.55-3.11	13,827
Female	28	5,569	0.50	0.34-0.71	5,597
Open	3	5,137	0.06	0.01-0.15	5,140
YOI/Juvenile	25	3,480	0.71	0.47-0.10	3,505
High Secure	72	1,841	3.76	2.97-4.68	1,913
TOTAL	**546**	**44,658**	**1.21**	**1.11-1.31**	**45,204**

10 $X^2(5) = 1100$, $p < 0.0001$.

11 $X^2(5) = 627$, $p < 0.001$.

11.2.2 Bedwatches: Planned and Emergency

By contrast, almost two-thirds of bedwatch episodes arose from emergencies. These data were missing for 9 cases, which have been excluded from the following analysis.

Nature of Episode	Bedwatch Episodes	% of Total	95% Confidence Interval
Planned Admission	917	36.3	34.5-38.2
Emergency	1,607	63.7	61.8-65.5
TOTAL	**2,524**	**100.0**	

Bedwatches: Proportion of Emergency Episodes

Prison type	Planned Inpatient Stay	Emergency	Emergency episodes as %	95% Confidence Interval	TOTAL
Trainer/Other	271	459	63	59-66	730
Local	398	694	64	61-66	1,092
Female	78	237	75	70-80	315
Open	18	29	62	48-75	47
YOI/Juvenile	56	104	65	57-72	160
High Secure	96	84	47	39-54	180
TOTAL	**917**	**1,607**	**64**	**62-66**	**2,524**

12 $X^2(5) = 41.1$, $p < 0.001$.

The proportion of planned versus emergency bedwatch episodes also varies significantly according to prison type.[12] There are far fewer emergency episodes from the high secure prisons and more emergency episodes from the female estate.

11.2.3 Escorts, Unaccompanied Visits and Bedwatches Combined

Data on whether or not the episode took place during office hours were missing for 33 cases, which have been excluded from the following analysis.

Timing	Number of Episodes	% of Total	95% Confidence Interval
During office hours	43,906	91.8	91.6-92.1
Outside office hours	3,918	8.2	7.9-8.4
TOTAL	**47,824**	**100.0**	

Escorts, Unaccompanied Visits and Bedwatches Combined: Out-of-Hours Analysis

	During office hours		Outside office hours		
Prison Type	Number of Episodes	% of Total	Number of Episodes	% of Total	TOTAL
With 24 hour cover	22,414	89.7	2,561	10.3	24,975
Without 24 hour cover	21,492	94.1	1,357	5.9	22,849
TOTAL	**43,906**	**91.8**	**3,918**	**8.2**	**47,824**

The definition of office hours was set out on the questionnaires as Monday to Friday 0900-1700. Prisons with 24-hour cover had a significantly[13] higher proportion of escort and bedwatch episodes outside office hours.

The following table presents escorts and unaccompanied visits on category of presenting complaint between those within and outside office hours. There is a statistically significant difference in the pattern of complaints within and outside office hours.[14] In particular, injuries and other trauma are greatly overrepresented in episodes outside office hours. The analysis excludes 1,333 cases for which data on category of presenting complaint are not available, in addition to the 33 cases mentioned above.

13 Fisher's exact test, $p < 0.0001$.

14 $X^2(14) = 920$, $p < 0.001$.

Escorts and Unaccompanied Visits: Category of Presenting Complaint by Timing of Episode

	Outside office hours		During office hours		% Difference (During office hrs – outside office hrs)
Category of presenting compaint	**Number of Episodes**	**% of Total**	**Number of Episodes**	**% of Total**	
Infectious and Parasitic Diseases	66	2.2	2,024	5.0	2.8
Cancers and Benign Tumours	50	1.7	1,720	4.3	2.6
Blood and Blood-Forming organs	26	0.9	532	1.3	0.4
Endocrine, nutritional and metabolic diseases	39	1.3	772	1.9	0.6
Mental & behavioural disorders	5	0.2	137	0.3	0.1
Nervous System	88	2.9	1,145	2.8	–0.1
Eye and Ear	136	4.5	3,532	8.7	4.2
Circulatory System	198	6.5	1,837	4.5	–2.0
Respiratory System	77	2.5	1,295	3.2	0.7
Digestive System	290	9.6	5,622	13.9	4.3
Skin & subcutaneous Tissue	84	2.8	2,136	5.3	2.5
Musculoskeletal system and connective system	178	5.9	5,306	13.1	7.2
Genitourinary system	335	11.1	3,676	9.1	–2.0
Pregnancy, childbirth & the puerperium	45	1.5	745	1.8	0.3
Injury, poisoning & other consequences of external causes	1,406	46.5	9,909	24.5	–22.0
TOTAL	**3,023**	**100.00**	**40,388**	**100.00**	

11.3 Clinical Analysis

11.3.1 Escorts and Unaccompanied Visits: By Condition

The most common category of presenting complaint for escorts and unaccompanied visits was 'Injury, poisoning and other consequences of external causes'. The high proportion of these for which no reported reason was given (36.9%) is partly due to the central Prison Health team having recoded episodes originally coded incorrectly as 'Musculoskeletal system and connective tissue' or as 'Skin and subcutaneous tissue'. In addition, a number of questionnaires were returned with this data item uncompleted, sometimes because of

difficulties with retrospectively completing questionnaires for episodes involving prisoners transferred between establishments.

The extremely small number of episodes for clinical reasons in the category 'Mental and behavioural disorders' repeats the finding of the first report.

The data on presenting complaint were missing for 1,333 cases. These have been excluded from the following analysis, along with the 546 mental health transfers.

Number of Escorts and Unaccompanied Visits: By Condition

Category of presenting complaint	Number of Escort Episodes	% of Total	95% Confidence Interval
Infectious and parasitic diseases	2,090	4.8	4.6-5.0
All cancers and benign tumours	1,770	4.1	3.9-4.3
Blood and blood-forming organs	558	1.3	1.2-1.4
Endocrine, nutritional and metabolic diseases	811	1.9	1.7-2.0
Mental and behavioural disorders	142	0.3	0.3-0.4
Nervous system	1,233	2.8	2.7-3.0
Eye and ear	3,668	8.4	8.2-8.7
Circulatory system	2,035	4.7	4.5-4.9
Respiratory system	1,372	3.2	3.0-3.3
Digestive system	5,912	13.6	13.3-13.9
Skin and subcutaneous tissue	2,220	5.1	4.9-5.3
Musculoskeletal system and connective system	5,484	12.6	12.3-12.9
Genitourinary system	4,011	9.2	9.0-9.5
Pregnancy, childbirth and the puerperium	790	1.8	1.7-1.9
Injury, poisoning and other consequences of external causes, *of which…*	11,349	26.1	25.7-26.5
Accident	4,805	42.3	41.4-43.3
Intentional self-harm	1,043	9.2	8.7-9.7
Assault	1,317	11.6	11.0-12.2
Unknown	4,191	36.9	36.0-37.8
TOTAL	**43,445**	**100.0**	

Note that, with the large amount of data collected, the confidence intervals are very narrow.

The following table shows the proportions of emergency escorts only from prisons with and without 24 hour cover, broken down by category of presenting complaint. Data were missing for 25 cases, which have been excluded.

Number of emergency escorts: By condition and availability of 24 hr cover

	Prisons without 24 hour cover		Prisons with 24 hour cover		
Category of presenting complaint	**Number of emergency escorts**	**% of Total**	**Number of emergency escorts**	**% of Total**	**Total**
Infectious and parasitic diseases	18	0.9	15	0.5	33
All cancers and benign tumours	13	0.7	17	0.5	30
Blood and blood-forming organs	14	0.7	32	1.0	46
Endocrine, nutritional and metabolic diseases	15	0.8	25	0.8	40
Mental and behavioural disorders	1	0.1	4	0.1	5
Nervous system	36	1.9	85	2.7	121
Eye and ear	62	3.2	66	2.1	128
Circulatory system	164	8.4	215	6.9	379
Respiratory system	52	2.7	58	1.9	110
Digestive system	183	9.4	109	3.5	292
Skin and subcutaneous tissue	27	1.4	20	0.6	47
Musculoskeletal system and connective tissue	82	4.2	43	1.4	125
Genitourinary system	36	1.9	73	2.3	109
Pregnancy, childbirth and the puerperium	19	1.0	67	2.1	86
Injury, poisoning etc.	1,228	62.97	2,315	73.6	3,543
TOTAL	**1,950**		**3,144**		**5,094**

The proportion of emergency escorts arising from trauma and pregnancy are notably higher in the prisons having 24 hour cover than in those without. Conversely, the proportions arising from circulatory system, respiratory system, digestive system and musculoskeletal system conditions are higher in the prisons without 24 hour cover.

11.3.2 Escorts and Unaccompanied Visits: By Outpatient Department

The highest proportion of escorted and unaccompanied visits are to Accident and Emergency (with a large number of planned follow-up visits to the fracture clinic), followed by outpatient visits to X-ray, orthopaedics/hand clinic and general surgery.

Escorts and Unaccompanied Visits: By Outpatient Department

Outpatient department	Planned	Emergency	TOTAL
Accident and Emergency	511	4,190	4,701
Fracture clinic	1,782	107	1,889
Dressing clinic	25	0	25
Acute assessment unit	10	5	15
Alcoholics Anonymous	19	0	19
Appliances, artificial limbs and prosthetics	115	0	115
Audiology	269	0	269
Breast care unit	274	2	276
Burns unit	34	1	35
Cardiology and chest pain clinic	1,065	30	1,095
Colorectal surgery	45	1	46
Counselling	25	0	25
Dental	2,118	110	2,228
Dermatology	1,342	8	1,350
Diabetes and endocrinology	508	3	511
Disablement services and wheelchair unit	48	0	48
Ear, nose and throat	1,611	24	1,635
Endoscopy	438	5	443
Gastroenterology	829	5	834
General medicine	448	9	457
General surgery	3,633	43	3,676
Haematology	533	8	541
Hepatology	182	2	184
Immunology	8	0	8
Infection and travel medicine	347	8	355
Maternity, gynaecology, women's health and family planning	863	71	934
Maxillofacial	822	20	842
Neurology and brain injury unit	910	7	917
Occupational therapy	16	0	16

Outpatient department	Planned	Emergency	TOTAL
Oncology	678	5	683
Ophthalmology	1,737	82	1,819
Optician	259	2	261
Orthopaedic and hand clinic	3,771	69	3,840
Paediatrics	24	1	25
Pain clinic	92	2	94
Physiology	4	0	4
Physiotherapy	1,808	3	1,811
Plastic surgery	516	20	536
Podiatry, chiropody and orthotics	211	1	212
Psychiatry and mental health	55	0	55
Renal unit	1,312	8	1,320
Respiratory and chest clinic	496	7	503
Rheumatology	196	0	196
Speech and language therapy	35	0	35
Spinal clinic	10	0	10
Stroke medicine and stroke clinic	6	0	6
Transgender clinic	11	0	11
Urology and genito-urinary medicine	2,504	24	2,528
Vascular surgery	160	1	161
X-Ray	4,033	207	4,240
Ultrasound	1,573	12	1,585
Computerised (Axial) Tomography (CT) scan	386	2	388
Radiology	389	4	393
Other (departments where there are less than 10 cases)	104	3	107
Missing			423

11.3.3 Escorts and Unaccompanied Visits: Tests and Procedures Performed

This table examines the tests and treatments carried out on prisoners escorted out on an outpatient or A&E visit. Information on tests carried out during inpatient treatment was not collected, as these would be part of a package of inpatient care. The numbers of tests and treatments collected will not reflect the true numbers due to under-reporting, but are indicative of the wide range of treatments carried out. The most commonly reported tests and treatments are X-rays, Computerised (Axial) Tomography (CT) scans, Magnetic Resonance Imaging (MRI) scans, visits to the dentist, ultrasound, blood tests, physiotherapy, minor surgery, dialysis endoscopy and electrocardiograms (ECG).

Test or procedure	Episodes	Test or procedure	Episodes
Abortion	6	Gastroscopy	2
Acupuncture	6	Heavy Goods Vehicle medical	1
Allergy test	15	Hallet botox injection	1
Angiogram	10	Heaf test	9
Appliance fitted (eye,leg,calliper,ect)	42	Hearing test	41
Arthroscopy	12	Heart monitor	16
Bacillus Calmette-Guerin (BCG)	1	Hickman line	1
Babies checked/immunised	17	Hydrotherapy	14
Barium	42	Laparoscopy	1
Biopsy	96	Liver biopsy	33
Blood test	1948	Lung function test	26
Blood transfusion	40	Magnetic Resonance Imaging Scan	607
Bone scan including isotope	15	Minor surgery	45
Cauterisation	1	Mammogram	4
Chemotherapy	74	Nasal scope	2
Circumcision	1	Nerve conduction	18
Coil checked/fitted	11	Occupational Therapy	151
Counselling	7	Physiotherapy	1498
Colposcopy	97	Plaster cast-applied/ removed/changed	54
Computerised (Axial) Tomography (CT) scan	555	Radiotherapy	198
Cystoscopy	78	Remove eyelash	1
Deep Vein Thrombosis (DVT) test	4	Sigmoidoscopy	19
Day surgery	1350	Speech therapy	3
Dentist	2504	Sterilisation male/female	2
Dialysis	1079	Suture (insert/remove)	45
Donate bone marrow	2	Tetanus injection	1
Doppler scan	4	Tracheotomy replace	1
Dressings applied/changed/checked	65	Ultra violet	18
Ear syringe	2	Ultrasound	2178
Electrocardiogram (ECG)	515	Urogram	18
Electroencephalogram (EEG)	122	Urine test	71
Endoscopy	528	Vaccination	13
Epidural	3	Venogram	7
Eye test/wash	25	X ray	6170
Foetal assessment	1		

11.3.4 Bedwatches: By Condition

The most common category of presenting complaint by far for bedwatches was 'Injury, poisoning and other consequences of external causes'. The data were missing for 103 cases, which have been excluded from the following analysis.

Number of Bedwatches: By Condition

Category of presenting complaint	Number of Escort Episodes	% of Total	95% Confidence Interval
Infectious and parasitic diseases	48	2.0	1.5-2.6
All cancers and benign tumours	89	3.7	3.0-4.5
Blood and blood-forming organs	38	1.6	1.1-2.1
Endocrine, nutritional	83	3.4	2.7-4.2
Mental and behavioural disorders and metabolic diseases	4	0.2	0.0-0.4
Nervous system	101	4.2	3.4-5.0
Eye and ear	67	2.8	2.2-3.5
Circulatory system	311	12.8	11.5-14.2
Respiratory system	148	6.1	5.2-7.1
Digestive system	349	14.4	13.0-15.8
Skin and subcutaneous tissue	81	3.3	2.7-4.1
Musculoskeletal system and connective system	137	5.6	4.8-6.6
Genitourinary system	165	6.8	5.8-7.8
Pregnancy, childbirth and the puerperium	97	4.0	3.3-4.8
Injury, poisoning and other consequences of external causes, *of which…*	712	29.3	27.5-31.1
Accident	201	28.2	25.0-31.6
Intentional self-harm	258	36.2	32.8-39.8
Assault	116	16.3	13.7-19.1
Unknown	137	19.2	16.5-22.2
TOTAL	**2,430**	**100.0**	

11.3.5 Escorts, Unaccompanied Visits: By Condition

'Injury, poisoning and other consequences of external causes' is the most common category of presenting complaint for escorts and unaccompanied visits from most prison types. This is most pronounced in the YOI/Juvenile estate, where it accounts for almost 60% of episodes. The exceptions are the open prisons and the women's estate, where 'Musculoskeletal system and connective tissue' and 'Digestive system' respectively are the most common causes. In both of these prison types, 'Injury, poisoning and other consequences of external causes' is the second most common category of presenting complaint. 'Genitourinary System' is the second most common category in the high secure and local prisons, while 'Digestive system' holds this position in the Trainer/Other prisons and 'Eye and ear' does so in the YOI/Juvenile establishments.

The relatively high proportion of episodes in the category 'Digestive System' may be accounted for by the fact that dental problems fall under this heading in the ICD-10 system of classifications.

The data on presenting complaint were missing for 1,333 cases. These have been excluded from the following analysis, along with the 546 mental health transfers.

Number of Escorts and Unaccompanied Visits: By Condition and Prison Type

Category of presenting complaint	Trainer/Other		Local		Female		Open		YOI/Juvenile		High Secure		
	Number of Episodes	% of Total	Number of Episodes	% of Total	Number of Episodes	% of Total	Number of Episodes	% of Total	Number of Episodes	% of Total	Number of Episodes	% of Total	TOTAL
Infectious and parasitic diseases	648	4.4	494	3.8	347	6.3	403	8.0	155	4.6	43	2.4	2,090
All cancers and benign tumours	597	4.0	587	4.5	285	5.2	168	3.3	60	1.8	73	4.1	1,770
Blood and blood-forming organs	103	0.7	184	1.4	94	1.7	139	2.8	18	0.5	20	1.1	558
Endocrine, nutritional and metabolic diseases	299	2.0	238	1.8	97	1.8	112	2.2	35	1.0	30	1.7	811
Mental and behavioural disorders	32	0.2	22	0.2	10	0.2	67	1.3	8	0.2	3	2.0	142
Nervous system	383	2.6	489	3.8	142	2.6	47	0.9	84	2.5	88	4.9	1,233
Eye and ear	1,409	9.6	1,014	7.8	371	6.8	443	8.8	249	7.4	182	10.1	3,668
Circulatory system	700	4.7	681	5.2	208	3.8	271	5.4	46	1.4	129	7.2	2,035
Respiratory system	503	3.4	484	3.7	111	2.0	153	3.0	71	2.1	50	2.8	1,372
Digestive system	2,403	16.3	1,331	10.2	1,037	19.0	650	12.9	246	7.3	245	13.6	5,912
Skin and subcutaneous tissue	867	5.9	554	4.3	236	4.3	358	7.1	132	3.9	73	4.1	2,220
Musculoskeletal system and connective tissue	2,242	15.2	1,198	9.2	476	8.7	1,278	25.3	137	4.1	153	8.5	5,484
Genitourinary system	1,257	8.5	1,546	11.9	448	8.2	218	4.3	200	6.0	342	19.0	4,011
Pregnancy, childbirth and the puerperium	0	0.0	69	0.5	721	13.2	0	0.0	0	0.0	0	0.0	790
Injury, poisoning and other consequences of external causes	3,308	22.4	4,126	31.7	888	16.2	743	14.7	1,919	57.1	365	20.3	11,349
TOTAL	**14,751**	**100.0**	**13,017**	**100.0**	**5,471**	**100.0**	**5,050**	**100.0**	**3,360**	**100.0**	**1,796**	**100.0**	**43,445**

11.3.6 Bedwatches: By Condition and Prison Type

'Injury, poisoning and other consequences of external causes' is the most common category of presenting complaint for bedwatches from most prison types. Again, this was most pronounced in the YOI/Juvenile estate, where it accounts for more than 40% of bedwatches. The exceptions are once again the open prisons and the women's estate, where 'Circulatory system and Pregnancy, childbirth and the puerperium' respectively are the most common causes. In both of these prison types, 'Injury, poisoning and other consequences of external causes' is the second most common category of presenting complaint. 'Digestive system' is the second most common category in the Local, YOI/Juvenile and Trainer/Other prisons. In the High Secure prisons this position is held jointly by 'Digestive system' and 'Circulatory system'.

The data were missing for 103 cases, which have been excluded from the following analysis.

Number of Bedwatches: By Condition and Prison Type

Category of presenting complaint	Local		Trainer/Other		Female		High Secure		YOI/Juvenile		Open		
	Number of Episodes	% of Total	Number of Episodes	% of Total	Number of Episodes	% of Total	Number of Episodes	% of Total	Number of Episodes	% of Total	Number of Episodes	% of Total	TOTAL
Infectious and parasitic diseases	24	2.3	16	2.3	3	1.0	1	0.6	4	2.6	0	0.0	48
All cancers and benign tumours	31	3.0	23	3.3	7	2.2	18	10.1	8	5.2	2	4.4	89
Blood and blood-forming organs	25	2.4	10	1.4	1	0.3	2	1.1	0	0.0	0	0.0	38
Endocrine, nutritional and metabolic diseases	48	4.6	16	2.3	8	2.5	4	2.2	7	4.5	0	0.0	83
Mental and behavioural disorders	2	0.2	1	0.1	0	0.0	0	0.0	1	0.6	0	0.0	4
Nervous system	48	4.6	12	1.7	28	8.9	5	2.8	6	3.9	2	4.4	101
Eye and ear	22	2.1	29	4.1	4	1.3	9	5.1	3	1.9	0	0.0	67
Circulatory system	135	13.1	108	15.3	24	7.6	26	14.6	4	2.6	14	31.1	311
Respiratory system	51	4.9	48	6.8	18	5.7	20	11.2	8	5.2	3	6.7	148
Digestive system	152	14.7	110	15.6	28	8.9	26	14.6	29	18.7	4	8.9	349
Skin and subcutaneous tissue	26	2.5	32	4.5	11	3.5	4	2.2	5	3.2	3	6.7	81
Musculoskeletal system and connective system	49	4.7	65	9.2	6	1.9	8	4.5	4	2.6	5	11.1	137
Genitourinary system	67	6.5	43	6.1	17	5.4	24	13.5	9	5.8	5	11.1	165
Pregnancy, childbirth and the puerperium	2	0.2	0	0.0	95	30.3	0	0.0	0	0.0	0	0.0	97
Injury, poisoning and other consequences of external causes	351	34.0	192	27.2	64	20.4	31	17.4	67	43.2	7	15.6	712
TOTAL	**1,033**	**100.0**	**705**	**100.0**	**314**	**100.0**	**178**	**100.0**	**155**	**100.0**	**45**	**100.0**	**2,430**

12. Annex C: Analysis of Audit Data by Prison

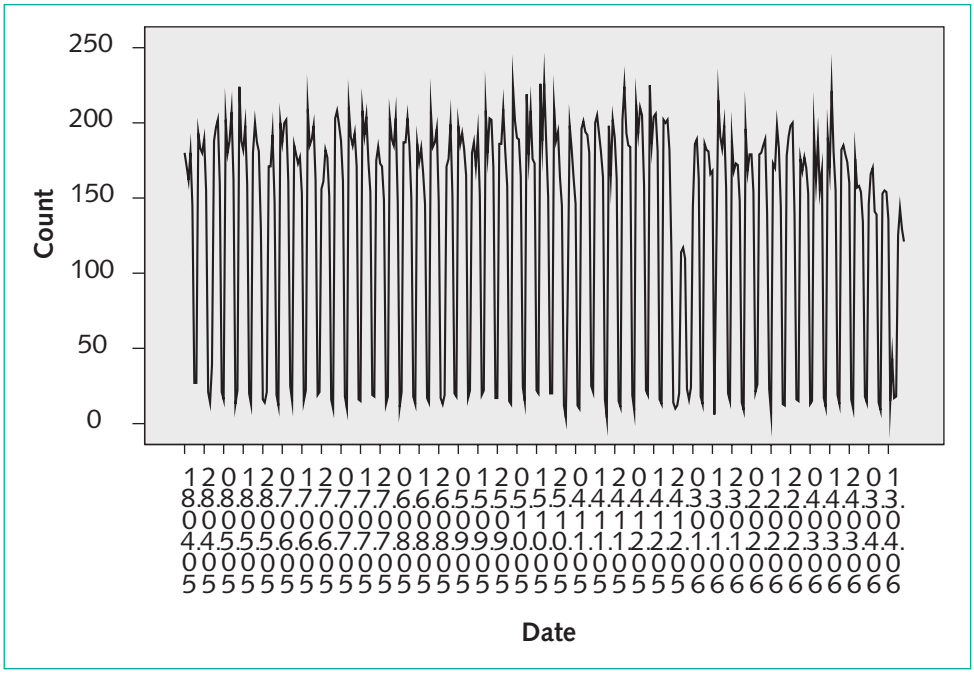
The number of episodes, escorts or bedwatches, was counted for each establishment for comparison across establishments. These figures were adjusted to take into account the operational capacity of a prison, which stands as an approximate measure of the prison population at each establishment.

12.1 Under-Reporting

There is some under-reporting in the dataset: that is, episodes (escorts, unaccompanied visits or bedwatches) that were not recorded in the audit. While sporadic failure to report may affect the entire dataset, it is likely that under-reporting varies most by prison and by date.

This is not a major cause of concern for the analysis of the data by episode. However, for an analysis of the number of episodes *per* establishment, it is necessary to differentiate between establishments with low numbers of episodes and establishments with poor reporting rates.

The following diagram illustrates the number of episodes reported per day of the audit period. It indicates that whilst there is a weekly variation (episodes are much less frequent at the weekends), there is no obvious sign of seasonal variation, save for a drop in the last week of December. Reporting rates appear fairly flat across the whole year, except that there is a dip in April/May 2006. Further analysis (below) suggests this is because a number of establishments were under-reporting in the first and last weeks of the audit period.



The dates of the first and last five reported episodes were therefore examined for each establishment to see if there was an initial or final period of low or non-reporting. This was apparent in several establishments. For some smaller establishments, the lack of any reported episodes outside the first and last week of data collection may simply reflect a reality of no episodes in those weeks. However, multiple institutions appear to have started reporting late and/or stopped reporting early. In particular, several appear to have stopped reporting at the end of March 2006.[15]

Given there is no seasonality observed, it is reasonable to calculate the rate of episodes excluding time periods at the beginning and end of data collection. Note that the number of missing episodes has been identified for the purpose of costing.

For results of validation exercise, see Annex E.

12.2 Rate Analysis and Modelling

The rate of episodes for each establishment was calculated in terms of the number of escort or bedwatch episodes per operational capacity place per year. This is the number of reported episodes divided by the operational capacity, adjusted for the time period of data collection.[16]

Figures were recalculated for those establishments where periods of non-reporting are evident (see Section 12.1) by calculating an appropriate corrected figure for the number of episodes per place per year. This affected 59 of 141 establishments.

15 There are two special cases to consider. HMP Buckley Hall was a female prison at the beginning of the data collection period. In September 2005, it re-roled as a male prison and the last Female prisoners left on 03 December 2005 for male prisoners to arrive from 05 December 2005. Reporting since Buckley Hall became a male prison has been extremely low (two episodes reported in March and two in April 2006) and this period is consequently excluded from subsequent analyses. HMP Weare closed in July 2005, so it has been excluded from subsequent analyses.

16 Operational capacity figures are taken from the Prisons Handbook 2006 (published November 2005) where available or the HMPS website. For 5 establishments, the CNA figure given in the Prisons Handbook is larger than the operational capacity figure and this has been used instead. It is important to recognise that these are necessarily approximate figures, with operational capacity and occupation rates varying over the data collection period.

Female

Establishment	Number of episodes *per* operational capacity place *per* year	Establishment	Number of episodes *per* operational capacity place *per* year
Askham Grange	3.24	Eastwood Park	1.21
Brockhill	1.27	Foston Hall	1.31
Bronzefield	1.28	Holloway	0.9
Buckley Hall	0.32	Low Newton	0.76
Bullwood Hall	1.36	Morton Hall	1
Cookham Wood	0.64	New Hall	1.41
Downview	1	Send	0.46
Drake Hall	2	Styal	0.29
East Sutton Park	6.37		

High Secure

Establishment	Number of episodes *per* operational capacity place *per* year	Establishment	Number of episodes *per* operational capacity place *per* year
Belmarsh	0.46	Manchester	0.36
Frankland	0.49	Wakefield	0.67
Full Sutton	0.29	Whitemoor	0.3
Long Lartin	0.37	Woodhill	0.21

Open

Establishment	Number of episodes *per* operational capacity place *per* year	Establishment	Number of episodes *per* operational capacity place *per* year
Blantyre House	1.59	Leyhill	1.02
Ford	1.2	Moorland Open	0.58
Hewell Grange	1.12	North Sea Camp	2.09
Hollesley Bay	0.62	Prescoed	0.49
Kirkham	0.91	Spring Hill	0.63
Kirklevington Grange	1.39	Standford Hill	0.66
Latchmere House	0.97	Sudbury	0.96

Local

Establishment	Number of episodes *per* operational capacity place *per* year	Establishment	Number of episodes *per* operational capacity place *per* year
Altcourse	0.25	Holme House	0.42
Bedford	0.6	Hull	0.57
Birmingham	0.61	Leeds	0.77
Blakenhurst	0.48	Leicester	0.45
Bristol	0.98	Lewes	0.55
Brixton	0.47	Lincoln	0.48
Bullingdon	0.3	Liverpool	0.52
Cardiff	0.52	Norwich	0.63
Chelmsford	0.54	Nottingham	0.55
Doncaster	0.32	Parc	0.53
Dorchester	0.81	Pentonville	0.55
Durham	0.96	Peterborough	0.25
Elmley	0.28	Preston	1.75
Exeter	0.62	Shrewsbury	0.98
Forest Bank	0.4	Wandsworth	0.45
Gloucester	0.86	Winchester	0.43
High Down	0.32	Wormwood Scrubs	0.36

YOI/Juvenile

Establishment	Number of episodes *per* operational capacity place *per* year	Establishment	Number of episodes *per* operational capacity place *per* year
Ashfield	0.45	Onley	0.29
Aylesbury	0.64	Portland	0.43
Brinsford	0.42	Reading	0.69
Castington	0.32	Rochester	0.6
Deerbolt	0.29	Stoke Heath	0.69
Feltham	0.33	Swinfen Hall	0.19
Glen Parva	0.15	Thorn Cross	0.8
Hindley	0.62	Warren Hill	0.6
Huntercombe	0.24	Werrington	1.59
Lancaster Farms	0.47	Wetherby	0.49
Northallerton	0.28		

Trainer/Other

Establishment	Number of episodes *per* operational capacity place *per* year	Establishment	Number of episodes *per* operational capacity place *per* year
Acklington	0.54	Lindholme	0.42
Albany	0.79	Littlehey	0.8
Ashwell	0.55	Lowdham Grange	0.84
Blundeston	0.6	Maidstone	0.8
Camp Hill	0.43	Moorland Closed	0.29
Canterbury	0.9	Parkhurst	0.65
Channings Wood	0.69	Ranby	1
Coldingley	0.71	Risley	0.36
Dartmoor	0.59	Rye Hill	0.25
Dovegate	0.53	Shepton Mallet	2.03
Dover	0.37	Stafford	0.59
Edmunds Hill	0.41	Stocken	1.51
Erlestoke	0.77	Swaleside	1.35
Everthorpe	0.43	Swansea	0.44
Featherstone	0.57	The Mount	0.66
Garth	0.7	The Verne	0.66
Gartree	0.67	Usk	0.31
Grendon	1.15	Wayland	0.29
Guys Marsh	0.66	Wealstun	0.51
Haslar	0.8	Weare	0.82
Haverigg	0.36	Wellingborough	0.48
Highpoint	0.66	Whatton	0.34
Kingston	1.3	Wolds	0.58
Lancaster Castle	1.16	Wymott	0.75

There is considerable variation between episode rates: the interquartile range is 0.42-0.84 episodes per place per year. There are various explanations for this variation. Some obvious possibilities are:

- under-reporting could explain cases where an establishment reports fewer episodes. However, adjustments have been made to compensate for this;
- some individual prisoner's health problems can account for multiple episodes, thus inflating the number of episodes for particular establishments (i.e. episodes are not statistically independent events);
- differences between prisons may lead to more or fewer episodes.

The episode rate at prisons where the figures were adjusted for non-reporting do not differ significantly from those with unadjusted figures.[17] This suggests that prisons with initial and/or final periods of non-reporting did not have systematically lower reporting rates throughout the data collection period.

A further analysis by prison category indicates that i) Female and Open prisons have significantly[18] higher rates than the other categories but not each other ii) High Secure Trainer/Other and YOI/Juvenile prisons have significantly lower rates than the other prison categories but not each other ii) Trainer/Other and Local prisons have significantly lower rates then High Secure and YOI/Juvenile prisons, but do not significantly differ from each other. This is indicated in the table below.

Rate Analysis and Variance by Prison Type

Prison category	Geometric mean number of episodes per place per year	Median number of episodes per place per year	Variance
Female	1.19	1.24	0.47
Open	1.11	1.16	0.17
Trainer/Other	0.61	0.66	0.13
Local	0.51	0.53	0.14
YOI/Juvenile	0.39	0.33	0.24
High Secure	0.35	0.36	0.10

17 $t_{140} = 1.0$, $p = 0.3$. All analyses have been performed on log transformed data.

18 $F_{5, 136} = 21.9$, $p < 0.001$.

The relatively higher rates in the Open prisons do not present a high staff cost as the majority will be unaccompanied episodes and may indicate positive practice in encouraging prisoners to independently seek healthcare provision in the community prior to their release. Similarly, the three Female prisons with the highest rates (East Sutton Park, Askham Grange and Drake Hall) are open or semi-open prisons. The higher variance within the Female prisons may therefore result from the fact that open prisons are not categorised separately from closed prisons as they are in the male estate.

Prisons with 24-hour healthcare cover have significantly lower rates than prisons without.[19]

Rate Analysis by Type of Cover in Health Care Centre

Presence of 24 hour cover	Geometric mean number of episodes per place per year	Median number of episodes per place per year
No	0.74	0.69
Yes	0.51	0.49

Contracted-out prisons do not have significantly different rates.[20] Among the female prisons, those with mother and baby units do not have significantly different rates.[21] However, it should be noted that this test is on a small sample size.

There is no interaction between prison category and the presence of 24-hour healthcare cover.[22]

From the survey of clinics and procedures within prison healthcare centres (see Annex H: Survey of Clinics and Procedures within Prison Healthcare Centres), the number of hours per week when healthcare is available was calculated for each establishment. A normal office day was presumed to be 8 hours and a half day was 4 hours. The majority of prisons offer 24-hour cover. The lower quartile was 56 hours per week (i.e. ¾ of establishments offer this or more). The lowest figure was 24 hours per week.

There is a negative correlation between the hours of healthcare available and the episode rate (i.e. the rate of escorts and bedwatches decreases with increasing hours of healthcare availability).[23]

19 $t_{140} = 4.2$, $p < 0.001$.

20 $t_{140} = 1.6$, $p = 0.11$. The ANOVA appears well-behaved in terms of residuals and leverages. There is some heteroscedasticity, chiefly around the Female prisons. Buckley Hall, East Sutton Park and Werrington (discussed above) appear as model outliers.

21 t16 = 0.46, $p = 0.7$.

22 $F_{6, 135} = 19.4$, $p < 0.001$.

23 $r = –0.32$, $p < 0.001$.

The number of clinics provided out of eighteen options covered in the survey was calculated for each prison. The options were: Genito-Urinary Medicine (GUM), (Sexual Health), Health Visitor, Asthma, Coronary Heart Disease (CHD), Well Woman/Man, Blood Borne Virus (BBV) Screening, Mental Health, Dentist, Physiotherapy, General Practice (GP), Contraception, Diabetes, Chiropodist, Smoking Cessation, Venepuncture, Optician, X-Ray and Occupational Therapy. The relationship between the episode rate and the number of clinics is negative, but is not statistically significant.[24]

Considering the Female prisons only, there is no statistically significant difference in rate of escorts and bedwatches between those that have a maternity clinic and those that do not.[25]

The number of services provided out of five options covered by the survey was calculated for each establishment. The options were: taking bloods, changing dressings, undertaking minor surgery, suturing and vaccination. There is a negative correlation between the episode rate and the number of services.[26]

The rate of escorts per operational capacity place per year for five clinical reasons (GUM, dental, physiotherapy, optician and X-Ray) was calculated for each prison on the basis that these represent the higher number of audit returns and/or relative ease in providing the service in a prison. Prisons with the relevant clinics have far significantly fewer escorts for these reasons as demonstrated in the following table:

Clinic	Median rate with clinic (per 100 cases)	Median rate without clinic (per 100 cases)
GUM[27]	0.5	2.4
Dentist[28]	1.3	10.2
Physiotherapy[29]	0.4	2.0
Optician[30]	0	2.8
X-Ray[31]	1.8	6.5

24 $r = -0.08$, $p = 0.3$.

25 $t16 = 0.25$, $p = 0.8$.

26 $r = -0.23$, $p = 0.006$.

27 Mann-Whitney $z = 4.1$, $p < 0.001$.

28 Mann-Whitney $z = 2.0$, $p = 0.044$.

29 Mann-Whitney $z = 3.8$, $p < 0.001$.

30 Mann-Whitney $z = 5.1$, $p < 0.001$.

31 Mann-Whitney $z = 5.0$, $p < 0.001$.

12.3 Conclusion

Escort and bedwatch episode rates vary by prison category. They are highest in Female and Open prisons (1.2 and 1.1 episodes per place per year respectively), moderate in Trainer/Other and Local prisons (0.6 and 0.5 episodes per place per year respectively) and lowest in YOI/Juvenile and High Secure prisons (0.4 episodes per place per year).

The health services offered varies by prison category, as would be expected. The hours of healthcare provided and the number of clinics available help to predict the rate of escort and bedwatch episodes. However, these factors offer no improved statistical prediction beyond knowing prison category.

The number of clinics offered from the overall healthcare clinic survey does not demonstrate a statistically significant relationship with overall episode rate suggesting that the variety of clinics available is not a big factor in reducing escorts and bedwatches. However, availability of specific clinics within the establishment does significantly reduce the number of escorts for the clinical purposes relevant to those clinics.

13. Annex D: Individual Audit Data by Prison Type

13.1 Female Prisons

TABLE 1: ESCORTS DATA

Female Prisons Escorts and Unaccompanied Visits Data

Prison	Planned outpatient appointment	Emergency visit to A&E/other emergency facility	Mental health transfer	Total	Infectious and parasitic diseases	All cancers and benign tumours	Blood and blood-forming organs	Endocrine, nutritional and metabolic diseases	Mental and behavioural disorders	Nervous system	Eye and ear	Circulatory system	Respiratory system	Digestive system	Skin and subcutaneous tissue	Musculoskeletal system and connective tissue	Genitourinary system	Pregnancy, childbirth and the puerperium	Injury, poisoning and other consequences of external causes
Askham Grange	343	79	0	422	4	5	14	14	0	6	8	4	6	218	23	45	25	17	25
Brockhill	151	39	4	194	4	14	6	0	0	9	6	1	5	13	0	7	2	93	29
Bronzefield	219	62	1	282	23	12	1	2	2	9	3	12	1	11	3	16	18	119	49
Buckley Hall	53	4	0	57	6	2	0	1	0	1	3	0	1	16	4	1	5	5	12
Bullwood Hall	154	18	0	172	23	3	1	6	0	18	13	7	5	14	4	4	8	22	44
Cookham Wood	82	8	0	90	6	6	3	1	0	10	4	3	1	12	2	10	15	1	16
Downview	304	30	0	334	32	27	4	15	0	9	20	12	6	46	9	41	33	7	67
Drake Hall	595	35	0	630	93	37	8	2	3	10	137	22	7	75	40	96	63	5	30
East Sutton Park	584	14	0	598	30	11	7	6	1	2	59	4	20	300	11	40	37	13	18
Eastwood Park	217	143	1	361	7	27	2	1	1	7	15	5	6	42	10	13	7	76	137
Foston Hall	271	62	0	333	5	24	4	10	0	11	12	9	3	86	14	30	32	8	85

TABLE 1: ESCORTS DATA

Female Prisons Escorts and Unaccompanied Visits Data

Prison	Planned outpatient appointment	Emergency visit to A&E/other emergency facility	Mental health transfer	Total	Infectious and parasitic diseases	All cancers and benign tumours	Blood and blood-forming organs	Endocrine, nutritional and metabolic diseases	Mental and behavioural disorders	Nervous system	Eye and ear	Circulatory system	Respiratory system	Digestive system	Skin and subcutaneous tissue	Musculoskeletal system and connective tissue	Genitourinary system	Pregnancy, childbirth and the puerperium	Injury, poisoning and other consequences of external causes
Holloway	328	21	6	355	20	19	4	1	2	11	22	8	7	35	6	24	21	76	58
Low Newton	141	59	0	200	11	4	0	0	0	2	8	2	3	11	9	23	12	37	77
Morton Hall	388	4	0	392	24	19	8	25	0	4	29	18	15	41	35	50	54	14	56
New Hall	458	80	16	554	20	26	24	9	0	14	11	57	12	33	19	46	51	121	93
Send	223	27	0	250	14	35	7	2	0	12	13	5	8	38	35	16	42	2	21
Styal	342	31	0	373	25	14	1	2	1	7	8	39	5	46	12	14	23	105	71
TOTAL	**4853**	**716**	**28**	**5597**	**347**	**285**	**94**	**97**	**10**	**142**	**371**	**208**	**111**	**1037**	**236**	**476**	**448**	**721**	**888**

TABLE 2: BEDWATCHES DATA

Female Prisons Bedwatches Data (Planned or Emergency Hospital Stay)																		
Prison	**Planned outpatient appointment**	**Emergency visit to A&E/other emergency facility**	**Total**	**Infectious and parasitic diseases**	**All cancers and benign tumours**	**Blood and blood-forming organs**	**Endocrine, nutritional and metabolic diseases**	**Mental and behavioural disorders**	**Nervous system**	**Eye and ear**	**Circulatory system**	**Respiratory system**	**Digestive system**	**Skin and subcutaneous tissue**	**Musculoskeletal system and connective tissue**	**Genitourinary system**	**Pregnancy, childbirth and the puerperium**	**Injury, poisoning and other consequences of external causes**
Askham Grange	1	6	7	0	0	0	1	0	0	0	0	0	0	4	1	0	1	0
Brockhill	1	20	21	0	0	0	1	0	0	0	0	0	3	3	0	0	13	1
Bronzefield	2	8	10	1	0	0	1	0	1	0	1	1	0	0	0	0	2	3
Buckley Hall	1	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Bullwood Hall	3	4	7	0	0	0	0	0	0	1	0	0	0	1	0	1	2	2
Cookham Wood	0	3	3	0	0	0	0	0	1	0	0	0	0	0	0	0	0	2
Downview	3	4	7	0	2	0	0	0	2	0	2	1	0	0	0	0	0	0
Drake Hall	3	4	7	0	2	0	0	0	0	0	0	0	1	0	1	1	0	2
East Sutton Park	3	6	9	0	0	0	0	0	0	0	0	2	3	0	0	2	0	2
Eastwood Park	13	49	62	2	1	0	1	0	3	0	2	5	7	1	1	4	18	17
Foston Hall	9	20	29	0	0	0	2	0	6	0	0	1	4	1	1	5	1	8
Holloway	3	3	6	0	1	0	0	0	1	0	0	0	0	1	0	0	2	0

TABLE 2: BEDWATCHES DATA

Female Prisons Bedwatches Data (Planned or Emergency Hospital Stay)

Prison	Planned outpatient appointment	Emergency visit to A&E/other emergency facility	Total	Infectious and parasitic diseases	All cancers and benign tumours	Blood and blood-forming organs	Endocrine, nutritional and metabolic diseases	Mental and behavioural disorders	Nervous system	Eye and ear	Circulatory system	Respiratory system	Digestive system	Skin and subcutaneous tissue	Musculoskeletal system and connective tissue	Genitourinary system	Pregnancy, childbirth and the puerperium	Injury, poisoning and other consequences of external causes
Low Newton	7	14	21	0	0	1	0	0	0	0	0	0	0	0	1	0	5	14
Morton Hall	2	4	6	0	0	0	0	0	0	0	1	0	2	0	0	1	1	1
New Hall	8	46	54	0	0	0	0	0	2	0	10	3	2	0	1	1	24	11
Send	2	19	21	0	1	0	0	0	9	2	4	0	3	0	0	2	0	0
Styal	17	27	44	0	0	0	2	0	3	1	4	5	2	0	0	0	26	1
TOTAL	**78**	**237**	**315**	**3**	**7**	**1**	**8**	**0**	**28**	**4**	**24**	**18**	**28**	**11**	**6**	**17**	**95**	**64**

13.2 Local Prisons

TABLE 1: ESCORTS DATA

Local Prisons Escorts and Unaccompanied Visits Data

Prison	Planned outpatient appointment	Emergency visit to A&E/other emergency facility	Mental health transfer	Total	Infectious and parasitic diseases	All cancers and benign tumours	Blood and blood-forming organs	Endocrine, nutritional and metabolic diseases	Mental and behavioural disorders	Nervous system	Eye and ear	Circulatory system	Respiratory system	Digestive system	Skin and subcutaneous tissue	Musculoskeletal system and connective tissue	Genitourinary system	Pregnancy, childbirth and the puerperium	Injury, poisoning and other consequences of external causes
Altcourse	179	7	17	203	0	1	0	1	0	10	25	8	11	8	7	8	5	0	101
Bedford	226	40	8	274	34	19	20	5	1	4	18	3	6	12	14	20	6	0	104
Birmingham	611	191	0	802	15	30	17	7	0	34	70	40	38	46	8	24	144	0	318
Blakenhurst	364	60	21	445	4	3	6	15	2	23	35	14	8	44	25	73	13	0	146
Bristol	477	50	25	552	8	37	4	1	2	26	44	20	45	60	13	138	33	0	95
Brixton	288	48	34	370	12	9	22	2	0	13	33	15	12	29	6	8	79	0	89
Bullingdon	230	34	14	278	3	9	4	4	0	12	39	19	0	39	18	38	14	0	65
Cardiff	336	26	10	372	9	28	5	6	1	13	19	9	10	37	14	27	19	0	165
Chelmsford	251	34	2	287	7	3	4	0	0	8	35	19	11	50	11	16	23	0	97
Doncaster	288	21	20	329	5	17	2	15	0	16	26	16	5	43	6	37	55	0	66
Dorchester	178	23	2	203	14	2	6	4	0	5	13	24	13	23	7	22	8	0	60

TABLE 1: ESCORTS DATA

Local Prisons Escorts and Unaccompanied Visits Data

Prison	Planned outpatient appointment	Emergency visit to A&E/other emergency facility	Mental health transfer	Total	Infectious and parasitic diseases	All cancers and benign tumours	Blood and blood-forming organs	Endocrine, nutritional and metabolic diseases	Mental and behavioural disorders	Nervous system	Eye and ear	Circulatory system	Respiratory system	Digestive system	Skin and subcutaneous tissue	Musculoskeletal system and connective tissue	Genitourinary system	Pregnancy, childbirth and the puerperium	Injury, poisoning and other consequences of external causes
Durham	521	99	17	637	32	4	13	23	3	37	43	32	46	32	19	75	41	0	219
Elmley	245	12	2	259	10	19	4	2	1	11	18	11	4	32	2	11	31	0	90
Exeter	207	88	1	296	1	13	0	2	0	7	16	30	14	22	10	2	5	0	166
Forest Bank	396	4	0	400	67	30	0	5	0	5	24	16	3	11	4	6	3	0	150
Gloucester	221	44	4	269	11	4	0	3	2	15	24	13	6	60	5	5	7	0	110
High Down	193	15	1	209	3	9	3	6	0	7	22	6	4	27	7	24	19	0	53
Holme House	336	41	3	380	18	11	0	11	0	25	35	15	11	47	22	28	10	0	132
Hull	477	30	13	520	6	30	5	18	0	22	47	20	32	54	68	20	28	0	132
Leeds	733	159	2	894	19	50	5	21	1	27	33	69	31	93	82	52	213	0	196
Leicester	108	30	2	140	6	16	0	2	0	3	9	7	2	11	7	16	2	0	56
Lewes	268	20	4	292	16	1	12	2	1	11	23	15	3	40	15	32	35	0	64
Lincoln	318	6	4	328	20	52	0	0	1	9	18	14	8	34	12	15	30	0	93

TABLE 1: ESCORTS DATA

Local Prisons Escorts and Unaccompanied Visits Data

Prison	Planned outpatient appointment	Emergency visit to A&E/other emergency facility	Mental health transfer	Total	Infectious and parasitic diseases	All cancers and benign tumours	Blood and blood-forming organs	Endocrine, nutritional and metabolic diseases	Mental and behavioural disorders	Nervous system	Eye and ear	Circulatory system	Respiratory system	Digestive system	Skin and subcutaneous tissue	Musculoskeletal system and connective tissue	Genitourinary system	Pregnancy, childbirth and the puerperium	Injury, poisoning and other consequences of external causes
Liverpool	460	202	5	667	7	20	4	15	4	24	51	59	14	40	12	33	86	0	293
Norwich	386	84	16	486	6	47	7	9	0	13	24	23	25	63	42	74	39	0	98
Nottingham	179	74	9	262	5	2	1	1	0	9	18	7	9	22	6	58	18	0	97
Parc	360	69	2	431	0	31	4	3	0	12	31	22	26	73	23	50	53	0	100
Pentonville	540	28	60	628	65	14	8	10	0	17	32	8	11	31	3	17	78	0	173
Peterborough	352	30	0	382	11	9	6	8	1	8	22	6	3	33	8	95	18	69	81
Preston	440	92	9	541	18	18	5	2	1	22	48	24	27	42	6	69	65	0	185
Shrewsbury	126	47	1	174	13	0	1	5	0	10	16	16	6	8	5	25	3	0	64
Wandsworth	747	16	50	813	39	47	8	18	1	12	58	46	14	87	13	9	325	0	85
Winchester	268	4	14	286	0	0	0	2	0	9	13	5	4	27	34	45	17	0	67
Wormwood Scrubs	343	57	18	418	10	2	8	10	0	10	32	30	22	51	20	26	21	0	115
TOTAL	**11652**	**1785**	**390**	**13827**	**494**	**587**	**184**	**238**	**22**	**489**	**1014**	**681**	**484**	**1331**	**554**	**1198**	**1546**	**69**	**4125**

TABLE 2: BEDWATCHES DATA

Local Prisons Bedwatches Data (Planned Or Emergency Hospital Stay)																		
Prison	**Planned outpatient appointment**	**Emergency visit to A&E/other emergency facility**	**Total**	**Infectious and parasitic diseases**	**All cancers and benign tumours**	**Blood and blood-forming organs**	**Endocrine, nutritional and metabolic diseases**	**Mental and behavioural disorders**	**Nervous system**	**Eye and ear**	**Circulatory system**	**Respiratory system**	**Digestive system**	**Skin and subcutaneous tissue**	**Musculoskeletal system and connective tissue**	**Genitourinary system**	**Pregnancy, childbirth and the puerperium**	**Injury, poisoning and other consequences of external causes**
Altcourse	9	17	26	1	0	0	1	0	7	2	1	1	1	0	1	1	0	10
Bedford	6	20	26	0	2	0	0	0	1	1	2	2	2	0	1	8	0	7
Birmingham	20	36	56	0	1	0	2	0	2	1	2	1	2	0	1	4	0	35
Blakenhurst	13	31	44	2	0	1	2	0	2	2	5	1	9	0	3	5	0	11
Bristol	11	36	47	1	0	0	13	0	2	2	7	3	2	1	5	1	0	10
Brixton	4	17	21	1	0	1	1	0	0	0	4	0	3	0	2	2	0	5
Bullingdon	2	9	11	0	0	1	0	0	0	0	0	3	1	2	2	0	0	2
Cardiff	13	10	23	0	1	0	3	0	1	1	3	1	2	1	2	1	0	7
Chelmsford	9	17	26	0	2	0	0	0	2	0	4	1	9	1	0	2	0	5
Doncaster	8	4	12	0	0	0	0	0	0	3	2	0	2	2	1	0	0	2
Dorchester	1	9	10	0	0	0	1	0	1	0	4	1	0	0	0	0	0	3
Durham	21	43	64	4	0	2	8	1	5	2	8	0	8	2	3	3	0	18

TABLE 2: BEDWATCHES DATA

Local Prisons Bedwatches Data (Planned Or Emergency Hospital Stay)

Prison	Planned outpatient appointment	Emergency visit to A&E/other emergency facility	Total	Infectious and parasitic diseases	All cancers and benign tumours	Blood and blood-forming organs	Endocrine, nutritional and metabolic diseases	Mental and behavioural disorders	Nervous system	Eye and ear	Circulatory system	Respiratory system	Digestive system	Skin and subcutaneous tissue	Musculoskeletal system and connective tissue	Genitourinary system	Pregnancy, childbirth and the puerperium	Injury, poisoning and other consequences of external causes
Elmley	4	3	7	0	0	0	0	0	0	0	0	0	3	0	0	1	0	3
Exeter	12	24	36	0	1	0	1	0	2	0	7	0	5	0	0	0	0	19
Forest Bank	24	0	24	0	1	2	0	0	1	0	2	1	5	1	0	1	0	5
Gloucester	2	17	19	0	0	0	0	0	0	0	0	0	7	0	2	2	0	4
High Down	15	12	27	1	1	0	3	0	3	0	5	3	10	1	2	1	0	12
Holme House	14	28	42	0	2	1	0	0	4	3	8	5	15	4	2	1	0	35
Hull	50	34	84	0	0	4	0	0	3	0	13	9	5	2	5	7	0	29
Leeds	15	63	78	6	4	0	0	0	1	0	7	1	4	1	3	1	0	6
Leicester	22	12	34	0	0	1	1	0	0	0	1	0	2	0	2	2	0	4
Lewes	5	8	13	0	0	0	0	0	1	0	3	1	4	0	0	1	0	5
Lincoln	7	8	15	0	0	3	5	0	1	0	10	3	9	3	3	3	0	28
Liverpool	11	57	68	0	3	1	1	0	2	0	2	3	4	2	2	2	0	12

TABLE 2: BEDWATCHES DATA

Local Prisons Bedwatches Data (Planned Or Emergency Hospital Stay)

Prison	Planned outpatient appointment	Emergency visit to A&E/other emergency facility	Total	Infectious and parasitic diseases	All cancers and benign tumours	Blood and blood-forming organs	Endocrine, nutritional and metabolic diseases	Mental and behavioural disorders	Nervous system	Eye and ear	Circulatory system	Respiratory system	Digestive system	Skin and subcutaneous tissue	Musculoskeletal system and connective tissue	Genitourinary system	Pregnancy, childbirth and the puerperium	Injury, poisoning and other consequences of external causes
Norwich	14	21	35	0	1	0	0	0	0	1	0	2	1	1	1	1	0	2
Nottingham	3	7	10	0	1	1	0	0	0	1	5	2	2	0	1	1	0	11
Parc	9	16	25	1	5	0	0	0	0	0	1	0	1	0	0	1	0	6
Pentonville	22	1	23	1	0	0	1	0	0	0	1	0	2	0	1	0	2	3
Peterborough	3	8	11	0	2	1	0	0	2	0	5	0	13	0	2	6	0	17
Preston	12	36	48	0	0	0	1	0	1	0	4	3	2	1	2	0	0	4
Shrewsbury	5	13	18	4	3	2	4	1	4	3	12	2	5	0	0	6	0	23
Wandsworth	23	46	69	1	0	0	0	0	0	0	0	1	1	0	0	0	0	5
Winchester	2	6	8	1	1	4	0	0	0	0	7	1	11	1	0	3	0	3
Wormwood Scrubs	7	25	32	24	31	25	48	2	48	22	135	51	152	26	49	67	2	351
TOTAL	**398**	**694**	**1092**	**48**	**62**	**50**	**96**	**4**	**96**	**44**	**270**	**102**	**304**	**52**	**98**	**134**	**4**	**702**

13.3 High Secure Prisons

TABLE 1: ESCORTS DATA

High Secure Prisons Escorts and Unaccompanied Visits Data

Prison	Planned outpatient appointment	Emergency visit to A&E/other emergency facility	Mental health transfer	Total	Infectious and parasitic diseases	All cancers and benign tumours	Blood and blood-forming organs	Endocrine, nutritional and metabolic diseases	Mental and behavioural disorders	Nervous system	Eye and ear	Circulatory system	Respiratory system	Digestive system	Skin and subcutaneous tissue	Musculoskeletal system and connective tissue	Genitourinary system	Pregnancy, childbirth and the puerperium	Injury, poisoning and other consequences of external causes
Belmarsh	354	12	30	396	2	3	1	1	1	10	21	14	6	34	11	7	179	0	75
Frankland	305	27	0	332	4	21	5	3	0	13	38	35	12	57	4	22	58	0	42
Full Sutton	152	13	2	167	6	4	7	5	0	10	16	13	4	30	17	21	13	0	17
Long Lartin	156	30	3	189	1	5	0	1	0	21	23	17	1	27	8	11	29	0	42
Manchester	360	20	36	416	11	29	2	10	2	17	35	14	21	49	18	34	18	0	120
Wakefield	150	12	1	163	14	4	1	4	0	10	27	8	2	17	5	25	23	0	21
Whitemoor	84	9	0	93	2	4	4	2	0	2	8	13	2	18	3	16	6	0	12
Woodhill	153	4	0	157	3	3	0	4	0	5	14	15	2	13	7	17	16	0	36
TOTAL	**1714**	**127**	**72**	**1913**	**43**	**73**	**20**	**30**	**3**	**88**	**182**	**129**	**50**	**245**	**73**	**153**	**342**	**0**	**365**

TABLE 2: BEDWATCHES DATA

High Secure Prisons Bedwatches Data (Planned Or Emergency Hospital Stay)

Prison	Planned outpatient appointment	Emergency visit to A&E/other emergency facility	Total	Infectious and parasitic diseases	All cancers and benign tumours	Blood and blood-forming organs	Endocrine, nutritional and metabolic diseases	Mental and behavioural disorders	Nervous system	Eye and ear	Circulatory system	Respiratory system	Digestive system	Skin and subcutaneous tissue	Musculoskeletal system and connective tissue	Genitourinary system	Pregnancy, childbirth and the puerperium	Injury, poisoning and other consequences of external causes
Belmarsh	14	17	31	0	1	0	0	0	2	3	5	0	7	0	0	8	0	4
Frankland	14	19	33	1	4	1	0	0	1	2	4	6	3	0	2	4	0	5
Full Sutton	11	4	15	0	0	0	4	0	0	0	1	6	0	0	0	2	0	2
Long Lartin	14	11	25	0	0	0	0	0	0	1	1	3	5	2	4	5	0	4
Manchester	14	13	27	0	3	0	0	0	2	0	4	2	4	0	0	1	0	11
Wakefield	4	14	18	0	1	1	0	0	0	0	5	3	4	0	0	3	0	1
Whitemoor	21	6	27	0	9	0	0	0	0	2	5	0	3	2	2	0	0	4
Woodhill	4	0	4	0	0	0	0	0	0	1	1	0	0	0	0	1	0	0
TOTAL	**96**	**84**	**180**	**1**	**18**	**2**	**4**	**0**	**5**	**9**	**26**	**20**	**26**	**4**	**8**	**24**	**0**	**31**

13.4 Open Prisons

TABLE 1: ESCORTS DATA

Open Prisons Escorts and Unaccompanied Visits Data

Prison	Planned outpatient appointment	Emergency visit to A&E/other emergency facility	Mental health transfer	Total	Infectious and parasitic diseases	All cancers and benign tumours	Mental and behavioural disorders	Nervous system	Eye and ear	Circulatory system	Respiratory system	Digestive system	Skin and subcutaneous tissue	Musculoskeletal system and connective tissue	Genitourinary system	Pregnancy, childbirth and the puerperium	Injury, poisoning and other consequences of external causes
Blantyre House	178	17	0	195	3	9	0	0	35	12	10	19	23	43	4	0	30
Ford	624	29	3	656	13	12	30	7	82	39	5	37	41	194	48	0	74
Hewell Grange	133	17	0	150	24	0	0	0	20	1	1	20	9	31	5	0	32
Hollesley Bay	169	23	0	192	6	9	3	2	21	16	8	34	10	36	6	0	34
Kirkham	507	16	0	523	46	4	0	4	36	34	8	77	45	134	16	0	73
Kirklevington Grange	284	12	0	296	20	4	11	4	6	0	14	18	37	105	26	0	49
Latchmere House	135	1	0	136	1	0	0	0	11	1	4	17	1	26	1	0	51
Leyhill	493	21	0	514	40	15	0	8	18	23	50	80	47	130	24	0	73
Moorland Open	145	8	0	153	41	4	0	1	11	14	2	4	18	11	3	0	22
North Sea Camp	342	12	0	354	18	1	0	1	61	6	2	139	15	69	3	0	23
Prescoed	262	35	0	297	41	43	0	0	11	39	5	31	21	47	1	0	56

TABLE 1: ESCORTS DATA

Female Prisons Escorts and Unaccompanied Visits Data

Prison	Planned outpatient appointment	Emergency visit to A&E/other emergency facility	Mental health transfer	Total	Infectious and parasitic diseases	All cancers and benign tumours	Mental and behavioural disorders	Nervous system	Eye and ear	Circulatory system	Respiratory system	Digestive system	Skin and subcutaneous tissue	Musculoskeletal system and connective tissue	Genitourinary system	Pregnancy, childbirth and the puerperium	Injury, poisoning and other consequences of external causes
Spring Hill	187	4	0	191	5	2	3	8	30	8	5	40	10	50	11	0	6
Standford Hill	643	63	0	706	41	49	2	8	53	34	18	60	36	193	44	0	102
Sudbury	747	30	0	777	104	16	18	4	48	44	21	74	45	209	26	0	118
TOTAL	**4849**	**288**	**3**	**5140**	**403**	**168**	**67**	**47**	**443**	**271**	**153**	**650**	**358**	**1278**	**218**	**0**	**743**

TABLE 2: BEDWATCHES DATA

Open Prisons Bedwatches Data (Planned Or Emergency Hospital Stay)

Prison	Planned outpatient appointment	Emergency visit to A&E/other emergency facility	Total	Infectious and parasitic diseases	All cancers and benign tumours	Mental and behavioural disorders	Nervous system	Eye and ear	Circulatory system	Respiratory system	Digestive system	Skin and subcutaneous tissue	Musculoskeletal system and connective tissue	Genitourinary system	Pregnancy, childbirth and the puerperium	Injury, poisoning and other consequences of external causes
Blantyre House	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Hewell Grange	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Hollesley Bay	3	11	14	0	1	0	0	0	0	0	7	0	0	2	0	3
Latchmere House	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Leyhill	3	10	13	0	1	0	0	0	2	0	5	2	1	0	0	0
North Sea Camp	0	2	2	0	0	0	0	0	0	0	0	0	0	1	0	0
Prescoed	2	2	4	0	0	0	0	0	0	0	0	0	1	0	0	1
Spring Hill	4	2	6	0	0	0	0	0	0	0	0	0	3	1	0	0
Standford Hill	0	1	1	0	0	0	0	0	0	0	0	0	0	1	0	0
Sudbury	4	0	4	0	0	0	0	0	0	0	2	1	0	0	0	1
TOTAL	**18**	**29**	**47**	**0**	**2**	**0**	**0**	**0**	**2**	**0**	**14**	**3**	**5**	**5**	**0**	**7**

13.5 Trainer/Other Prisons

TABLE 1: ESCORTS DATA

Trainer/Other Prisons Escorts and Unaccompanied Visits Data

Prison	Planned outpatient appointment	Emergency visit to A&E/other emergency facility	Mental health transfer	Total	Infectious and parasitic diseases	All cancers and benign tumours	Blood and blood-forming organs	Endocrine, nutritional and metabolic diseases	Mental and behavioural disorders	Nervous system	Eye and ear	Circulatory system	Respiratory system	Digestive system	Skin and subcutaneous tissue	Musculoskeletal system and connective tissue	Genitourinary system	Pregnancy, childbirth and the puerperium	Injury, poisoning and other consequences of external causes
Acklington	374	52	0	426	23	3	5	1	0	7	29	32	25	48	33	75	25	0	117
Albany	356	20	0	376	1	23	0	16	0	12	35	26	15	59	19	66	9	0	64
Ashwell	265	20	0	285	6	6	3	2	1	10	19	13	16	34	29	83	15	0	47
Blundeston	250	39	0	289	21	36	8	4	0	6	19	7	8	40	15	37	13	0	67
Buckley Hall	4	0	0	4	0	0	0	0	0	0	0	0	0	0	1	1	0	0	1
Camp Hill	216	32	0	248	29	20	6	0	2	1	9	11	17	27	6	17	26	0	77
Canterbury	213	60	0	273	8	10	5	5	0	7	16	30	11	34	17	65	15	0	48
Channings Wood	419	30	0	449	8	23	4	0	0	9	64	11	43	79	49	77	17	0	65
Coldingley	229	38	0	267	12	5	0	16	0	0	34	7	5	74	9	36	14	0	46
Dartmoor	367	4	0	371	5	31	1	3	0	26	28	9	5	126	6	13	15	0	71
Dovegate	283	3	0	286	5	4	2	6	1	4	37	11	24	35	11	36	17	0	93

TABLE 1: ESCORTS DATA

Trainer/Other Prisons Escorts and Unaccompanied Visits Data

Prison	Planned outpatient appointment	Emergency visit to A&E/other emergency facility	Mental health transfer	Total	Infectious and parasitic diseases	All cancers and benign tumours	Blood and blood-forming organs	Endocrine, nutritional and metabolic diseases	Mental and behavioural disorders	Nervous system	Eye and ear	Circulatory system	Respiratory system	Digestive system	Skin and subcutaneous tissue	Musculoskeletal system and connective tissue	Genitourinary system	Pregnancy, childbirth and the puerperium	Injury, poisoning and other consequences of external causes
Dover	110	24	0	134	2	0	1	2	0	2	15	2	2	70	1	0	0	0	30
Edmunds Hill	103	42	0	145	17	0	4	2	0	1	15	12	3	6	7	16	11	0	51
Erlestoke	290	32	0	322	10	18	3	6	0	3	25	9	16	49	24	70	24	0	65
Everthorpe	175	7	0	182	20	1	0	2	0	13	20	2	4	26	22	37	10	0	25
Featherstone	273	63	1	337	4	3	0	13	0	23	58	13	8	34	19	54	33	0	73
Garth	388	40	4	432	16	21	0	7	0	10	28	13	17	59	29	28	39	0	161
Gartree	378	11	6	395	5	53	0	5	0	11	40	24	16	56	27	74	24	0	52
Grendon	247	17	0	264	7	8	0	9	0	4	22	7	4	59	27	49	21	0	46
Guys Marsh	292	12	0	304	4	8	2	3	1	14	18	10	14	69	37	60	7	0	42
Haslar	121	7	0	128	43	14	0	2	0	0	16	2	14	7	0	9	10	0	10
Haverigg	164	28	0	192	4	7	0	2	0	3	20	6	1	25	10	52	14	0	48
Highpoint	310	47	0	357	37	3	0	0	1	6	25	11	29	49	9	12	12	0	121

TABLE 1: ESCORTS DATA

Trainer/Other Prisons Escorts and Unaccompanied Visits Data																			
Prison	**Planned outpatient appointment**	**Emergency visit to A&E/other emergency facility**	**Mental health transfer**	**Total**	**Infectious and parasitic diseases**	**All cancers and benign tumours**	**Blood and blood-forming organs**	**Endocrine, nutritional and metabolic diseases**	**Mental and behavioural disorders**	**Nervous system**	**Eye and ear**	**Circulatory system**	**Respiratory system**	**Digestive system**	**Skin and subcutaneous tissue**	**Musculoskeletal system and connective tissue**	**Genitourinary system**	**Pregnancy, childbirth and the puerperium**	**Injury, poisoning and other consequences of external causes**
Kingston	168	4	0	172	0	4	1	13	0	3	22	8	3	19	14	58	9	0	18
Lancaster Castle	240	28	0	268	13	6	5	2	3	3	36	5	6	34	21	42	10	0	68
Lindholme	294	45	3	342	30	2	1	1	0	10	28	7	8	61	27	56	23	0	84
Littlehey	524	29	0	553	51	13	0	19	6	17	57	20	9	51	32	20	190	0	68
Lowdham Grange	366	36	1	403	5	13	0	7	0	3	27	16	6	12	11	66	164	0	72
Maidstone	391	35	1	427	19	27	5	14	0	12	46	47	9	43	25	88	38	0	53
Moorland Closed	213	7	0	220	6	13	2	4	1	2	9	14	13	22	27	26	42	0	39
Parkhurst	310	0	0	310	11	5	2	3	0	9	26	24	2	64	25	36	23	0	80
Ranby	437	54	0	491	4	15	0	2	0	8	22	14	9	55	15	63	41	0	204
Risley	541	27	0	568	3	1	3	28	6	41	87	36	6	109	27	83	50	0	88
Rye Hill	288	6	0	294	24	11	4	4	0	4	26	9	9	41	17	62	17	0	62
Shepton Mallet	163	12	0	175	4	3	0	0	0	0	32	15	8	22	21	33	11	0	26

TABLE 1: ESCORTS DATA

Trainer/Other Prisons Escorts and Unaccompanied Visits Data

Prison	Planned outpatient appointment	Emergency visit to A&E/other emergency facility	Mental health transfer	Total	Infectious and parasitic diseases	All cancers and benign tumours	Blood and blood-forming organs	Endocrine, nutritional and metabolic diseases	Mental and behavioural disorders	Nervous system	Eye and ear	Circulatory system	Respiratory system	Digestive system	Skin and subcutaneous tissue	Musculoskeletal system and connective tissue	Genitourinary system	Pregnancy, childbirth and the puerperium	Injury, poisoning and other consequences of external causes
Stafford	433	2	0	435	13	17	5	6	0	9	13	11	7	71	10	59	25	0	131
Stocken	274	69	0	343	26	26	4	7	2	12	22	14	11	29	12	38	27	0	113
Swaleside	310	14	1	325	13	6	2	7	0	6	42	15	3	47	15	74	45	0	41
Swansea	53	5	6	64	0	0	0	0	1	3	9	1	3	10	4	1	2	0	24
The Mount	413	34	0	447	11	51	1	5	0	6	44	19	13	107	21	10	28	0	108
The Verne	376	1	0	377	15	35	2	7	0	11	47	22	12	75	7	31	16	0	43
Usk	153	6	0	159	13	2	3	9	0	0	17	11	7	32	13	20	13	0	14
Wayland	285	41	0	326	31	16	0	7	7	8	45	15	15	54	11	45	21	0	48
Wealstun	664	73	0	737	47	7	8	23	0	20	47	43	9	187	31	220	17	0	77
Weare	31	2	1	34	2	0	0	3	0	0	0	2	2	8	2	0	1	0	13
Wellingborough	207	46	1	254	0	0	0	0	0	3	10	0	3	40	19	6	19	0	108
Whatton	114	0	0	114	2	4	2	7	0	2	21	9	2	20	9	11	14	0	11

TABLE 1: ESCORTS DATA

Trainer/Other Prisons Escorts and Unaccompanied Visits Data

Prison	Planned outpatient appointment	Emergency visit to A&E/other emergency facility	Mental health transfer	Total	Infectious and parasitic diseases	All cancers and benign tumours	Blood and blood-forming organs	Endocrine, nutritional and metabolic diseases	Mental and behavioural disorders	Nervous system	Eye and ear	Circulatory system	Respiratory system	Digestive system	Skin and subcutaneous tissue	Musculoskeletal system and connective tissue	Genitourinary system	Pregnancy, childbirth and the puerperium	Injury, poisoning and other consequences of external causes
Wolds	198	3	0	201	12	2	1	4	0	4	10	3	12	45	15	59	12	0	22
Wymott	611	103	3	717	6	21	8	11	0	15	72	52	19	80	29	68	28	0	273
TOTAL	**13884**	**1310**	**28**	**15222**	**648**	**597**	**103**	**299**	**32**	**383**	**1409**	**700**	**503**	**2403**	**867**	**2242**	**1257**	**0**	**3308**

TABLE 2: TRAINER/OTHER BEDWATCHES DATA

Trainer/Other Prisons Bedwatches Data (Planned Or Emergency Hospital Stay)																		
Prison	**Planned outpatient appointment**	**Emergency visit to A&E/other emergency facility**	**Total**	**Infectious and parasitic diseases**	**All cancers and benign tumours**	**Blood and blood-forming organs**	**Endocrine, nutritional and metabolic diseases**	**Mental and behavioural disorders**	**Nervous system**	**Eye and ear**	**Circulatory system**	**Respiratory system**	**Digestive system**	**Skin and subcutaneous tissue**	**Musculoskeletal system and connective tissue**	**Genitourinary system**	**Pregnancy, childbirth and the puerperium**	**Injury, poisoning and other consequences of external causes**
Acklington	5	4	9	1	0	0	0	0	0	0	1	0	2	0	1	1	0	3
Albany	3	1	4	0	1	0	0	0	0	0	0	0	1	1	0	1	0	0
Ashwell	7	9	16	1	1	0	0	0	1	0	2	0	5	0	3	0	0	3
Blundeston	1	3	4	0	0	0	0	0	0	0	3	0	0	0	1	0	0	0
Camp Hill	3	11	14	0	0	0	1	0	0	0	4	2	0	0	1	3	0	3
Canterbury	2	10	12	1	0	0	1	0	0	1	5	0	0	1	1	2	0	0
Channings Wood	14	5	19	1	2	0	0	0	0	1	2	2	2	1	5	0	0	3
Coldingley	2	11	13	1	0	1	1	0	0	0	1	0	1	0	1	1	0	6
Dartmoor	4	0	4	0	0	0	0	0	0	0	1	0	3	0	0	0	0	0
Dover	0	1	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Edmunds Hill	1	7	8	1	0	0	0	0	0	0	3	0	0	1	1	0	0	2
Erlestoke	2	9	11	0	0	0	0	0	0	0	0	1	1	0	0	2	0	7

TABLE 2: TRAINER/OTHER BEDWATCHES DATA

Trainer/Other Prisons Bedwatches Data (Planned Or Emergency Hospital Stay)																		
Prison	**Planned outpatient appointment**	**Emergency visit to A&E/other emergency facility**	**Total**	**Infectious and parasitic diseases**	**All cancers and benign tumours**	**Blood and blood-forming organs**	**Endocrine, nutritional and metabolic diseases**	**Mental and behavioural disorders**	**Nervous system**	**Eye and ear**	**Circulatory system**	**Respiratory system**	**Digestive system**	**Skin and subcutaneous tissue**	**Musculoskeletal system and connective tissue**	**Genitourinary system**	**Pregnancy, childbirth and the puerperium**	**Injury, poisoning and other consequences of external causes**
Everthorpe	3	8	11	1	0	0	0	0	0	1	1	4	0	1	1	0	0	2
Featherstone	3	15	18	0	0	0	1	0	0	0	3	1	6	1	1	0	0	5
Garth	9	28	37	1	1	0	0	0	1	3	5	3	4	2	1	1	0	15
Gartree	6	1	7	1	1	0	0	0	0	0	1	1	0	1	1	0	0	1
Grendon	3	7	10	1	0	0	0	0	0	0	3	1	2	1	0	2	0	0
Guys Marsh	0	2	2	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0
Haslar	1	1	2	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0
Haverigg	6	6	12	0	1	0	0	0	0	1	0	1	3	0	0	2	0	4
Highpoint	3	45	48	0	0	0	0	0	0	2	8	3	3	0	0	0	0	24
Kingston	5	3	8	0	0	0	0	0	0	0	2	0	0	1	2	1	0	2
Lancaster Castle	6	1	7	0	0	0	0	0	0	3	0	1	0	0	0	0	0	3
Lindholme	8	7	15	0	0	0	0	0	0	2	0	1	3	0	4	1	0	4

TABLE 2: TRAINER/OTHER BEDWATCHES DATA

Trainer/Other Prisons Bedwatches Data (Planned Or Emergency Hospital Stay)																		
Prison	**Planned outpatient appointment**	**Emergency visit to A&E/other emergency facility**	**Total**	**Infectious and parasitic diseases**	**All cancers and benign tumours**	**Blood and blood-forming organs**	**Endocrine, nutritional and metabolic diseases**	**Mental and behavioural disorders**	**Nervous system**	**Eye and ear**	**Circulatory system**	**Respiratory system**	**Digestive system**	**Skin and subcutaneous tissue**	**Musculoskeletal system and connective tissue**	**Genitourinary system**	**Pregnancy, childbirth and the puerperium**	**Injury, poisoning and other consequences of external causes**
Littlehey	10	9	19	0	0	0	0	0	0	1	3	7	2	1	0	1	0	4
Lowdham Grange	5	14	19	0	2	0	0	0	0	0	3	1	0	0	4	4	0	5
Maidstone	10	16	26	0	1	2	1	0	0	1	5	1	5	0	7	1	0	2
Moorland Closed	2	6	8	0	0	0	1	0	0	1	1	1	2	0	0	0	0	2
Parkhurst	3	0	3	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Ranby	5	11	16	0	2	0	0	0	0	0	1	1	3	1	0	3	0	5
Risley	22	26	48	0	1	0	2	0	3	2	9	3	6	1	8	5	0	8
Rye Hill	3	14	17	0	1	2	0	0	0	0	0	0	0	1	1	0	0	11
Shepton Mallet	4	9	13	0	0	0	0	0	0	0	6	1	3	0	2	0	0	1
Stafford	10	0	10	0	1	0	0	0	0	1	0	1	1	0	0	0	0	3
Stocken	8	19	27	0	0	0	0	0	2	2	1	0	3	3	6	3	0	7
Swaleside	10	3	13	0	0	0	0	0	2	0	0	0	0	1	4	0	0	4

TABLE 2: TRAINER/OTHER BEDWATCHES DATA

Trainer/Other Prisons Bedwatches Data (Planned Or Emergency Hospital Stay)																		
Prison	**Planned outpatient appointment**	**Emergency visit to A&E/other emergency facility**	**Total**	**Infectious and parasitic diseases**	**All cancers and benign tumours**	**Blood and blood-forming organs**	**Endocrine, nutritional and metabolic diseases**	**Mental and behavioural disorders**	**Nervous system**	**Eye and ear**	**Circulatory system**	**Respiratory system**	**Digestive system**	**Skin and subcutaneous tissue**	**Musculoskeletal system and connective tissue**	**Genitourinary system**	**Pregnancy, childbirth and the puerperium**	**Injury, poisoning and other consequences of external causes**
Swansea	4	10	14	0	0	0	0	0	0	0	1	0	0	1	1	1	0	10
The Mount	7	19	26	1	4	1	0	0	2	0	0	2	6	0	1	1	0	8
The Verne	2	0	2	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Usk	2	2	4	0	0	0	0	0	0	0	1	0	1	1	0	1	0	0
Wayland	18	23	41	4	2	1	1	0	0	2	4	1	10	2	2	0	0	11
Wealstun	13	5	18	0	0	0	2	0	0	4	0	0	7	0	3	0	0	2
Weare	2	0	2	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0
Wellingborough	3	19	22	1	0	2	1	0	0	0	4	1	3	1	0	2	0	3
Whatton	3	0	3	0	0	0	0	0	0	0	0	0	2	1	0	0	0	0
Wolds	9	0	9	0	0	0	1	0	0	0	0	1	5	0	1	1	0	0
Wymott	19	59	78	0	2	1	3	1	0	0	23	5	12	5	1	3	0	18
TOTAL	**271**	**459**	**730**	**16**	**23**	**10**	**16**	**1**	**12**	**29**	**108**	**48**	**110**	**32**	**65**	**43**	**0**	**192**

13.6 YOI/Juvenile Prisons

TABLE 1: ESCORTS DATA

YOI/Juvenile Prisons Escorts and Unaccompanied Visits Data

Prison	Planned outpatient appointment	Emergency visit to A&E/other emergency facility	Mental health transfer	Total	Infectious and parasitic diseases	All cancers and benign tumours	Blood and blood-forming organs	Endocrine, nutritional and metabolic diseases	Mental and behavioural disorders	Nervous system	Eye and ear	Circulatory system	Respiratory system	Digestive system	Skin and subcutaneous tissue	Musculoskeletal system and connective tissue	Genitourinary system	Pregnancy, childbirth and the puerperium	Injury, poisoning and other consequences of external causes
Ashfield	91	85	0	176	0	0	0	0	1	2	4	0	2	3	4	0	7	0	151
Aylesbury	225	44	0	269	5	1	0	0	0	10	13	2	5	13	13	5	15	0	187
Brinsford	118	65	9	192	7	6	2	2	0	11	17	6	2	9	3	3	5	0	108
Castington	101	25	0	126	4	2	0	1	0	1	6	1	0	11	2	2	12	0	78
Deerbolt	89	42	0	131	4	1	0	0	0	4	1	2	1	9	3	1	9	0	91
Feltham	160	82	2	244	9	2	0	0	2	12	12	7	5	16	10	4	12	0	151
Glen Parva	115	5	0	120	5	8	5	4	0	2	9	2	1	3	0	6	4	0	71
Hindley	154	103	5	262	1	10	0	0	0	4	14	6	5	28	3	8	8	0	161
Huntercombe	76	10	0	86	2	1	0	2	0	3	5	0	0	1	4	2	5	0	61
Lancaster Farms	134	91	3	228	8	2	2	1	0	0	2	2	2	6	2	8	15	0	175
Northallerton	54	11	0	65	3	1	0	2	0	0	1	0	0	4	2	7	7	0	38

TABLE 1: ESCORTS DATA

YOI/Juvenile Prisons Escorts and Unaccompanied Visits Data

Prison	Planned outpatient appointment	Emergency visit to A&E/other emergency facility	Mental health transfer	Total	Infectious and parasitic diseases	All cancers and benign tumours	Blood and blood-forming organs	Endocrine, nutritional and metabolic diseases	Mental and behavioural disorders	Nervous system	Eye and ear	Circulatory system	Respiratory system	Digestive system	Skin and subcutaneous tissue	Musculoskeletal system and connective tissue	Genitourinary system	Pregnancy, childbirth and the puerperium	Injury, poisoning and other consequences of external causes
Onley	118	31	0	149	9	0	0	2	0	6	19	6	10	17	8	16	8	0	48
Portland	220	36	0	256	12	3	4	5	0	6	16	1	11	19	38	13	32	0	89
Reading	72	15	4	91	1	0	0	2	0	3	4	1	1	10	2	11	1	0	45
Rochester	53	22	0	75	1	2	1	2	0	1	7	0	2	8	3	2	16	0	30
Stoke Heath	152	32	0	184	10	17	1	3	2	1	25	3	1	16	3	0	6	0	92
Swinfen Hall	246	31	0	277	43	3	0	2	0	4	24	4	12	11	7	7	14	0	67
Thorn Cross	79	20	0	99	10	0	0	0	3	1	4	0	5	8	6	18	11	0	33
Warren Hill	53	12	0	65	1	0	0	0	0	3	6	0	3	14	1	3	3	0	31
Werrington	164	70	0	234	19	0	1	2	0	8	53	3	3	27	9	6	3	0	100
Wetherby	112	61	2	175	1	1	2	5	0	2	7	0	0	13	9	15	7	0	111
TOTAL	**2586**	**893**	**25**	**3504**	**155**	**60**	**18**	**35**	**8**	**84**	**249**	**46**	**71**	**246**	**132**	**137**	**200**	**0**	**1918**

TABLE 2: YOI/JUVENILE BEDWATCHES DATA

YOI/Juvenile Prisons Bedwatches Data (Planned Or Emergency Hospital Stay)																		
Prison	**Planned outpatient appointment**	**Emergency visit to A&E/other emergency facility**	**Total**	**Infectious and parasitic diseases**	**All cancers and benign tumours**	**Blood and blood-forming organs**	**Endocrine, nutritional and metabolic diseases**	**Mental and behavioural disorders**	**Nervous system**	**Eye and ear**	**Circulatory system**	**Respiratory system**	**Digestive system**	**Skin and subcutaneous tissue**	**Musculoskeletal system and connective tissue**	**Genitourinary system**	**Pregnancy, childbirth and the puerperium**	**Injury, poisoning and other consequences of external causes**
Ashfield	5	2	7	0	0	0	0	0	0	0	0	0	0	0	1	1	0	5
Aylesbury	10	6	16	0	0	0	0	0	0	1	0	0	3	1	0	0	0	11
Brinsford	2	14	16	0	0	0	1	0	1	1	0	0	2	0	2	1	0	7
Castington	3	2	5	0	0	0	1	0	0	0	0	0	0	0	0	0	0	3
Deerbolt	2	2	4	0	0	0	0	0	1	0	0	0	1	0	0	0	0	2
Feltham	2	14	16	1	0	0	0	0	3	0	0	0	6	0	0	0	0	6
Glen Parva	2	2	4	1	0	0	1	0	0	0	1	1	0	0	0	0	0	0
Hindley	5	5	10	0	0	0	0	0	0	0	0	2	2	0	0	0	0	6
Huntercombe	1	3	4	0	0	0	0	0	1	0	0	0	0	0	0	0	0	2
Lancaster Farms	2	10	12	0	0	0	1	0	0	0	0	1	4	0	0	1	0	5
Northallerton	1	4	5	0	0	0	1	0	0	0	1	0	1	1	0	0	0	1
Onley	5	15	20	1	1	0	1	0	0	0	1	1	3	3	0	2	0	6

TABLE 2: YOI/JUVENILE BEDWATCHES DATA

YOI/Juvenile Prisons Bedwatches Data (Planned Or Emergency Hospital Stay)

Prison	Planned outpatient appointment	Emergency visit to A&E/other emergency facility	Total	Infectious and parasitic diseases	All cancers and benign tumours	Blood and blood-forming organs	Endocrine, nutritional and metabolic diseases	Mental and behavioural disorders	Nervous system	Eye and ear	Circulatory system	Respiratory system	Digestive system	Skin and subcutaneous tissue	Musculoskeletal system and connective tissue	Genitourinary system	Pregnancy, childbirth and the puerperium	Injury, poisoning and other consequences of external causes
Portland	3	4	7	0	1	0	0	0	0	0	0	0	1	0	1	0	0	4
Reading	2	2	4	0	0	0	0	0	0	0	0	2	0	0	0	0	0	2
Rochester	1	3	4	0	0	0	1	0	0	0	0	0	3	0	0	0	0	0
Stoke Heath	3	6	9	0	4	0	0	1	0	0	1	0	2	0	0	0	0	1
Swinfen Hall	4	4	8	0	2	0	0	0	0	0	0	1	0	0	0	3	0	2
Thorn Cross	1	1	2	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Warren Hill	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Werrington	0	4	4	0	0	0	0	0	0	0	0	0	0	0	0	1	0	2
Wetherby	1	1	2	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
TOTAL	**56**	**104**	**160**	**4**	**8**	**0**	**7**	**1**	**6**	**3**	**4**	**8**	**29**	**5**	**4**	**9**	**0**	**67**

14. Annex E: Results of Validation Exercise

14.1 Number of Forms Returned

For various reasons, as detailed in section 3.3, not all health related escort and bedwatch events resulted in a completed form being sent back for the audit. Returns were monitored using a tracker system and throughout the audit period, prison healthcare departments were contacted if gaps seemed evident. Extra efforts were made towards the end of the audit period and although more time was taken after the end of the audit to chase returns, it was evident that some gaps remained.

These gaps are too small to have any significant effect on the statistical analysis of the data by event. However, for the purposes of budgetary calculation it was important to make sure that the data was as accurate as possible. A validation exercise was therefore carried out whereby missing incidents were identified for inclusion in the final budget assessment.

14.2 Identification of Missing Returns

The data from the forms was sorted by month for each prison and two elements were used to identify missing returns:

- Where complete missing months were evident from the dataset, these were identified and an extrapolated adjusted figure for the complete year shown in the "Adjusted for Missing Months" column.

  For further comments on under-reporting, see Section 12.1.

- A summary of episodes by month was circulated to all prison establishments in July 2006 requesting confirmation that the establishment was content with their reported figures. The instruction stated that nil returns would be taken as agreement. 37 of 141 prisons submitted amendments to their data. These figures are shown in the "Prison Validation response – July 2006" column, after an adjustment to reflect the fact that April 2005 and April 2006 were not complete months in the audit. Where there was a relatively large variation between figures calculated by the central team in the case of missing months and the prison-submitted amendments, the data was verified by telephone.

The evidence from both elements was considered and a figure agreed for each establishment that more accurately represents actual events during the audit period. This is shown as "Final Accepted Figure" column.

In total, an additional 4,166 escort events (9%) and 473 bedwatch events (19%) were added to the audit figures for the purposes of the budget calculation.

The following figures were then removed for the purposes of the costing calculation:

	Escorts	Bedwatches
Contracted Out Estate (COE)	3462	146
Open (O)	5163	40
Welsh Estate (WE)	1586	70
Female Open (FO)	1064	11
TOTAL	**11,275**	**267**

These prisons are marked in bold italics in the detailed table overleaf.

The final figures used for the purposes of the costing calculations are therefore:

Type of Event	Number
Bedwatches	2,740
Escorts	38,264
	41,004

14.3 Validation Results

Prison	Response to Validation	Escort Events: Number of months missing from audit returns	Escort Events: Audit Dataset Figure	Escort Events: Adjusted for Missing Months (where necessary)	Escort Events: Prison Validation response – July 2006	Escort Events: Final Accepted Figure	Bedwatch Events: Audit Dataset Figure	Bedwatch Events: Adjusted for Missing Months	Bedwatch Events: Prison Validation response – July 2006	Bedwatch Events: Final Accepted Figure
Acklington	Amendments	1.25	426	474	609	**559**	9	10	13	**13**
Albany	Amendments	1	377	411	397	**397**	3		21	**21**
Altcourse	*Yes (No response)*		*203*			***203***	*26*			***26***
Ashfield	*Amendments*		*176*		*207*	***207***	*7*		*8*	***8***
Ashwell	Yes (No response)		293			**293**	16			**16**
Askham Grange	*Yes (No response)*		*423*			***423***	*6*			***6***
Aylesbury	Yes (No response)		269			**269**	16			**16**
Bedford	Yes (No response)		275			**275**	26			**26**
Belmarsh	Yes (No response)		396			**396**	31		60	**60**
Birmingham	Amendments		806		1270	**1270**	57		141	**141**
Blakenhurst	Yes (No response)	0.75	445	474		**474**	44	47		**47**
Blantyre House	*Yes (No response)*		*195*			***195***	*1*			***1***
Blundeston	Yes (No response)		289			**289**	4			**4**
Brinsford	Yes		192			**192**	10			**10**
Bristol	Amendments		552		559	**559**	47		47	**47**

		Escort Events				Bedwatch Events				
Prison	**Response to Validation**	**Number of months missing from audit returns**	**Audit Dataset Figure**	**Adjusted for Missing Months (where necessary)**	**Prison Validation response – July 2006**	**Final Accepted Figure**	**Audit Dataset Figure**	**Adjusted for Missing Months**	**Prison Validation response – July 2006**	**Final Accepted Figure**
Brixton	Amendments		374		397	397	**21**		25	**25**
Brockhill	Yes (No response)		194			194	**21**			**21**
Bronzefield	*Yes (No response)*	*6.25*	*282*	*576*		*576*	***10***	*20*		***20***
Buckley Hall	Yes (No response)		61			61	**1**			**1**
Bullingdon	Amendments	0.5	278	290	341	341	**11**		53	**53**
Bullwood Hall	Yes (No response)	3.75	172	248		248	**7**	10		**10**
Camp Hill	Amendments		252		267	267	**14**		14	**14**
Canterbury	Yes (No response)		273			273	**12**			**12**
Cardiff	Yes (No response)		373			373	**23**			**23**
Castington	Amendments		126		140	140	**5**		5	**5**
Channings Wood	Yes (No response)		449			449	**19**			**19**
Chelmsford	Amendments		287		299	299	**26**		26	**26**
Coldingley	Yes (No response)		267			267	**13**			**13**
Cookham Wood	Yes (No response)	1.75	90	105		105	**3**	4		**4**
Dartmoor	Yes (No response)		371			371	**4**			**4**
Deerbolt	Yes (No response)		131			131	**4**			**4**

		Escort Events					Bedwatch Events				
Prison	Response to Validation	Number of months missing from audit returns	Audit Dataset Figure	Adjusted for Missing Months (where necessary)	Prison Validation response – July 2006	Final Accepted Figure	Audit Dataset Figure	Adjusted for Missing Months	Prison Validation response – July 2006	Final Accepted Figure
Doncaster	*Yes (No response)*		*329*			*329*	***12***			***12***
Dorchester	Yes (No response)		203			203	**10**			**10**
Dovegate	*Yes (No response)*	*4.75*	*286*	*467*		*467*	***0***			***0***
Dover*	Yes (No response)		134			134	**1**			**1**
Downview	Yes (No response)	0.75	334	356		356	**7**			**7**
Drake Hall	Yes (No response)		630			630	**7**			**7**
Durham	Yes (No response)		637			637	**64**			**64**
East Sutton Park	*Yes (No response)*	*0.75*	*602*	*641*		*641*	***5***			***5***
Eastwood Park	Yes (No response)	1	373	406		406	**64**	70		**70**
Edmunds Hill	Yes (No response)		145			145	**8**			**8**
Elmley	Amendments		259		311	311	**7**		7	**7**
Erlestoke	Amendments		322		339	339	**11**		33	**33**
Everthorpe	Yes (No response)		181			181	**12**			**12**
Exeter	Yes (No response)		301			301	**39**			**39**
Featherstone	Yes		337			337	**19**			**19**
Feltham	Amendments		245		266	266	**16**		11	**16**

		Escort Events				Bedwatch Events			
Prison	**Response to Validation**	**Number of months missing from audit returns**	**Audit Dataset Figure**	**Adjusted for Missing Months (where necessary)**	**Prison Validation response – July 2006**	**Final Accepted Figure**	**Audit Dataset Figure**	**Adjusted for Missing Months**	**Prison Validation response – July 2006**	**Final Accepted Figure**
Ford	Yes		656			656	**0**	0		**0**
Forest Bank	*Amendments*		*400*		*400*	*400*	***24***			***24***
Foston Hall	Amendments		333		388	388	**29**		29	**29**
Frankland	Amendments		332		424	424	**33**		33	**33**
Full Sutton	Yes (No response)		167			167	**15**			**15**
Garth	Yes (No response)		431			431	**38**			**38**
Gartree	Yes (No response)		404			404	**7**			**7**
Glen Parva	Yes (No response)	1	120	131		131	**4**			**4**
Gloucester	Yes (No response)		269			269	**19**			**19**
Grendon	Yes (No response)	1	264	287		287	**10**	11		**11**
Guys Marsh	Yes (No response)	2.5	304	382		382	**2**	3		**3**
Haslar*	Amendments		128		132	132	**2**		2	**2**
Haverigg	Amendments	1	192	209	245	245	**12**	13	12	**12**
Hewell Grange	*Yes (No response)*	*2.75*	*151*	*195*		*195*	***0***			***0***
High Down	Yes (No response)		210			210	**28**			**28**
Highpoint	Yes (No response)	3.25	357	486		486	**48**	65		**65**

		Escort Events					Bedwatch Events			
Prison	**Response to Validation**	**Number of months missing from audit returns**	**Audit Dataset Figure**	**Adjusted for Missing Months (where necessary)**	**Prison Validation response – July 2006**	**Final Accepted Figure**	**Audit Dataset Figure**	**Adjusted for Missing Months**	**Prison Validation response – July 2006**	**Final Accepted Figure**
Hindley	Yes (No response)		281			281	**10**			**10**
Hollesley Bay	Yes (No response)		192			192	**14**			**14**
Holloway	Yes (No response)	2.5	367	461		461	**6**	8		**8**
Holme House	Yes (No response)		382			382	**42**			**42**
Hull	Yes (No response)		520			520	**93**			**93**
Huntercombe	Amendments		53		86	86	**4**		4	**4**
Kingston	Yes (No response)	3.75	172	248		248	**8**	12		**12**
Kirkham	*Yes (No response)*		*523*			*523*	***0***			***0***
Kirklevington Grange	*Yes (No response)*	*0.75*	*295*	*314*		*314*	***1***			***1***
Lancaster Castle	Yes		268			268	**7**			**7**
Lancaster Farms	Yes	0.75	228	243		243	**12**	13		**13**
Latchmere House	*Yes (No response)*	*2.75*	*136*	*175*		*175*	***1***			***1***
Leeds	Yes (No response)		894			894	**78**			**78**
Leicester	Yes (No response)		140			140	**34**			**34**
Lewes	Yes (No response)		292			292	**13**			**13**
Leyhill	Yes (No response)		514			514	**13**			**13**

		Escort Events					Bedwatch Events			
Prison	**Response to Validation**	**Number of months missing from audit returns**	**Audit Dataset Figure**	**Adjusted for Missing Months (where necessary)**	**Prison Validation response – July 2006**	**Final Accepted Figure**	**Audit Dataset Figure**	**Adjusted for Missing Months**	**Prison Validation response – July 2006**	**Final Accepted Figure**
Lincoln	Yes (No response)		328			328	**15**			**15**
Lindholme	Yes (No response)		342			342	**15**			**15**
Littlehey	Yes (No response)		553			553	**19**			**19**
Liverpool	Yes (No response)		667			667	**68**			**68**
Long Lartin	Yes (No response)		189		193	193	**25**		25	**25**
Low Newton	Amendments	3	200	265	269	269	**21**	28	31	**31**
Lowdham Grange	*Yes (No response)*		*403*			*403*	***19***			***19***
Maidstone	Yes (No response)		427			427	**26**			**26**
Manchester	Amendments		416		416	416	**27**		33	**33**
Moorland Closed	Yes (No response)		220			220	**8**			**8**
Moorland Open	*Yes (No response)*		*159*			*159*	***0***			***0***
Morton Hall	Amendments		392		412	412	**6**		6	**6**
New Hall	Yes (No response)		554			554	**54**			**54**
North Sea Camp	*Yes (No response)*	*5.5*	*354*	*642*		*642*	***2***	*4*		***4***
Northallerton	Yes		65			65	**5**			**5**
Norwich	Yes (No response)		486			486	**35**			**35**

		Escort Events					Bedwatch Events			
Prison	**Response to Validation**	**Number of months missing from audit returns**	**Audit Dataset Figure**	**Adjusted for Missing Months (where necessary)**	**Prison Validation response – July 2006**	**Final Accepted Figure**	**Audit Dataset Figure**	**Adjusted for Missing Months**	**Prison Validation response – July 2006**	**Final Accepted Figure**
Nottingham	Yes (No response)		262			262	**10**			**10**
Onley	Yes		149			149	**20**			**20**
Parc	*Amendments*	*2.25*	*415*	*508*	*693*	*693*	***25***	*31*	*25*	*25*
Parkhurst	Amendments	0.75	310	330	333	333	**3**		17	**17**
Pentonville	Amendments		629		629	629	**23**		69	**69**
Peterborough	*Yes*		*382*			*382*	***11***			***11***
Portland	Yes (No response)		256			256	**4**			**4**
Prescoed	*Yes (No response)*		*297*			*297*	***4***			***4***
Preston	Yes (No response)	0.75	541	576		576	**48**	51		**51**
Ranby	Amendments	3.75	491	708	690	690	**16**	23	53	**53**
Reading	Amendments		91		94	94	**4**		4	**4**
Risley	Yes (No response)		568			568	**48**			**48**
Rochester	Amendments	0.75	75	80	119	119	**4**		7	**7**
Rye Hill	*Yes (No response)*		*294*			*294*	***17***			***17***
Send	Yes (No response)	4.75	250	408		408	**21**	34		**34**
Shepton Mallet	Yes		175			175	**13**			**13**

Prison	Response to Validation	Escort Events					Bedwatch Events			
		Number of months missing from audit returns	Audit Dataset Figure	Adjusted for Missing Months (where necessary)	Prison Validation response – July 2006	Final Accepted Figure	Audit Dataset Figure	Adjusted for Missing Months	Prison Validation response – July 2006	Final Accepted Figure
Shrewsbury	Yes (No response)		173			173	**19**			**19**
Spring Hill	*Yes (No response)*	*4.5*	*195*	*308*		*308*	***9***	*14*		***14***
Stafford	Yes (No response)		435			435	**10**			**10**
Standford Hill	*Yes (No response)*		*704*			*704*	***3***			***3***
Stocken	Amendments	1.75	343	400	412	412	**27**	32	44	**44**
Stoke Heath	Amendments		185		230	230	**9**		12	**12**
Styal	Yes (No response)	0.75	374	398		398	**43**	46		**46**
Sudbury	*Yes*		*778*			*778*	***3***			***3***
Swaleside	Yes (No response)		325			325	**13**			**13**
Swansea	*Yes (No response)*		*64*			*64*	***14***			***14***
Swinfen Hall	Yes (No response)		383			383	**8**			**8**
The Mount	Yes (No response)		447			447	**26**			**26**
The Verne	Amendments	2.5	377	474	428	428	**2**	3	15	**15**
Thorn Cross	Yes (No response)		99			99	**2**			**2**
Usk	*Yes (No response)*		*159*			*159*	***4***			***4***
Wakefield	Amendments	4.5	163	258	286	286	**18**	28	28	**28**

		Escort Events					Bedwatch Events			
Prison	**Response to Validation**	**Number of months missing from audit returns**	**Audit Dataset Figure**	**Adjusted for Missing Months (where necessary)**	**Prison Validation response – July 2006**	**Final Accepted Figure**	**Audit Dataset Figure**	**Adjusted for Missing Months**	**Prison Validation response – July 2006**	**Final Accepted Figure**
Wandsworth	Amendments		813		878	878	**69**		85	**85**
Warren Hill	Yes (No response)		65			65	**1**			**1**
Wayland	Yes (No response)		326			326	**41**			**41**
Wealstun	Yes (No response)		735			735	**20**			**20**
Weare	Yes (No response)		34			34	**2**			**2**
Wellingborough	Yes (No response)		254			254	**22**			**22**
Werrington	Yes (No response)		234			234	**4**			**4**
Wetherby	Amendments		179		182	182	**2**		2	**2**
Whatton	Amendments	6.75	114	254	291	291	**3**	7	21	**21**
Whitemoor	Amendments	2.75	93	120	142	142	**27**	35	28	**28**
Winchester	Amendments		286		471	286	**8**		125	**8**
Wolds	*Yes (No response)*		*201*			*201*	***9***			***9***
Woodhill	Yes (No response)		163			163	**2**			**2**
Wormwood Scrubs	Yes (No response)		425			425	**34**			**34**
Wymott	Yes		717			717	**78**			**78**
TOTAL ALL PRISONS	**45,373**			**49,539**	**2,534**			**3,007**		

Establishments noted in bold Italics are excluded from costing calculations on the basis that they form part of the contracted out, open or Welsh estates.

15. Annex F: Event Profiles

Standard Profile of Escort Event

	Activity	Number of Staff Involved	Staff Type	Duration (Minutes)
1	Need for escort identified SEE NOTE A	2	Both	10-15
2	Need for Escort agreed by GP/nurse SEE NOTE B	1	Healthcare	10-15
3	Appointment Booked/ Ambulance Called SEE NOTE A	1	Both	10-15
4	Notify detail staff of appointment/ need for escort SEE NOTE C	1	Healthcare	10-15
5	Complete prisoner risk assessment	2	Both	10-15
6	Escort staff ordered (and special payments approved SEE NOTE D)	1	Security	15-30
7	Transport booked SEE NOTE E	1	Security	10-15
8	Prepare prisoner to leave	1	Security	10-15
9	Complete relevant sections of Prisoner Escort Record (PER)	2	Both	15-20
10	Obtain signature of Security/ Duty Governor on PER	1	Security	10-15
11	Escort takes place SEE NOTE F	N/A	N/A	N/A
12	Reception back into prison	2	Security	15-20
13	Security escort staff inform healthcare staff of feedback and further appointments	1	Security	10-15

Notes:

a) Performed by healthcare staff unless an emergency event.

b) Not always necessary if emergency out-of-hours event.

c) Planned appointments are notified to detail on a weekly basis. 1 Hr per week activity.

d) For out-of-hours emergencies only.

e) Unless ambulance has been called.

f) Costed separately. Time and number of staff dependant on outcome of Activity 5 and medical treatment required.

g) On-Site risk assessment of local NHS hospitals and other facilities completed on an annual basis. 2 day event involving 2-4 security staff.

h) Activities are not necessarily dependant upon one another and may take place simultaneously.

Standard Profile of Bedwatch Event

	Activity	Number of Staff Involved	Staff Type	Duration (Minutes)
1	Need for bedwatch identified SEE NOTE A	1-2	Both	10-15
2	Need for bedwatch agreed by Doctor	1-2	Healthcare	15-30
3	Inpatient stay booked	1	Healthcare	10-15
4	Notify detail staff of bedwatch SEE NOTE B	1	Healthcare	10-15
5	Complete prisoner risk assessment	2	Both	10-15
6	Escort staff ordered (and special payments approved SEE NOTE C)	2-3	Security	15-30
7	Transport booked SEE NOTE D	1	Security	10-15
8	Prepare prisoner to leave	1	Security	10-15
9	Complete relevant sections of Prisoner Escort Record (PER)	2	Both	10-15
10	Obtain signature of Security/ Duty Governor on PER	1	Security	10-15
11	Prisoner Escorted to Hospital from Prison SEE NOTE E	N/A	N/A	N/A
12	Daily update of medical records/inpatient log	1	Healthcare	10-15
13	Governor or designated person visit SEE NOTE F	1	Security	120
14	Staff Changeover x 3 SEE NOTE F i)	2	Security	60
15	Prisoner Escorted to Prison from Hospital SEE NOTE E	N/A	N/A	N/A
16	Reception back into prison	2	Security	15-30
17	Security escort staff inform healthcare staff of feedback and further appointments	1	Security	10-15

Notes:

a) Performed by healthcare staff unless an emergency event.
b) Planned appointments are notified to detail on a weekly basis. 1 Hr per week activity.
c) For out-of-hours emergencies only.
d) Unless ambulance has been called.
e) Time and number of staff dependant on outcome of Activity 5 and medical treatment required.
f) i) Includes travelling time ii) Dependant on length of stay but minimum of one per week.
g) Activities 1-11 will not be necessary for escorts which turn into bedwatches.
h) Activities are not necessarily dependant upon one another and may take place simultaneously.
i) On-Site risk assessment of local NHS hospitals and other facilities completed on an annual basis. 2 day event involving 2-4 security staff.

Standard Profile of Mental Health Transfer Event

	Activity	Number of Staff Involved	Staff Type	Duration (Minutes)
1	Need for transfer identified by doctor/ psychiatrist	2	Healthcare	10-15
2	Inform Mental Health Unit, PCT Commissioner and Forensic Case Manager (where applicable)	1	Healthcare	90-105
3	Arrange 2nd medical assessment through NHS	1	Healthcare	60
4	Inform Mental Health Unit	1	Healthcare	10-15
5	Inform appropriate PCT	1	Healthcare	10-15
6	Liaise with hospital to arrange movement of prisoners	2	Healthcare	10-15
7	Prepare medical records to accompany prisoner	1	Healthcare	60
8	Complete prisoner risk assessment	2	Both	10-15
9	Escort staff ordered	1	Security	10-15
10	Transport ordered	1	Security	10-15
12	Prepare prisoner to leave	2	Both	15-30
13	Complete and Sign relevant sections of PER	2	Both	10-15
12	Prisoner Escorted to Hospital from Prison SEE NOTE A	N/A	N/A	N/A

Notes:

a) Time and number of staff dependant on outcome of activity 8.

b) Activities are not necessarily dependant upon one another and may take place simultaneously.

16. Annex G: Comparison with National Admissions Data

16.1 Method

Prison Health requested data from Hospital Episode Statistics (HES) for finished consultant episodes during 2004-05. The HES data were specified according to the Tenth Revision of the International Classification of Diseases (ICD-10) category, gender, age group (to match those used in the escorts and bedwatches audit) and day case/non-day case.

The day case data were isolated and removed from the HES dataset to leave overnight admissions only, consistent with the definition of bedwatches used in the audit data collection. Episodes missing data for gender, age or ICD-10 category were excluded from both datasets. The data were grouped by age and gender according to the distribution of bedwatch episodes in the audit data: male 18-34, female 18-34, male 35-64, female 35-64, male 65+ (there were no bedwatches involving women aged 65+ and very few in the age group 0-17 for either gender). The table below shows absolute numbers of events used in the comparison.

Gender and age group	HES data	Bedwatches
Male 18-34	438,532	981
Female 18-34	1,539,960	224
Male 35-64	1,281,760	957
Female 35-64	1,439,653	91
Male 65+	1,618,355	114

Within these groups, the proportion of admissions resulting from primary diagnosis within each ICD-10 category were compared between the prison population and the general population. For the HES data, these proportions are given both as a percentage of the total episodes and as a percentage of the total minus those with an ICD-10 classification not collected in the audit. These classifications are as follows: 'Certain conditions originating in the perinatal period' (P00-P96), 'Congenital malformations, deformations and chromosomal abnormalities' (Q00-Q99), 'Symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified' (R00-R99) and 'Factors influencing health status and contact with health services' (Z00-Z99).

16.2 Results

The following table contains the corresponding data from HES and the escorts and bedwatches audit.

			Infectious and parasitic diseases	All cancers and benign tumours	Blood and blood-forming organs	Endocrine, nutritional and metabolic diseases	Mental and behavioural disorders	Nervous system	Eye and ear	Circulatory system	Respiratory system	Digestive system	Skin and subcutaneous tissue	Musculoskeletal system and connective tissue	Genitourinary system	Pregnancy, childbirth and the puerperium	Injury, poisoning and other consequences of external causes
Male 18-34	**HES 2004-05 non-day case admissions**	**% of total**	2.2	2.4	1.1	1.9	7.7	2.4	1.3	3.0	7.6	10.9	4.3	6.1	4.9	0.0	26.6
		% of total excluding 'Other'	2.6	2.9	1.4	2.3	9.3	2.9	1.6	3.7	9.2	13.3	5.2	7.4	6.0	0.0	32.3
	E&BW Audit – % of total		1.8	2.7	1.5	3.0	0.3	3.2	3.6	5.5	6.1	15.1	3.4	6.1	6.6	0.0	41.2
Female 18-34	**HES 2004-05 non-day case admissions**	**% of total**	0.8	0.9	0.3	0.6	1.4	0.8	0.4	0.7	2.5	3.5	0.8	1.5	3.9	60.7	3.6
		% of total excluding 'Other'	0.9	1.1	0.4	0.8	1.7	1.0	0.4	0.8	3.0	4.3	1.0	1.8	4.8	73.6	4.4
	E&BW Audit – % of total		0.9	1.8	0.4	1.3	0.0	8.0	1.3	6.7	4.5	8.0	3.6	0.9	3.6	34.4	24.6

			Infectious and parasitic diseases	All cancers and benign tumours	Blood and blood-forming organs	Endocrine, nutritional and metabolic diseases	Mental and behavioural disorders	Nervous system	Eye and ear	Circulatory system	Respiratory system	Digestive system	Skin and subcutaneous tissue	Musculoskeletal system and connective tissue	Genitourinary system	Pregnancy, childbirth and the puerperium	Injury, poisoning and other consequences of external causes
Male 35-64	HES 2004-05 non-day case admissions	% of total	1.2	8.0	0.9	1.5	4.1	2.9	1.4	15.5	7.4	11.8	2.7	7.1	5.1	0.0	10.6
		% of total excluding 'Other'	1.5	10.0	1.1	1.9	5.1	3.7	1.7	19.3	9.2	14.8	3.3	8.8	6.3	0.0	13.3
	% of total excluding 'Other'		0.9	1.1	0.4	0.8	1.7	1.0	0.4	0.8	3.0	4.3	1.0	1.8	4.8	73.6	4.4
	E&BW Audit – % of total		2.6	4.5	2.0	4.6	0.0	3.3	2.8	20.2	6.4	14.7	3.7	6.3	6.9	0.0	22.0
Female 35-64	HES 2004-05 non-day case admissions	% of total	0.9	9.7	1.0	1.3	2.9	2.4	1.2	6.7	6.1	9.6	1.7	7.1	8.4	14.8	6.8
		% of total excluding 'Other'	1.1	12.0	1.2	1.6	3.6	3.0	1.5	8.4	7.6	11.9	2.2	8.8	10.4	18.3	8.4
	E&BW Audit – % of total		2.2	3.3	0.0	5.5	0.0	9.9	1.1	9.9	8.8	9.9	3.3	4.4	9.9	19.8	12.1
Male 65+	HES 2004-05 non-day case admissions	% of total	1.0	11.1	1.4	1.4	1.4	2.2	1.1	21.3	12.0	9.5	1.6	5.1	6.1	0.0	5.6
		% of total excluding 'Other'	1.3	13.7	1.7	1.7	1.7	2.7	1.3	26.3	14.9	11.8	2.0	6.3	7.5	0.0	7.0
	E&BW Audit – % of total		0.0	7.9	2.6	0.9	0.0	2.6	0.9	33.3	7.0	18.4	0.9	6.1	12.3	0.0	7.0

As expected, the proportions of bedwatches arising from 'Injury, poisoning and other consequences of external causes' were markedly higher than in the general population. This was the case in all age and gender groups apart from men aged 65+, for whom the proportions are roughly equal. The difference is most pronounced in women aged 18-34, for whom less than 5% of hospital admissions in the community arose from this category of presenting complaint while almost a quarter of all bedwatches did.

Proportions were high for 'Endocrine, nutritional and metabolic diseases' in all groups except men aged 65+. This might be explained by a link between socio-economic factors and conditions such as diabetes, obesity and malnutrition. Similarly, conditions affecting the circulatory system are higher in the prison population than in the community for all groups, the most marked disparity being found in women aged 18-34. Perhaps, less expectedly, proportions were also relatively high for 'Eye and ear' in men aged 18-34, men aged 35-64 and women aged 18-34. It is possible that some of these episodes may have been trauma associated with the eyes and therefore wrongly reported under this category.

The category 'Nervous system' is markedly higher in female prisoners only. While a higher level of meningitis and other inflammatory diseases of the nervous system may be a reflection of the socio-economic background of prisoners, the gender-specificity of the disparity is puzzling. The small sample size female prisoners represent in relation to the general female population may be a factor.

The proportion of bedwatches with the ICD-10 classification 'Mental and behavioural disorders' was lower than such admissions in the general community, as would be predicted by the low levels found in the audit returns generally. This may reflect the impact of mental health in-reach teams or, less positively, a high degree of unmet mental health need.

The levels of bedwatches resulting from the 'Musculoskeletal system and connective tissue' and 'Genitourinary system' categories are mostly similar to those found in the HES data with one exception: there is a lower proportion of women aged 35-64 being admitted for musculoskeletal conditions. This suggests that the recoding of episodes reported in these categories as 'Injury, etc.' and 'Infectious and parasitic diseases' has been successful.

The proportion of bedwatches resulting from 'Infectious and parasitic diseases' was found to be roughly the same or slightly lower than the general population for the younger age group. This is a surprising finding given the high levels of sexually transmitted diseases which are anecdotally found in the prison population. In the 35-64 age group, the proportions are slightly higher than those in the general population. It should be noted, however, that the high levels of injury and other trauma in the bedwatches data are depressing the percentages for the other categories of presenting complaint.

Similarly, the proportions of bedwatches due to cancers and other tumours are markedly lower for both men and women aged 35 and over. This may also partly be a result of the effect of high levels of trauma, although the proportion remains relatively low for men aged 65+, despite the level of trauma being roughly equal to that in the community. Furthermore, the proportions of bedwatches arising from respiratory conditions are lower for men but slightly higher for women.

The proportion of admissions related to pregnancy is much lower in the female 18-34 group, perhaps due to a combination of the effect of high levels of trauma with a real reduction in rates of pregnancy due to the presence of medium and long term prisoners in the sample.

Levels of admissions for diseases of the blood and blood-forming organs appear roughly the same for both populations. Levels relating to the skin and subcutaneous tissue are mostly similar but slightly higher for female prisoners aged 18-34. This may be due to complications subsequent to episodes of self-harm.

17. Annex H: Survey of Clinics and Procedures within Prison Healthcare Centres

A one-page questionnaire was sent out electronically to all healthcare managers via the HMPS intranet to determine what levels of treatments are available within prison healthcare centres. Information was obtained from 100% of prisons (141). Respondents were also asked about the availability of healthcare, 20% reported it was available weekdays during the day, 28% seven days a week during the day and 52% that 24 hour cover was provided. Those that provide 24 hour cover do not all have inpatient beds, but a small number have healthcare staff on duty all night.

A number of prisons provided additional services such as acupuncture, epilepsy clinics, bereavement counselling, yoga, speech and language therapy, audiology, dermatology, services for the elderly and gynaecology. One prison had a specialist 'snoezlen' or chill out room. A number had managed to secure the services of visiting consultants from the local PCTs.

One of the contracted out female establishments is having difficulty in persuading the local PCT to provide maternity services into the prison, as they have a mother and baby unit, resulting in the women having to go out for all such services.

A small number reported having a full range of primary care services, including applying Plaster of Paris for undisplaced fractures, catheterisation, management of central lines, sigmoidoscopy and peritoneal dialysis.

Clinic/procedure	Number (%)	Clinic/procedure	Number (%)
Asthma	120 (85)	Physiotherapy	64 (45)
Diabetes	120 (85)	Occupational therapy	29 (21)
Coronary heart disease	84 (60)	Optician	130 (92)
Blood Borne Virus Screening (BBV)	121 (86)	X ray	21 (15)
Sexual health (GUM)	97 (69)	Health visitor	8 (6)
Wellman/woman	105 (74)	Maternity	11 (8)
General Practice (GP)	138 (98)	Contraception	29 (21)
Venepuncture	135 (96)	Change dressings	141(100)
Smoking cessation	128 (91)	Minor surgery	68 (48)
Mental health	135 (96)	Suture	108 (77)
Dentist	133 (94)	Vaccinate	139 (99)

The table above indicates the variable numbers of clinics and treatments provided in the different prisons, interestingly 100% report changing dressings while only 77% suture on site. A small number report stapling, gluing and using steristrip, in place of suturing.

18. Annex I: Literature Review

18.1 Purpose

Prison Health conducted the following literature review in order:

- to determine the current state of academic scholarship in the subjects of prison healthcare escorts and the provision of secondary care to prisoners
- to gain an overview of the range and scope of 'grey literature' dealing with prison healthcare escorts and bedwatches.

18.2 Method

The review of the academic literature was carried out using electronic databases accessed via the internet gateway ATHENS, with helpful input from the staff of the DH library. The search was restricted to literature published after the establishment of the Prison Health Policy Unit and Task Force in 1999 (later combined as Prison Health). Editorials and unreferenced opinion pieces were excluded from the review.

The review of the 'grey literature' was conducted in two parts. Firstly, using those reports published on the website of HM Inspectorate of Prisons, all prison inspection reports dated from January 2000 onwards were searched using the keywords 'escort', 'bedwatch' and 'bed watch'. Secondly, other materials were sourced with the help of the DH library and colleagues in the wider HO and HMPS.

18.3 Results

18.3.1 Academic literature

Very few papers were sourced that dealt directly with the issues of healthcare escorts and bedwatches. By far the most intensively studied area was found to be mental health services, with a number of papers examining issues related to mental health transfers. Two further subdivisions have been made in the literature, dealing with general issues in prison healthcare services and with non-mental health aspects of prisoners' healthcare needs.

General issues in prison health services

Cunningham *et al.* (2002) appraise the results of retrospective and prospective health needs assessments carried out in eight London prisons between 1999 and 2001 using the University of Birmingham's toolkit. The authors conclude that, while a detailed needs assessment was not necessary to determine what was needed to improve healthcare for prisoners in London,

the process was helpful in bringing together NHS and HMPS colleagues with a common goal. They recommend pan-London or even wider approaches to improve mental health services, clinical standards, information management and technology, training and education and integration into local healthcare systems.

Watson *et al.* (2003) have conducted a systematic literature review in order to identify models of prison healthcare from which lessons could be learned. They find the major areas of health problems covered in the literature to be mental health, communicable diseases and substance abuse. Women and older prisoners were identified as two groups within the prison population with specific health needs, while health promotion and wider public health outside of the prison environment are drawn out as underlying themes across the literature reviewed. Partnership with external agencies and the use of telemedicine are recognised as two commonly identified models of delivery.

Weiskopf (2004) has conducted and analysed in-depth interviews with nurses working in correctional settings in the USA. She finds that these nurses faced frustrations arising from the different cultures of custody and care and struggled to create a caring environment.

Healthcare escorts

Eyre and Bird (2005) discuss their statistical analysis of the Scottish Prison Service's report to the Justice Committee on prisoner escort in Scotland by the private contractor Reliance from April 2004 to March 2005. The authors state that the figures indicate that activity levels exceeded by 14% the projected figure cited by Audit Scotland (2004, discussed elsewhere in this review). The discussion is largely within the context of the journalistic uses of statistics.

From the receiving hospital's point of view, Boyce *et al.* (2003) carried out a survey to determine the impact of the opening of HMP Kilmarnock in April 1999 on the A&E department of the local Crosshouse Hospital. The results showed only a slight increase in the workload of the A&E department. Tuite *et al.* (2006) have conducted a survey into the attitudes and practice of consultants and junior hospital doctors in a hospital adjacent to a prison towards treating prisoners in the hospital. The results showed a low awareness of BMA guidelines regarding confidentiality between prisoners and healthcare staff.

Mental health services to prisoners

A large number of recent articles deal with the service provided to mentally disordered prisoners, addressing both the services within the prison and the transfer of prisoners to NHS facilities under the provisions of the Mental Health Act 1983.

Shaw and Humber (2004) outline current developments in policy for mental health services in prisons and assess the potential for improvement in the standard of care provided. They conclude that changes in attitude and role of staff are required and will need to be managed

carefully and state that any changes in service must be evaluated in terms of outcomes for staff and patients.

Harty *et al.* (2003) apply a systematic needs assessment instrument to samples of men with psychotic illnesses from both the UK prison population and the general community. They find significantly higher levels of need and of unmet need in the prison sample and propose the existence of an 'inverse care law' (high rates of need and low levels of treatment and care).

Parsons *et al.* (2001) have carried out a study to determine the level of psychiatric morbidity among female remand prisoners and to compare this with the numbers of women identified as having a mental disorder by the then current reception screening process. The authors find that 60% of the women in their sample were suffering from a current mental disorder and that 11% were acutely psychotic. Only a minority of these were identified by the reception screening process. Gavin *et al.* (2003) examine the revised screening tool, using it to review the reception screening questionnaires for all new admissions to HMP Holme House over a 15-week period. They conclude that large increases in psychiatric resources would not be needed if the new protocol were rolled out, but that some reorganisation of services may be necessary.

Leonard (2004) reports on the evaluation study of a telepsychiatry service between HMP Parkhurst and Ravenswood House medium secure unit in Fareham, Hampshire. She finds that videoconferencing was able to provide reliable assessment of a wide range of psychiatric signs and that it was practical to use this method within a prison. The author stresses the need to gain the support of prison staff if this type of service is to be successful.

Coid *et al.* (2003a and 2003b) have undertaken surveys in order to determine whether any correlation could be found between severe mental illness and confinement in segregation units and special cells. They find that such a correlation does exist in the latter case, but find no evidence of prison staff treating illness-related behavioural disorders as disciplinary offences. They conclude that the use of special cells for this purpose reflects the lack of more appropriate facilities for disturbed mentally disordered individuals in prison and psychiatric hospitals, and the failure of diversion to NHS psychiatric inpatient facilities.

A recent issue of the *Journal of forensic psychiatry and psychology* presents the results of two national studies of admissions to and discharges from medium secure units in England and Wales, commissioned by DH in 1998. Three papers by Melzer *et al.* (2004a and 2004b) and Grounds *et al.* (2004) are of interest in relation to mental health transfers. Melzer *et al.* (2004a) examine the relationships between assessed need for medium secure psychiatric care and admissions to these facilities, finding that a mismatch exists between these two. They conclude that insufficient range of provision leads to inappropriate use of medium secure

beds. Grounds *et al.* (2004) aim to elucidate the values, beliefs and professional insights underlying decisions to admit to medium secure units, using semi-structured interviews. The authors conclude that admission decisions entail complex professional judgements about admissions ethos and the wider context and that clinicians resist pressures they perceive to be in conflict with the primary therapeutic purpose of their service. Melzer *et al.* (2004b) aim to quantify the needs for treatment and care of a nationally representative sample of patients assessed for admission to medium secure units. They conclude that there is a substantial shortage of medium secure beds, especially for long term placements.

Hargreaves (1999) investigates the use of section 47 in a large dispersal prison (HMP Wakefield) and finds that prisoners with greater chronicity of illness, multiple handicaps and the need for long-term care are more likely to be rejected for transfer. The author concludes that there is a continuing shortfall of severe hospital provision, particularly for those needing long-term care. Rutherford and Taylor (2004) examine those women transferred from HMP Holloway to NHS secure psychiatric facilities during 1995. They find that women whose disorder is classified as 'psychopathic disorder' under the Mental Health Act remained significantly longer in prison awaiting a hospital bed than those under the classification 'mental illness'. Isherwood and Parrott (2002) have audited mental health transfers from HMP Belmarsh for a twelve month period following the development in December 1998 of a partnership agreement between the prison and Oxleas NHS trust to provide psychiatric care to Belmarsh. They find that transfers under section 48 increased in comparison with the previous two years, as did the proportion of transfers to high secure facilities. The average delay in transfer remained lengthy and a trend was evident of increasing delay with increasing level of placement security.

Mackay and Machin (2000) provide a detailed analysis of section 48 transfers of remand prisoners undertaken in 1992, the section 48 process and the effect this had on the ultimate disposal of transferees. They conclude that most cases were dealt with very quickly once action was initiated, with the few delays usually involving the need for a high security bed. The majority of cases (57% of those convicted) were made subject to a hospital order and not returned to prison. The authors recommend extending the scope of section 48 in three ways: to include people suffering from mental impairment and psychopathic disorder, to make transfers available for the purpose of testing for the 'treatability' of psychopaths and to cater for assessment as well as treatment.

In response to the evidence of lengthy delays in mental health transfer, Earthrowl *et al.* (2003) suggest that existing case law can be used to support a policy of providing treatment under common law to prisoners with mental disorders who lack decision-making capacity, pending completion of their transfer arrangements.

Other healthcare needs of prisoners

Lester *et al.* (2003) present information on health determinants collected directly from prisoners at HMP Cardiff using a questionnaire, covering education, previous occupation, alcohol and substance misuse, smoking, perceived threats, worries, diet, access to services and the Hospital Anxiety and Depression (HAD) scale. The authors report high levels of adverse health determinants and suggest targeting these to improve the health of prisoners and reduce re-offending.

Fazel *et al.* (2001) have conducted an assessment of the health of men over the age of 60 held in a sample of 15 prisons in England and Wales, using semi- structured interviews and a review of the medical notes. They find high levels of morbidity in major illnesses recorded in the patients' notes and in chronic illnesses reported by the patients themselves. The most common major illnesses recorded in the medical records were psychiatric, cardiovascular, musculoskeletal and respiratory. Comparison of the health problems of this sample with those of younger prisoners and elderly people at home (reported in other studies) showed a different pattern from either. The authors draw the implication that planning for the health needs of the growing population of elderly prisoners cannot be made on estimates of morbidity in younger prisoners or elderly people in the community.

Gould and Payne (2004) review studies of young offenders and boys aged 12-17 years in secure units to extrapolate information about the health needs of children in prison. They advocate a study to identify these needs and suggest that provisions should be put in place similar to those recommended for Looked After children.

Harvey *et al.* (2005) review ongoing efforts and plans to modernize the dental services provided to prisoners in England, drawing on an analysis of the prison dental health action plans, interviews with health care managers, DH data and case study visits. They outline the challenges to providing dental services to prisoners and some of the ways these are being addressed most effectively, with some recommendations for prisons, PCTs and Strategic Health Authorities. Availability of escorts is cited as a source of difficulty in providing for complicated health care needs or where service or equipment in the prison dental surgery is limited.

18.3.2 Her Majesty's Chief Inspector of Prisons (HMCIP) Reports

68 reports were sourced using the method described above.

A large number of reports comment on the wider impact on the prison caused by the need to supply staff for healthcare escorts and bedwatches. In addition to exacerbating general staffing difficulties (HMCIP, 2000g, 2001c, 2002c), specific areas mentioned have been the provision of in-house healthcare services (HMCIP, 2000a, 2003b, 2005e), depletion of the PE programme (HMCIP, 2000c), cancellation of staff race relations training (HMCIP,

2000g), depletion of the mandatory drug testing programme (HMCIP, 2002f), cancellation of association (HMCIP, 2003j, 2005g), non-attainment of searching targets (2003k) and disruption of therapeutic community groups (HMCIP, 2004b).

The costs of bedwatches are remarked upon in several reports. HMCIP (2000b) notes that extra bedwatch payments of £31,000 had been made in a five month period to staff at HMP Eastwood Park in the context of vacancies having been left open to save money. HMCIP (2002a) describes a case of escort and bedwatch costs increasing due to consultants having stopped visiting the prison. Elsewhere, the need to take account of higher bedwatch rates in a women's prison (HMCIP, 2001a) and in those with an older age profile (HMCIP, 2005b and 2005g) are stressed.

Cancellation of external healthcare appointments due to availability of escorting staff has been cited as a problem throughout the period covered by the review (HMCIP, 2000i, 2000l, 2000m, 2000n, 2001b, 2001d, 2001e, 2002c, 2002e, 2003a, 2003c, 2003e, 2003g, 2003h, 2003l, 2004g, 2004k, 2004m, 2005c, 2005f, 2005j, 2005k, 2005l and 2006b). HMCIP repeatedly remarks that this is a two-fold problem, as it both results in delayed treatment for the prisoner and imposes a burden on local NHS services.

Albeit much less frequently, cancellation of appointments by the NHS has also been cited as a problem (HMCIP, 2003h, 2004c and 2004k).

With increasing frequency, however, the reports note low or reduced cancellation rates (HMCIP, 2000h, 2001f, 2002g, 2003b, 2003d, 2004d, 2004f, 2004j, 2005b, 2005d, 2005h, 2005i, 2006a).

A number of reports cite examples of good practice. Within the prison, good co-operation with security and central allocation staff is noted in a number of reports (HMCIP, 2002h, 2004a, 2005a, 2005h, 2006c). Good relationships with local trusts are also cited (HMCIP, 2001d, 2003a, 2004a). HMCIP notes establishments where attempts are made to retain prisoners' places on waiting lists after transfer into the prison, either by escorting outside the establishments' immediate catchment area (HMCIP, 2004d, 2005d) or by special arrangements with the local NHS trust to honour time spent on any waiting list (HMCIP, 2004m). Other examples cited are the use of admin staff to reduce clerical demands on nurses in arranging external appointments (HMCIP, 2003e) and the introduction of a clinical IT system (HMCIP, 2004k) and hearing/sight screening within the prison to reduce the need for escorts (HMCIP, 2005i).

Regarding specific means to reduce healthcare escorts in particular establishments, HMCIP (2000e) cites a case of prisoners being escorted for suturing, despite a nurse having been trained to carry out this procedure. HMCIP (2000k) states that greater use should be made

of ROTL from HMP Lancaster Castle, while HMCIP (2004i) notes that arrangements being made for an ultrasonographer to scan within HMP Holloway ought to remove the need for women being escorted for dating scans.

However, HMCIP (2001b) describes an "unwritten policy" of appointments not being booked for non-urgent treatment for remand prisoners, while HMCIP (2001e) refers to a policy of governors and discipline staff questioning the necessity of NHS referrals.

Regarding the quality of the patient experience of escort, HMCIP (2003h, 2004i and 2005e) report on inappropriate handcuffing of prisoners. On the other hand, HMCIP (2000d) includes a comment from a prisoner on a long term bedwatch that the escorting staff had been 'thoroughly professional and caring.'

In an isolated case, HMCIP (2000j) describes a prison doctor referring prisoners to private care against the provisions of Standing Order 13 (1991), which states that escort and bedwatch expenses must be included in the costs of any inpatient treatment provided in a private facility.

18.3.3 Other 'Grey Literature'

Audit Scotland (2004) has undertaken an audit of the procurement by the Scottish Prison Service from the private contractor Reliance for prisoner escort and court custody services, in which hospital escorts are included. The report concludes that the SPS set clear objectives for the contract, but that it was too early at time of writing to judge if these had been achieved. The authors state that key to success is that the performance standards must be demanding, but that the lack of historical data means that Reliance's performance cannot be assessed against the previous in-house provision of escorts. They accept that the SPS has worked on ensuring that Reliance can deliver on the contract, but argue that it must put in place contingency arrangements, should Reliance default on the contract. A key strength of the contract is identified as the requirement for Reliance to report regularly on a range of performance information, with failings in performance being tied to financial levies. The authors state that there are signs of improvement in the performance of Reliance, despite it having been responsible for releasing prisoners in error.

Stevens (2006) reports on the findings of a recent project undertaken by Justice Health (the statutory authority responsible for providing health services to prisoners and detainees in New South Wales, Australia). The aim of this project was to answer the question: 'What improvements may be made to the process by which JH manages planned appointments, to improve efficiency and effectiveness, within existing resource constraints?' Waiting lists for prisoners accessing secondary care are centrally managed, though local systems also exist at individual clinics, and women's appointments are managed separately. The author recommends that a senior cross-agency body be established to take responsibility for waiting

list performance, that existing structure and processes be reviewed to facilitate improved governance of waiting list management, and that continuity of care processes be reviewed. Furthermore, she recommends a comprehensive review of JH internal outpatient facilities, including consideration of service provision by telehealth.

Williams, Lloyd and Hayre (2005) discuss the treatment of mentally disordered offenders following the publication of *The Future Organisation of Prison Health Care* (HM Prison Service/NHS Executive, 1999) and the *National Service Framework for Mental Health* (1999), putting these developments within a historical context of changing social attitudes towards mental illness and confinement. They conclude that effective care is reliant upon partnership working across a range of agencies and argue for a review of the Mental Health Act (1983) to allow compulsory treatment of prisoners and for a more robust implementation of the Care Plan Approach in prisons.

Bolger (2005) describes the palliative needs of prisoners and argues that improved partnership working presents an opportunity to develop palliative care services for prisoners, focussing on needs analysis, staff training and development, adapting protocols and evaluating prisoners' palliative experiences.

18.4 Conclusion

Very little research has been published within the period covered by this review dealing explicitly with the issues of prison healthcare escorts and bedwatches. However, there has been some interest from a healthcare perspective in the impact of prisoners on hospital services and in levels of awareness among hospital medical staff of specific guidance relating to treating prisoners in the company of escorting officers.

The literature continues to report high levels of mental health morbidity among the prison population and a lack of sufficient accommodation in both medium and high security NHS facilities. The work of Earthrowl *et al.* (2003) indicates an interest in exploring alternative means of meeting these needs.

Interest appears to be growing among the research community in the health needs of older prisoners, including end of life issues, and in those of children in prison establishments. Further studies are required to identify the latter definitively. Both of these areas have implications for future service planning.

The HMCIP reports identify the following as main issues: the impact of healthcare escorts and bedwatches on the wider prison regime (in terms of both staff availability and costs), cancellation of external healthcare appointments (largely as a result of the unavailability of escorting staff) and the degree of co-operation with other departments within the prison and with NHS partners.

Other recurring themes which have been found in the literature are: the need for improved prison health information management and technology, the value of user perspectives in prison health service planning, the importance of integration with the wider healthcare community and the central importance of partnership working.

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19. Annex J: Statistical Glossary

Term	Definition
ANOVA	Analysis of variance: a method for testing hypotheses about means.
Confidence Interval	Describes the degree of statistical uncertainty in results. A confidence interval for a median describes the range of likely values for the median when we take into account the possible sampling error in a study.
Correlation	The degree to which two variables are related (does not necessarily mean there is a causal link).
Interquartile Range	Describes the spread of values: the interquartile range is the middle half of all the values, with one quarter of values below the interquartile range and one quarter above.
Mean	Commonly called the average. The result of all the scores divided by the number of scores. A good measure for roughly symmetric distributions but can be misleading in skewed distributions.
Median	The middle of a distribution: half of the scores are above the median and half are below the median. The median is less sensitive to extreme scores than the mean and this makes it a better measure than the mean for skewed distributions.
Normal Distribution	Normal distributions are symmetric with scores more concentrated in the middle than in the tails.
Skew	An asymmetric distribution, with one tail longer than the other, is described as skewed.
Standard Deviation	The most commonly used measure of spread. Computed as the square root of the variance.
Variance	A measure of how spread a distribution is. Computed as the average squared deviation of each number from its mean.

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