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Prison health

Twelfth Report of Session 2017–19

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Health and Social Care Committee

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Contacts

All correspondence should be addressed to the Clerk of the Health and Social Care Committee, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 6182; the Committee's email address is hsccom@parliament.uk.

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The Government is failing in its duty of care towards people detained in England's prisons.

Too many prisoners remain in unsafe, unsanitary and outdated establishments. Violence and self-harm are at record highs. Most prisons exceed their certified normal accommodation level and a quarter of prisoners over the last two years have lived in overcrowded cells. Staffing shortages have forced overstretched prisons to run restricted regimes, severely limiting not only opportunities for prisoners to engage in purposeful activity, but access to health and care services both in and outside prisons.

Too many prisoners die in custody or shortly after release. Whilst deaths, including by suicide, in prisons have fallen slightly since their peak in 2016, so-called natural cause deaths, the highest cause of mortality in prison, too often reflect serious lapses in care. We are also concerned about the increase in deaths during post-release supervision and reports of people being found unresponsive in their cells. Every suicide should be regarded as preventable and it is unacceptable that those known to be at risk face unacceptable delays awaiting transfer to more appropriate settings.

Prisons have also been grappling with the increasingly widespread use of novel psychoactive substances, which are a serious risk to the health and safety of users, fellow prisoners and staff alike. Evidence to our inquiry suggests the Government and the prison service are some way from having this under control.

Missed opportunities to break the cycle of disadvantage

The health of people in prison is a public health issue. Prisons could be an opportunity to address serious health inequalities which are part of the cycle of disadvantage faced by people in prison. No one is sentenced to worsened health but that, largely as a result of overstretched staff, overcrowding and poor facilities, is too often the outcome. Prison health and care services should be delivering standards of care, and health outcomes, for prisoners that are at least equivalent to that of the general population. Doing so involves identifying and addressing health and care needs, which may have gone unrecognised, and supporting prisoners to lead purposeful, healthier lives. We recommend that:

- the National Prison Healthcare Board work with stakeholders to agree a definition of equivalent care, and indicators to measure health inequalities between people in prison and the general population, which should then be reduced;
- the Board co-design with stakeholders a more comprehensive and robust approach to identifying the health and care needs of people in prison and those in contact with the criminal justice system;

- the Government name the date by which it expects to have enough prison officers in post to ensure the vast majority of prisoners can be unlocked for the recommended 10 hours per day;
- guidance on how prisons and prison staff use incentives should make clear that incentives should encourage prisoners to lead healthy lives and not deprive them of regular access to facilities and activities which promote a basic standard of wellbeing.

Prison reform

Supporting prisoners to lead healthy lives is consistent with the Government's aim to use prisons to rehabilitate offenders. Health, wellbeing, care and recovery need to be a core part of the Government's plans for prison reform.

A whole system approach

The challenge of providing a safer and healthier prison environment begins by managing the number of people going into prison. We agree with the Care Quality Commission that this requires "a whole system approach that has its roots in sentencing and release." An example of a whole system approach may be found in the Government's recent strategy on female offenders. We recommend that the Government's evaluation of this strategy reports on whether, and if so how, similar approaches could be applied to other parts of the prison population.

A whole prison approach

For those in prison, we support the National Prison Healthcare Board's intention to develop and implement a whole-prison approach to health, and recommend this priority is given much more prominence within the Board's future plans. The National Prison Healthcare Board should work with a group of national stakeholders over the next 12 months to define the core principles of a whole prison approach, together with guidance and resources to support more detailed plans at a local level.

A shared understanding of what a whole prison approach looks like and how such an approach, and best practice, can be effectively implemented is critical for success. The key factors that underpin the successful delivery of a whole prison approach are:

- a sufficient, stable and well-trained workforce, both of prison staff and health and care professionals, whose own safety and health is valued;
- strong local strategic relationships, with a shared ownership for improving prison health and care;
- a collaborative approach to commissioning, which ensures service provision reflects the needs of the prison population and gives governors the financial and other levers necessary to make prisons safer and healthier;
- a rigorous, respected inspection regime that provides a robust picture of the state of health and care in prisons and drives improvement through

reinforcing local whole prison approaches and equivalency in standards and health outcomes, ensuring best practice is effectively spread and lessons are learnt. Inspection reports need to be accompanied by real powers to drive implementation and consequences for failure to do so.

We recommend CQC should assess the range of services provided in prisons, including mental health, physical health (older people, adolescents), substance misuse and dentistry, as well as the prison environment, against their five criteria (safe, effective, caring, responsive and well-led).

We look forward to seeing a Government approach which brings all these factors together into a serious attempt to tackle the unacceptable health inequalities present in the current prison healthcare system.

1 The state of health and care in English prisons

1. Persistent concerns have been raised over a number of years about the overcrowded, unsafe and unsanitary conditions inside some of England's prisons. Evidence collected and presented by Her Majesty's Inspectorate of Prisons (HMIP), the Care Quality Commission (CQC) and others has shown a system struggling to cope with budget reductions, staffing shortages and outdated establishments. There are signs that the Government is beginning to address some of these problems, but also that it needs to go further. During the course of the inquiry which has led to this report, we have heard examples of good practice across the prison estate, but the scale of the challenge is immense.

2. The Justice Committee in 2015, and again in 2016, warned that available indicators pointed to a rapid deterioration in safety.[1] Rates of deaths, suicides, incidents of self-harm and violence inside prisons have risen considerably, reaching record highs over recent years.[2] There have also been reports of prisoners living in unacceptably poor conditions (e.g. at HMP Liverpool).

3. Deteriorating standards within English prisons followed significant reductions in public spending, which resulted in staffing levels falling substantially (from almost 25,000 in 2010 to just over 18,000 in 2014). These numbers remained low for a sustained period of time (the number of prison officers in post remained below 19,000 until September 2017). During this period thousands of experienced prison officers left the prison service, which further diminished the quality of staffing provision.[3]

4. During this time the prison population, which the Government had projected would fall, remained historically high.[4] The prison service has simultaneously been grappling with the rising use and impact of new psychoactive substances. These drugs, in particular spice,[5] are harmful not only to users, but to staff, who have to deal with the consequences. Widespread access to spice and other drugs has increased violence within prisons and contributed to the deterioration in safety.[6]

5. Our main concerns about the current state of health and care in English prisons are set out below.

6. **Many prisons remain unsafe**. Whilst deaths in prison have fallen slightly including self-inflicted deaths, since reaching a peak in 2016,[7] incidences of self-harm continued to rise during 2017 and 2018 and, according to the latest safety indicators, remain at a

1 Justice Committee, Sixth report of Session 2015–16, Prison Safety, HC 625
2 UK Prison Population Statistics, House of Commons Library Briefing Paper, Number CBP-04334, 23 July 2018 p15–16;
3 Institute for Government and the Chartered Institute of Public Finance and Accountancy, Performance tracker: A data driven analysis of the performance of government, Autumn 2017 p54–55
4 Q200 Digby Griffiths
5 Spice is a brand name for synthetic cannabinoids. These synthetic drugs aim to mimic the main active ingredient found in cannabis. They are sold in herbal smoking mixtures which means it can be difficult to know which substances are being consumed. The Psychoactive Substances Act, which passed in May 2016, made it illegal to produce, supply and import of synthetic cannabinoids for human consumption. For more information visit: https://www.talktofrank.com/drug/synthetic-cannabinoids).
6 Royal College of GPs (PRH0023)
7 UK Prison Population Statistics, House of Commons Library Briefing Paper, Number CBP-04334, 23 July 2018 p16

record high.[8,9] Levels of violence are of great concern too. The number of assaults and serious assaults in prison, including prisoner on prisoner assaults and assaults on staff, are also at record highs.[10] Her Majesty's Inspectorate of Prisons consistently finds safety levels declining between inspections, and has reported that many institutions are failing to address safety concerns relating to violence, suicide and self-harm and the supply of illicit drugs.[11]

7. **Even the most basic needs of people detained, such as their diet and living conditions, continue to be compromised in some English prisons**. HMIP's most recent annual report noted that inspections over the last year have identified poor, and even squalid, conditions in several prisons. Prison establishments frequently struggle, according to the inspectorate, to provide meals of sufficient quantity and quality on £2 per day per prisoner.[12]

8. **Short-staffed, overcrowded prisons severely limit access to healthcare and the ability of prisoners to lead healthy lives.** Prisoners spend the vast majority of their time in their cells, limiting their opportunity to move and engage in adequate levels of physical activity, and their access to healthcare, inside and outside prison, is restricted. Only 16% of prisoners report being unlocked for the recommended minimum of 10 hours per day. A third of people detained in local prisons[13] and almost 40% of people held in young adult prisons report spending less than 2 hours out of their cell a day.[14] Low staffing levels, excessive waiting times for some services and inadequate management of prisoners with chronic conditions are three recurrent concerns HMIP and CQC have about the delivery of healthcare in prisons, based on the findings of their joint inspections over the last year.[15]

9. **Governments, according to the World Health Organisation, have "a special duty of care for those in places of detention which should cover safety, basic needs and recognition of human rights, including the right to health."[16] The Government is failing in this duty of care towards people detained in prisons in England. Too many prisoners remain in unsafe, unsanitary conditions that fall far short of the standards we should expect. The Government must urgently fulfil its special duty of care for prisoners.**

8 UK Prison Population Statistics, House of Commons Library Briefing Paper, Number CBP-04334, 23 July 2018 p15–16;

9 Her Majesty's Inspectorate of Prison for England and Wales, Annual report 2017/18, July 2018, HC1254

10 Ministry of Justice, Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to June 2018 Assaults and Self-harm to March 2018, 26 July 2018

11 Her Majesty's Inspectorate of Prison for England and Wales, Annual report 2017/18, July 2018, HC1254

12 Her Majesty's Inspectorate of Prison for England and Wales, Annual report 2017/18, July 2018, HC1254

13 "Local prisons" serve courts and receive remand and post-conviction prisoners, prior to their allocation to other establishments.

14 Her Majesty's Inspectorate of Prison for England and Wales, Annual report 2017/18, July 2018, HC1254

15 Her Majesty's Inspectorate of Prison for England and Wales, Annual report 2017/18, July 2018, HC1254

16 *World Health Organisation,* Prisons and Health*, 2014*

2 Our inquiry

10. We launched our inquiry into prison health and healthcare with a call for written evidence on 27 April 2018. Our inquiry focused not only on prisoners' experiences of health and care services, but also on how the prison environment and regime affects their health and wellbeing. In addition, we have explored the effectiveness of current arrangements covering the oversight, commissioning and regulation of prisons and prisons health and care services. We received just under 60 written submissions and are grateful to everyone who took the time and effort to respond. This is a rich body of evidence which we hope will add to public and political debate on this issue.

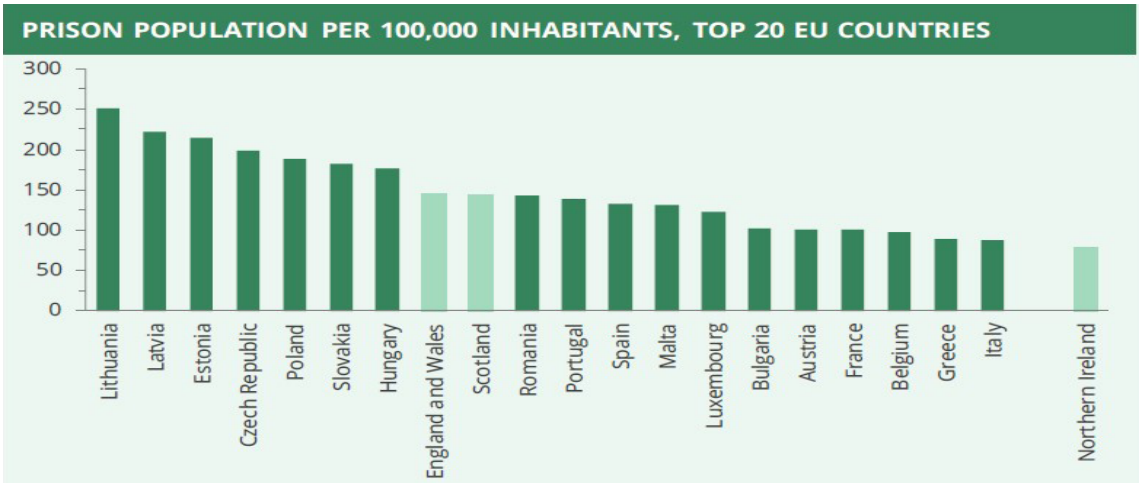
11. In addition to our open call for evidence, we worked with Inside Time, a national newspaper for prisoners and detainees, to seek responses from people detained in prison. We received 25 responses to our call. These responses, while disturbing in many instances, are descriptive and insightful accounts of the conditions inside some prisons, which have complemented much of what we have heard through other sources. We are grateful to Inside Time and all the people who wrote to us.

12. As part of our inquiry we visited the Greenwich Cluster in South East London in June. The cluster is home to three prisons: HMP Belmarsh, HMP Thameside and HMP/YOI Isis. These three prisons have been designed to cater for different categories of prisoners. The level of security varies accordingly. HMP Belmarsh and HMP Isis are both public prisons, while HMP Thameside is a private prison run by Serco. Our visit helped to build our understanding of the variation that exists across the prison estate and the key problems affecting health and healthcare inside prisons from those on the frontline. We toured the prisons and went inside a prison cell. We also spoke to prisoners, prison officers, senior management staff and with providers and commissioners of health and care services across the estate. We are grateful to everyone involved in our visits.

13. We held a workshop with 18 representatives from across the health and penal systems in June, at which we discussed their views on the main problems which were shown by the written evidence we had received, and on the objectives and priorities of the National Prison Healthcare Board's Partnership Agreement 2018–2021. This workshop helped form the basis of our oral evidence programme, which consisted of two sessions on 3rd and 10th of July. These sessions were held jointly with the Justice Committee, which is exploring the implications of changes to the prison population. The evidence we gathered during these sessions was enhanced by the active participation of the Justice Committee members, who brought their expertise to bear on questions relating to our inquiry. We are grateful to the Justice Committee and all the stakeholders we heard from, both at our workshop and in oral evidence.

3 People detained in prison

14. The prison population in England and Wales has remained historically high, but relatively stable, since 2010 and is projected to remain stable until 2022.[17] The prison population is also high by international standards. England and Wales have the 8th highest prison population per 100,000 in the EU (as shown by the chart below), higher than Germany, Norway, Netherlands, Denmark and Sweden, which are all outside the top 20.[18]



Source: Eurostat, *Prisoners by age and sex - number and rate for the relevant sex and age groups*, accessed 6 July 2018.

15. The prison population has shown a notable shift towards longer sentences. Only a third of the prison population had a determinate sentence over 4 years in 2010, compared to just under 50% in March 2018.[19] Similarly, the percentage of the prison population on indeterminate sentences and shorter sentences, either 1–4 years or less than a year, has fallen since 2010.[20]

16. The characteristics of the people detained in prisons fluctuates over time. However, the prison population is:

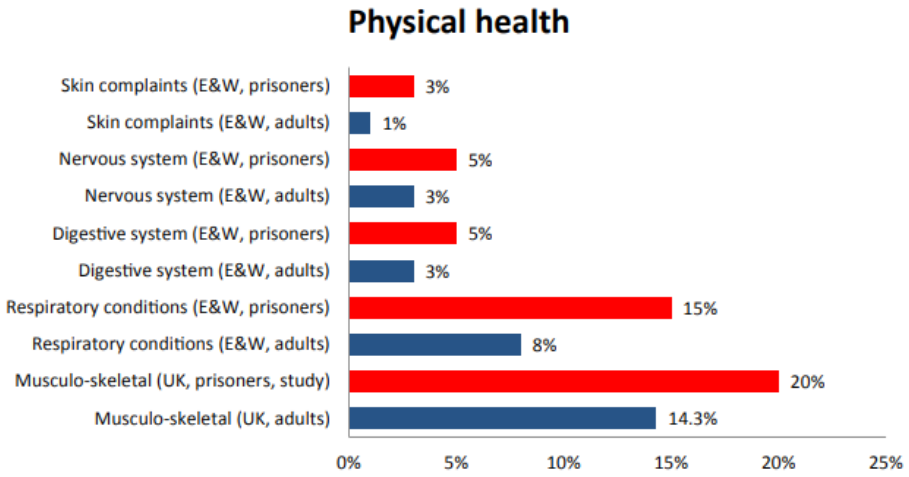
- **predominately male**. Just over 3800 of the 83,000 people detained in prison in England and Wales at the end of August 2018 were female.[21]
- **ageing**. People aged 50 and over now comprise 16% of the prison population, although most of the prison population are in their thirties (30%), forties (18%) or mid-twenties (18%). Over the last decade, the percentage of people aged 50+ has risen faster than any other age group.[22]
- **Mostly white and British, although ethnic minority groups are over-represented.** Foreign nationals account for only 11% of the prison population.

17 UK Prison Population Statistics, House of Commons Library Briefing Paper, Number CBP-04334, 23 July 2018
18 UK Prison Population Statistics, House of Commons Library Briefing Paper, Number CBP-04334, 23 July 2018
19 UK Prison Population Statistics, House of Commons Library Briefing Paper, Number CBP-04334, 23 July 2018
20 UK Prison Population Statistics, House of Commons Library Briefing Paper, Number CBP-04334, 23 July 2018
21 Prison population figures 2018, Population bulletin: weekly 31 August, Available at: https://www.gov.uk/government/statistics/prison-population-figures-2018
22 UK Prison Population Statistics, House of Commons Library Briefing Paper, Number CBP-04334, 23 July 2018

> The majority of the population is also white, although ethnic minority groups are over-represented in prison, particularly people identifying as Black and Black British or Asian and Asian British.[23]

17. People in contact with the criminal justice system, including those in prison and on probation, tend to be in poorer health than the general population and have a greater need for health and care. For many people detained in prison, their poor health status arises from, and/or has been exacerbated by, early childhood experiences (abuse, neglect and trauma) social circumstances (problems with housing and employment) and higher rates of smoking, alcohol and substance misuse.[24] The children of prisoners, we were told, are also three times more likely than their peers to engage in antisocial behaviour.[25] Incarceration of a parent is traumatic for a child and can be classed as an Adverse Childhood Experience.

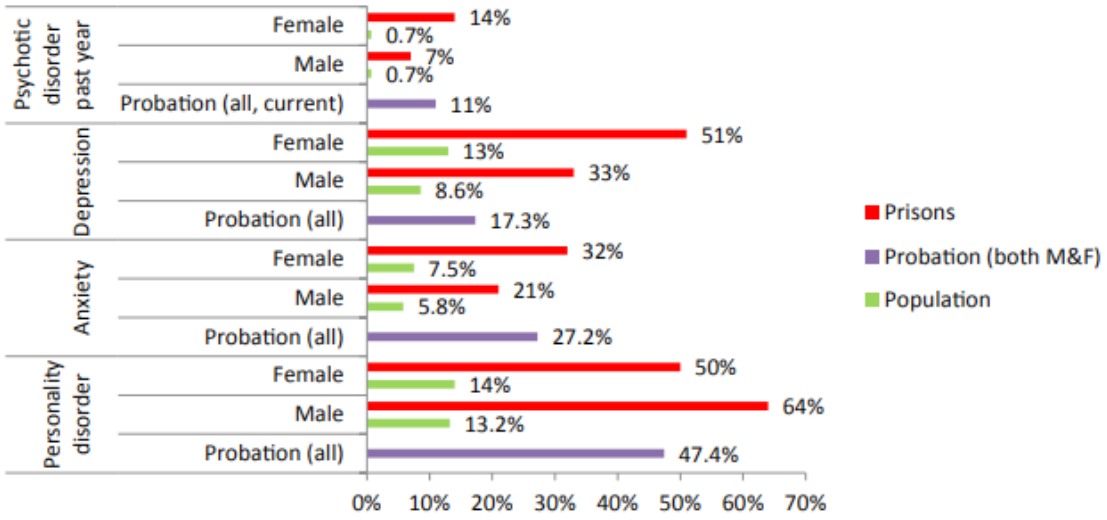
18. The physical health of the prison population, across a broad range of conditions, is much poorer than that of the general population, as shown by the chart below.[26] Incidences of blood borne viruses are particularly more prevalent among the prison population. Cases of tuberculosis per 100,000 are over five times higher among the prison population. Hepatitis C is more prevalent among people in prison, especially women in prison, compared to the general population (13% of female prisoners and 7% of male prisoners have hepatitis C compared to 0.4% of the general population). The prevalence of HIV, although slightly higher among men in prison, is much higher among women in prison when compared to the general population (1% of women in prison have HIV compared to 0.3% of men in prison and 0.2% of the general population).[27]



19. Mental health problems, including not only common mental health problems such as anxiety and depression, but also psychotic and personality disorders, are much higher

23 UK Prison Population Statistics, House of Commons Library Briefing Paper, Number CBP-04334, 23 July 2018
24 Home Office, Public Health England and Revolving Doors Agency (2017), Rebalancing Act: A resource for Directors of Public Health, Police and Crime Commissioners, the police service and other health and justice commissioners, service providers and users, January 2017.
25 Royal College of Midwives/Birth Companions (PRH0018)
26 Revolving Doors Agency (PRH0046)
27 Revolving Doors Agency (PRH0046)

among the prison population and people on probation.[28] The prevalence of mental health problems, although high for men, is also greater among women in prison, with the exception of personality disorders.[29]



20. Many people in prison have social care needs, with some of this need falling below the bar for publicly funded support.[30] An ageing prison population is associated with increasing demand for social care, although social care needs are not limited to older prisoners.[31] Evidence to our inquiry highlighted that learning disabilities, autism, ADHD and acquired brain inquiries are also common among the prison population. Many prisoners are also affected by Foetal Alcohol Spectrum Disorder.[32] However, these problems may have gone undiagnosed prior to entering prison. Twenty-five per cent of the prison population, according to the Revolving Doors Agency, a charity specialising in the criminal justice system, have problems communicating or handling complex information, although they might not strictly meet diagnostic criteria for a learning disability and, consequently, are unlikely to be eligible for support.[33]

21. The high prevalence of health and care needs among the prison population is reflective of the social circumstances these people experience before entering prison. Forty-one per cent of the people in prison have witnessed or experienced domestic abuse, either in childhood or adulthood. For example, over 50% of women in prison report having suffered domestic violence and experienced emotional, physical or sexual abuse during childhood.[34]

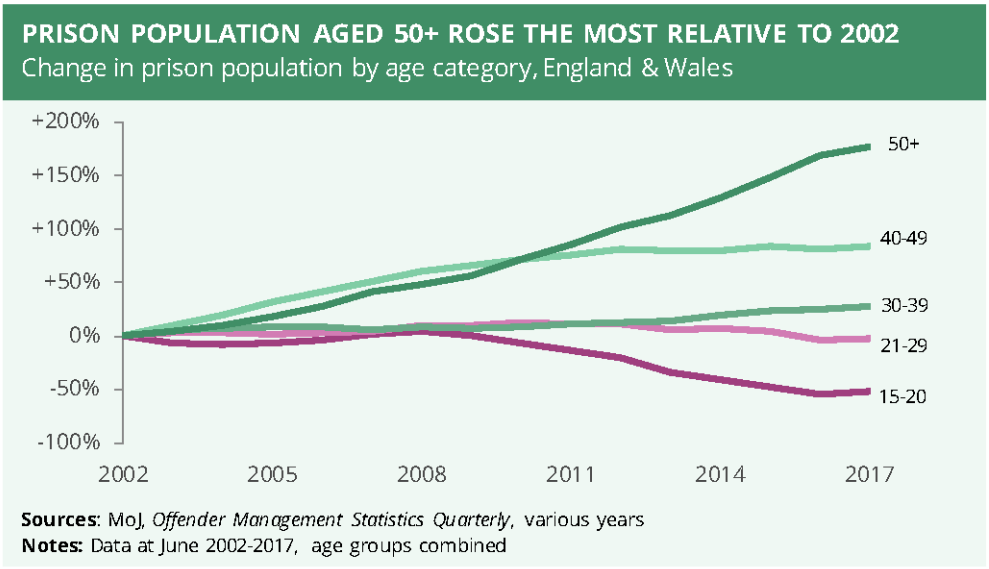
22. Prior problems with housing and employment are common among the prison population. Research by the Ministry of Justice found only a third of the prison population were in paid employment 4 weeks before going into custody and 13% report never having

28 Revolving Doors Agency (PRH0046)
29 Revolving Doors Agency (PRH0046)
30 Revolving Doors Agency (PRH0046), Association of Directors of Adult Social Services (ADASS) submission (PRH0051)
31 Care Quality Commission (PRH0004)CQC written evidence
32 National Organisation for Foetal Alcohol Syndrome, FASD Policy Focus Paper - No. 1: Overview of FASD Policy Debate in the Context of the Westminster Hall Debate on Alcohol Harm, 2 February 2017, 02/06/2017
33 Revolving Doors Agency (PRH0046)
34 Revolving Doors Agency (PRH0046)

had a job, with those in work being in typically low paid work.[35] Almost a quarter of people in homelessness accommodation are former prisoners or ex-offenders and a third of people sleeping rough in London in 2015/16 had spent time in prison.[36]

Older prisoners

23. As already noted, the prison population is ageing, which, as the graph below shows, has been clear for over a decade. The ageing prison population reflects shifts towards longer custodial sentences and an increase in the use of imprisonment for sex offences, including historic sex offences, as well as an ageing of the general population.[37] Her Majesty's Inspectorate of Prisons and the Prison and Probation Ombudsman have both criticised the Government's lack of strategic grip over the consequences of an ageing prison population.[38]



24. During our inquiry, concerns raised about the treatment of older prisoners remain the same as those identified by the Justice Committee five years ago, namely that older prisoners:

- are frequently held in prisons which, even with reasonable adjustments, are unfit for their needs;
- have limited opportunities to remain active and productive if they cannot participate in the usual prison regime; and
- are often released homeless, without social care support or being registered with a GP.[39]

25. Her Majesty's Prison and Probation Service has produced a model of operation to advise governors on how to approach growing numbers of older prisoners. However, Peter Clarke, Chief Inspector of Prisons, told us:

35 Revolving Doors Agency (PRH0046)
36 Revolving Doors Agency (PRH0046)
37 Prisons and Probation Ombudsman (PRH0017)
38 Prisons and Probation Ombudsman (PRH0017), Q61 Peter Clarke
39 Justice Committee, Fifth report of Session 2013–14, Older prisoners, July 2013

> The Ministry of Justice announced last year that they were going to create a strategy for older prisoners, and a steering group was set up. I was a member. It met once. A paper has now been produced, which, frankly, in my view, is not in any way strategic. It talks about more of the same. My view is that there needs to be a broader think about what needs to be done for a cohort of prisoners who, although they may need to remain in custody, do not necessarily need the same type of custody. There is good practice though, which needs to be picked up.[40]

Box 1: Experiences of older prisoners

In response to our call for evidence in Inside Time, one older prisoner wrote to us describing some of challenges older prisoners on his wing experienced. He informed us that all the prisoners on his wing are elderly and that they receive very little support from staff. Healthcare, he said, "try their best, but are restricted by the regime." He pointed out that "if we are unable to walk to healthcare we can be neglected". With limited access to healthcare, "often, prisoners with serious medical needs have to rely on other inmates for things like diabetes injections." He also described his living conditions, saying "this wing was built to house young offenders, not the elderly. Often, we have no hot water or heating. The sinks are tiny and we are not issued with plugs." In his view, prison living conditions are, without doubt, "detrimental for the infirm and elderly."

Source: Written response from Inside Time

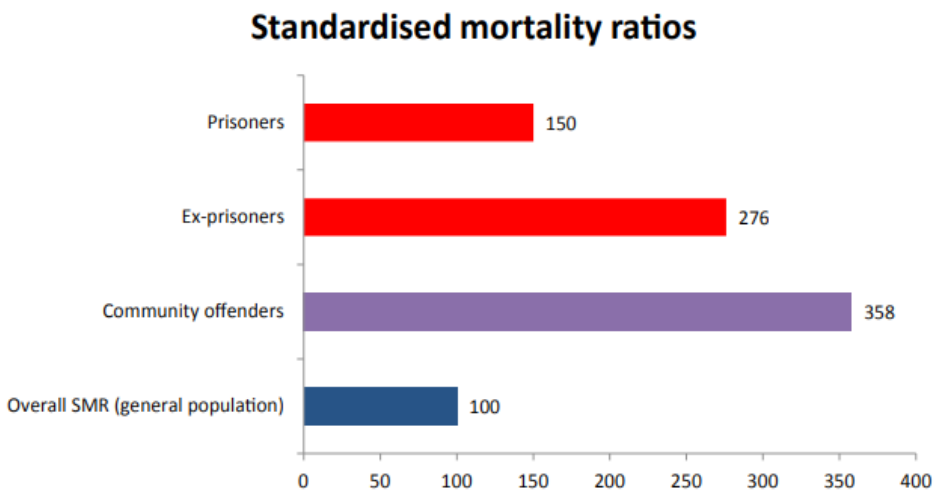
Life expectancy

26. The average age of death of people detained in prison in England is 56. The standardised mortality rate of prisoners is 50% higher than the general population. Dr O'Moore from Public Health England explained that this:

> […] represents the complex vulnerabilities that people have that they bring with them into prison, and then you are in an environment where maybe some of those needs are not well understood or well met. So, people presenting with particular signs and symptoms of disease or problems are not being managed in a particular way that one would expect.[41]

The mortality rate of ex-prisoners and offenders on community sentences is even higher than that of the prison population, as shown by the chart below.

40 Q61 Peter Clarke
41 Q205 Dr O'Moore



Revolving Doors Agency (PRH0046).

This also reflects some of the complex health needs of people in contact with the criminal justice system. For example, risk of death is highest immediately after release, often linked to substance misuse problems. Community offenders also show higher levels of accidental deaths, often relating to drugs and alcohol, as well as homicides.[42]

Natural cause deaths

27. Natural cause deaths are the leading cause of mortality in prisons, with the rate of natural cause deaths in 2017 equating to 2.15 deaths per 1000 prisoners. Of the 310 deaths in prisons in England and Wales from June 2017 to June 2018, 173 people died from natural causes.[43] The high rate of natural cause deaths in a large part reflects the poor health, and prior social circumstances, of the prison population. However, INQUEST told us that many of these so-called natural cause deaths are far from natural, but are instead often premature and avoidable deaths stemming in part from lapses in care.[44]

28. Investigations by the Prison and Probation Ombudsman, along with monitoring and casework carried out by INQUEST, reveal serious lapses in the delivery of, and access to, healthcare. These lapses include failures to make urgent referrals where it is suspected that prisoners might have cancer or a failure to "review and treat abnormal blood test results."[45] We have received similar complaints in response to our call in Inside Time. For example, one prisoner informed us of the death of his friend who complained repeatedly to healthcare services within the prison about pain he was experiencing. When healthcare services finally did help "it was too late, he had cancer and only had weeks to live."

42 Revolving Doors Agency (PRH0046), Revolving Doors Agency (supplementary evidence).
43 Ministry of Justice, Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to June 2018 Assaults and Self-harm to March 2018, 26 July 2018
44 INQUEST (PRH0027)
45 INQUEST (PRH0027)

Equivalent care

29. A prison sentence, we heard strongly, is a deprivation of someone's liberty: it is not a sentence to poorer health or poorer health and care services. The idea that people detained in prison retain their right to health is woven into international law.[46] The right to health includes:

> … a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health.[47]

30. The right to health underpins the idea of equivalence, in which prisoners' access and quality of services should be the same as that of the general public. Equivalence is endorsed internationally and has (in theory) been a core part of the Government's approach to the health of prisoners since the Joint Prison Service and National Health Service Executive Working Group in 1999 endorsed the following principle:

> To give prisoners access to the same quality and range of health care services as the general public receives from the National Health Service.[48]

31. Despite this endorsement and continued support, what equivalence means in practice has remained vague. For example, there is no resource describing how equivalence should be defined, measured and compared with health and care in the community.[49] The National Audit Office criticised the then partnership between the National Offender Management Service, NHS England and Public Health England for not having defined measurable outcomes of equivalence and for not measuring progress, saying: "it is not clear how partners can assess whether healthcare in prisons is equivalent to healthcare in the community."[50] One prisoner told us:

> It's a joke. We are told we are treated the same in prison as we would be out of prison. If you believe that then you may as well believe in fairies at the bottom of the garden.[51]

32. Ministers and senior officials told us the principle of equivalence remains the Government's overriding aim. However, the National Prison Healthcare Board's National Partnership Agreement for 2018–21, published in April 2018, does not include any reference to achieving equivalence. Instead, the agreement states that one of the Board's objectives is to "improve health outcomes and reduce health inequalities" for people in prison compared to the general population. This may be a useful first step, but the Board has yet to specify the degree of improvement it intends to achieve over this period.[52]

46 Royal College of General Practitioners, Equivalence of care in Secure Environments in the UK: Position statement, July 2018
47 Article 12 of the International Covenant on Economic, Social and Cultural Rights (23).
48 Her Majesty's Prison Service and NHS Executive, The Future Organisation of Prison Health Care: Report by the Joint Prison Service and National Health Service Executive Working Group, March 1999
49 Royal College of General Practitioners, Equivalence of care in Secure Environments in the UK: Position statement, July 2018
50 National Audit Office, Mental health in prisons, HC42 Session 2017–2019 29 June 2017
51 Written response from Inside Time
52 HM Government and NHS England, National Partnership Agreement for Prison Healthcare in England 2018–2021, April 2018

33. We heard strongly during our inquiry that the priority for prisons and prison health and care services, and the professionals within them, should be to achieve health outcomes for people in prison that are equivalent to those enjoyed by the wider population. Achieving equivalent outcomes is likely to require a different and, in many respects, enhanced level of provision than that which exists in the community.[53]

Conclusion

34. Prison health is a public health issue, given the poor health of people detained in prison. Prisons are also an opportunity to break the cycle of poor health and disadvantage. Accordingly, a core purpose of prisons and prison health and care services should be to ensure the health outcomes of people detained in prison are equivalent to that of the wider population. Prisons and prison health and care services cannot and do not provide services and treatment that mirror exactly the type of provision available in the wider community. Services and treatments for people detained in prison should, however, reflect the complexity of their needs and be at least equivalent to the range and quality found within the wider community. Despite the clear evidence of health inequality and need, that is not the case.

35. **We recommend that the National Prison Healthcare Board work with stakeholders over the next 12 months to agree a definition of "equivalent care" and indicators to measure the extent to which people detained in prison receive at least equivalent standards of care, and achieve equivalent health outcomes, as the population as a whole—in other words, to measure the health inequalities of people detained in prison.**

36. **In the meantime, in all future iterations of its strategy and plans, including its national partnership agreement, the National Prison Healthcare Board should explicitly state its commitment to achieve equivalent standards and health outcomes for people detained in prisons, compared to the population as a whole—that is, to reduce health inequality. Its plans should include an explanation of how its action to improve access to healthcare and enable prisoners to lead healthy lives will reduce health inequality.**

53 Note from stakeholder discussion

4 People's journey through prison

37. The evidence to our inquiry paints a dismal picture of conditions inside English prisons. This picture too frequently is one of overcrowded, unsanitary and outdated establishments. These establishments, due to staff shortages, severely restrict, and too often compromise, the safety and wellbeing of prisoners and staff alike and fail to provide an enabling environment consistent with the rehabilitative purpose of prisons. This section describes the problems raised with us through different points of a person's journey through prison, along with some of the potential solutions to these problems.

Entry into prison

Liaison and diversion

38. The solution to some of the problems inside English prisons begins with people's first contact with police and when they are charged. Liaison and Diversion schemes across police stations and courts are able to carry out assessments, refer people to treatment and support and provide information on alternative responses to prison, such as community sentences and out of court disposals. This approach helps to ensure that people are only imprisoned when it is appropriate. The Bradley Report in 2009 placed a renewed emphasis on the use of liaison and diversion,[54] but nine years on such schemes only cover 82% of the population, with full roll-out expected in 2020/21.[55]

39. Identification of vulnerabilities or need by liaison and diversion services does not necessarily translate into changes in sentencing practices. For example, since 2011 there has been a 25% decline in the use of hospital orders which allow defendants to be sent for medical treatment.[56] This is despite an initial evaluation of liaison and diversion finding an increase "in the number of people with vulnerabilities who were identified".[57] We heard that a lack of suitable community alternatives, including, for example, the provision of community mental health services to divert someone to, may be limiting the effectiveness of liaison and diversion. As the BMA explained:

> Effective liaison and diversion from the criminal justice system are, however, dependent on the community services being in place to enable appropriate care and support, and we are concerned that this is not always the case. A chronic shortfall in funding for mental health services (particularly child and adolescent services) continues to create problems of access for those in need of support.[58]

40. **We are disappointed that nearly a decade on from the Bradley report in 2009, liaison and diversion services do not yet exist in nearly 20% of the country. In the response to this report, the National Prison Healthcare Board should set out the remaining areas where it needs to roll out these services, the reasons for the delay and how the roll-out of these services to the rest of the country will be achieved.**

54 The Bradley Report, Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system, April 2009
55 DHSC, MoJ, HMPPS, NHS England and PHE (PRH0032), para 2.10.1.
56 UK National Preventative Mechanism (PRH0030), para 7
57 British Medical Association (PRH0019), para 1.4
58 British Medical Association (PRH0019), para 1.4

41. **We are also disappointed by the decline in the use of hospital orders, despite liaison and diversion services identifying more people with vulnerabilities who may be more appropriately directed to other services besides prisons. The Board should set out the reasons for the decline in hospital orders, what action it is taking to reverse that decline, and by when that action will be completed. There must also be sufficient resourcing of community mental health services so that people are not sent to prison because of a lack of appropriate community mental health care.**

Screening

42. Prisons are meant to screen new inmates for health conditions, and other health and care needs, upon arrival and again a few days later. Her Majesty's Inspectorate of Prisons expects that "immediate health, substance use and social care needs are recognised on reception and responded to promptly and effectively", and that prisoners then "receive a second health screen within seven days to look at wider health issues".[59] This can be a challenging process to manage, as Kate Davies from NHS England described:

> […] a lot of people are very chaotic and are coming in at weird times of the day and night, and often there may be one or two—even more—vans queued outside, so it is quite a challenging time to get that screening right.[60]

43. Most newly arrived prisoners, according to HMIP, receive a prompt initial health screening, despite late arrivals from court affecting the effectiveness of this process.[61] In contrast, the second health screen, according to HMIP, "was not consistently occurring in some prisons we inspected due to high non-attendance rates, difficulties accessing patients and staffing shortages".[62] The reception area of a prison, as described above, can be busy and stressful, potentially resulting in a rudimentary assessment upon arrival,[63] thereby making the second screen even more important.

44. The view of many stakeholders is that this process needs to be more comprehensive and robust to include a broader range of vulnerabilities prevalent among the prison population and the risks associated upon a person's entry into prison. In addition, we heard further training, particularly of prison officers, is needed to ensure screenings are carried out by staff with the right knowledge and skills to effectively identify a person's needs.

45. The National Prison Healthcare Board informed us that "new templates have been introduced to encourage a systematic and consistent approach to assessments on reception, medicines management, and release planning".[64] Kate Davies from NHS England also noted that over the last 18 months commissioners now require 72-hour follow-up, self-referral and a target response. Referring to these changes, Ms Davies said:

> We are monitoring it very closely to see how that reduces things like self-harm, but particularly deaths in custody, and improves the uptake

59 HMI Prisons (PRH0039)
60 Q184,Kate Davies
61 HMI Prisons (PRH0039)
62 HMI Prisons (PRH0039), para 25
63 British Medical Association (BMA) (PRH0019)
64 DHSC, MoJ, HMPPS, NHS England and PHE (PRH0032), para 2.10.3.

> of immediate understanding of people's needs, particularly a high level of learning disability, medication needs and continuity of medication management.[65]

46. Problems with the conduct of health screenings inside prisons, including the location of the screening, mean that both the NHS and the prison service are missing opportunities to identify and begin to address the health and care needs of a vulnerable population, including previously unrecognised and unmet needs. These missed opportunities affect prisoners, but also wider society. For example, current screening processes inside prisons, along with inadequate training of prison staff, means opportunities to spot and address the following conditions are being missed:

- problems with speech, language and communication. Left untreated these problems can be the cause of disruptive behaviour.[66]
- problems with oral health and swallowing difficulties.
- learning disabilities (e.g. autism), neurological problems (dementia and ADHD) and mental health problems (personality disorders and PTSD).

47. **Imprisonment represents an opportunity to identify, effectively diagnose and treat health and care needs, some of which may be drivers of behavioural problems, which may have gone unrecognised and/or unmet. We recommend that over the next 12 months the National Prison Healthcare Board, in collaboration with stakeholders, particularly those representative of health and care professions, develop a more comprehensive and robust approach to health screening in prisons, capable of testing for a broader range of health and care needs. Once a new approach is designed its implementation must be supported by a training programme for staff carrying out assessments.**

48. **In its next annual report, we recommend that Her Majesty's Inspectorate of Prisons comment specifically on the quality of health screenings, including the extent to which prisons are conducting a second health screening within 7 days.**

Prison environment

49. A quarter of the prison estate was built before 1900.[67] These older prisons, CQC told us, negatively affect prisoners' wellbeing and the safe delivery of care.[68] Parts of the prison estate are unfit, even with reasonable adjustments, to cater for the needs of older prisoners, yet continue to hold them. Northampton Healthcare Foundation Trust described typical conditions in these ageing buildings:

> premises are designed to hold a younger population and accommodation is often completely unsuitable, with most cells having narrow doorways

65 Q184 Kate Davies
66 RCSLT (PRH0026)
67 National Audit Office, Short guide to the Ministry of Justice, October 2017
68 Care Quality Commission (PRH0004)

> rendering it impossible to enter in a wheelchair; cells are tiny with fixed furniture, either bunk beds or very low fixed beds. Shower and washing facilities are inadequate.[69]

50. Overcrowding in prisons, coupled with staff shortages, over recent years has been one of the major drivers of deteriorating standards and conditions. Throughout 2016–17 and 2015–16, just under 25% of prisoners were held in a prison cell shared by more people than it was originally designed to hold. This is, we were told, Her Majesty's Prison and Probation Service definition of crowding.[70] However, prisons also have a certified normal accommodation (CNA) level. A prison's CNA is a standard of decent accommodation the prison service aspires to provide to all prisoners. Just under 60% of prisons at the end of March 2018 exceeded their certified normal accommodation.[71]

51. Letters from prisoners we received via Inside Time reflect concerns raised by stakeholders, including Her Majesty's Inspectorate of Prisons, about the poor, unsanitary, and even squalid, conditions inside some prisons. One example can be seen in the box on this page. In another case, we heard that a prison had no hot water for five months. One of the older prisoners, who was in poor health, was having to wash and shower in cold water during this time. His health deteriorated over this period and he later died in hospital.

One prisoner wrote to us saying "living conditions in prison are very poor. Sanitation and hot water are often unavailable and the ever-growing population of rats running around the communal areas are an ongoing risk of disease. The quality of food is a daily drain on mental wellbeing and the very old, torn and unsupportive mattresses make sleep very difficult or impossible."

52. Prison cells are cramped spaces in which people detained in prison often sleep, eat and go to the toilet. The CQC reported that:

> Overcrowding and lack of personal space are acknowledged stress factors for both prisoners and staff that impact on the delivery of an effective health service. The significant impact on prisoners' general health and wellbeing includes increased risks associated with privacy/confidentiality, communicable diseases, sleep hygiene and anxiety/depression.[72]

69 Northampton Healthcare Foundation Trust (PRH0035)
70 DHSC, MoJ, HMPPS, NHS England and PHE (PRH0032), para 3.5.1.
71 The Howard League (PRH0029), para 4.6 and UK Prison Population Statistics, House of Commons Library Briefing Paper, Number CBP-04334, 23 July 2018
72 Care Quality Commission (PRH0004)

Box 2: Our visit to a prison cell

At our visit to HMP Belmarsh, we were shown a three-bed cell, consisting of a bunk bed on the left-hand side and another bed up against the opposite wall, with a metre-wide gap between the two beds. There was little room to move; if all three men were standing up there was not enough space for them to pass each other without touching. To the right-hand side of the entrance there was a sink, a plastic bin and a tiny mirror, about the size of a small paperback book. There was a toilet in the right-hand corner of the room. The toilet had a small door with a gap below and above. However, not all cells, we were told, have a toilet door. The main door to the room was not barred, but the wall on the other side had a fairly large window, providing some natural light in the cell. There were two cupboards either side of the window, both broken.

Source: Visit to HMP Belmarsh, see Annex 1

53. **In response to this report, the Government should set out what its plan is to ensure that all prisons are clean and sanitary all of the time and by when and how they expect to stop overcrowding.**

Prison regime

54. In recent years, prisoners have spent the vast majority of their time in their cells. HMIP expect prisoners to be unlocked for at least 10 hours a day, but over the last two years have found this to be the case for only a minority of people in adult male prisons (16% in 2017/18 and 14% in 2016/17). Instead, one fifth said they spent less than two hours out of their cells on a weekday.[73] A high proportion of people detained in local prisons[74] and prisons catering for young adult males, in particular, report spending less than two hours out of their cells per day.[75] One prisoner who wrote to us had recently seen his association time reduced to 1hour 40minutes per day, which in his view "affects mental health greatly" and is inconsistent with the Government's aim to rehabilitate offenders. Too many prisons, according to HMIP, fail to provide "sufficient activity places and activity that is truly purposeful."[76] Too much time spent locked up without any purposeful activity, or access to sunlight and fresh air, is not only inconsistent with the rehabilitative aim of prison, but a risk to the safety of the environment.[77] As CLINKS describe:

> A lack of access to rehabilitative services and purposeful activity may have a cyclical impact, leading to increased boredom and frustration which can lead to violence, self-harm and drug use, which in turn leads to further lockdown and an exacerbation of the current difficulties.[78]

55. Time spent out of cells includes time to work, undergo education and training, access healthcare appointments and resettlement services, and carry out daily activities:

73 HMI Prisons (PRH0039) para 45
74 Her Majesty's Inspectorate of Prison for England and Wales, Annual report 2017/18, July 2018, HC1254
75 Her Majesty's Inspectorate of Prison for England and Wales, Annual report 2017/18, July 2018, HC1254
76 HMI Prisons (PRH0039), para 45
77 See Annex 1
78 Clinks (PRH0005) para 19

showering, eating and speaking on the telephone. Prisoners frequently have to choose whether to spend their allotted time exercising, taking a shower or on the phone.[79] One prisoner told us:

> There is also the issue that recreational facilities, such as outside exercise and opportunities to go to the gym, are the first things to be withdrawn if the prison have staff resource issues or if anything else happens. This type of entertainment is considered a privilege rather than a right!

56. The Howard League told us "exercise, showers, family contact and recreation time are all used as rewards for good behaviour or sanctions that can be taken away when behaviour is poor."[80] Jackie Doyle-Price, the Parliamentary Under-Secretary of State for Mental Health and Inequalities, responsible for prison health within the department, told us that these activities and facilities are "tools that affect people's behaviour."[81] However, while this might be the case, we agree with the Howard League that prisons should encourage prisoners to make healthy choices and, most importantly, not deprive them of regular access to facilities and activities that enable them to achieve a basic standard of wellbeing.

57. **In response to this report, we request that the Government set out its future plans for the recruitment of prison officers, including a date by when it expects to have enough prison officers in post to ensure the overwhelming majority of prisoners can be unlocked for the recommended 10 hours per day.**

58. **The Government's approach to prison reform emphasises the importance of harnessing incentives. Incentives should encourage prisoners to lead healthy lives. In addition, incentives should not deny prisoners regular access to facilities and activities that enable them to maintain basic standards of health and wellbeing. This point should be made clear in guidance on how prisons and prison staff use incentives. People in prison should not in effect be sentenced to a reduction in life expectancy or worsening health.**

Diet

59. People's diet in prison is constrained by resources. Prison establishments, according to HMIP's latest annual report, frequently struggle to provide meals of a reasonable quantity and quality with the daily food budget of £2 per person.[82] Prisoners have little choice over what they eat and healthy eating is difficult to promote.[83] We also heard that prisoners often receive their breakfast the night before.[84] Examples from the correspondence we received from prisoners themselves appear in the box on this page.

One prisoner told us "there is also limited thought or concern given to nutritional or dietary needs, it is a carb overload all the way!!", while another prisoner pointed out that "the diet is unhealthy and many elderly men are grossly obese and are not encouraged to exercise."

79 Her Majesty's Inspectorate of Prison for England and Wales, Annual report 2017/18, July 2018, HC1254
80 The Howard League (PRH0029)
81 Q177, Jackie Doyle-Price
82 Her Majesty's Inspectorate of Prison for England and Wales, Annual report 2017/18, July 2018, HC1254
83 Care Quality Commission (PRH0004)
84 See Annex 2 on Prison Health Stakeholder Discussion

60. **The Government must urgently ensure that all prisoners have access to a reasonable quantity and quality of food which supports health and wellbeing rather than adversely affecting it. Public Health England should carry out an assessment to determine whether the daily food budget of £2 per person can realistically deliver this objective and review the national food standards in prison, which should be consistently implemented across the prison estate.**

Experiences of safety

61. Violence in prisons is at a record high, including prisoner on prisoner assaults and assaults on staff, thereby creating an environment in which many prisoners and staff alike feel unsafe. Half of prisoners report having felt unsafe at some time, according to HMIP's annual report, which rises to 70% for prisoners in large inner city local prisons (e.g. HMP Liverpool, HMP Leeds and HMP Pentonville).[85] Exposure to persistent threats of violence and/or bullying, as well as other stressors in prison, creates an environment that is harmful to people's health. The threat of violence can heighten anxieties of prisoners with health conditions, who can feel vulnerable to attack. We heard accounts from prisoners with health problems who had isolated themselves through fear of being bullied or assaulted. According to HMIP's annual report, "much of the violence seemed to be linked to drugs and debt, as well as mental health and poor prison conditions."[86] In his oral evidence to us Peter Clarke, the Chief Inspector of Prisons, emphasised the impact of illicit drug use, saying:

> The issue of illicit drugs has clearly contributed not only directly to ill health in terms of the impact of the drug on the person when they take it, but to the environment as well, with the violence, the fear, the debt and the bullying it places many people in. They self-segregate and self-isolate, and instances of self-harm and suicide tragically flow from that."[87]

62. Almost half of the adult male prisons HMIP inspected over the last year had a main recommendation for addressing problems with violence, either due to high levels of violence or, in some respects more worryingly, a "lack of effective response from managers."[88]

Experience of health and social care

63. Demand for healthcare, as identified in Chapter 3, is high among people detained in prison. User Voice found almost 100% of prisoners in Kent, Surrey and Sussex required some form of treatment during their time in prison. They also found the majority (72%) report struggling to access services, while over half report being dissatisfied with the quality of care they received.[89] This section describes some of the common problems prisoners experience. The points below are based on prisoners' reported experiences of health and care services, including responses to our call for evidence in Inside Time. Boxes show some particular examples of the experiences reported. We have gone into more detail further on in this chapter about problems prisoners experience in accessing appointments and with support for mental health and social care needs.

85 Her Majesty's Inspectorate of Prison for England and Wales, Annual report 2017/18, July 2018, HC1254
86 Her Majesty's Inspectorate of Prison for England and Wales, Annual report 2017/18, July 2018, HC1254
87 Q61 Peter Clark
88 Her Majesty's Inspectorate of Prison for England and Wales, Annual report 2017/18, July 2018, HC1254
89 User Voice (PRH0031)

64. **Prisoners often struggle to get health concerns acted upon in timely way.** Prisoners frequently report long delays in having their health concerns acted upon. This can include worrying symptoms not being responded to in a timely manner, if at all. Letters we received from prisoners include accounts where deaths of fellow prisoners were preceded by long delays in prison and healthcare staff responding signs of ill health

> *One prisoner wrote to us describing the case of a fellow prisoner, saying: "on the 20th November 2017 Stephen (not his real name) was having issues eating and drinking. He went to healthcare with these problems, but these issues got worse over the coming weeks. Then in March 2018 he was taken to our local hospital where, after doing tests, he was told he had cancer."*

65. **Prisoners can experience problems getting help in an emergency.** This includes prisoners experiencing suspected stroke or heart attacks, those with serious health conditions (e.g. a cancer diagnosis) or prisoners in a mental health crisis.[90] Prisoners frequently complain about waiting a long time for call bells to be answered or not having calls answered at all.[91] Getting help in an emergency is particularly difficult during periods of low staffing (e.g. at night).[92]

> *"So I rang my emergency call bell for medical attention and was given a behaviour IEP for the pleasure! When I was seen 12 hours later I was rushed to hospital."*

66. Prisoners report having to convince prison staff that they need urgent treatment. Even if they do, healthcare staff are not always available to assist them and when staff are available responses still can be poor.[93] When emergency services are called they can often experience long delays in gaining access. For example, the Prison Reform Trust told us of an occasion in which an ambulance, responding to a serious medical emergency, had to wait 30 minutes outside the prison gate.[94]

> *One prisoner wrote to us saying "both staff on the wing and in healthcare here in my experience are wholly inadequate in dealing with urgent or emergency care. Prisoners who have self-harmed are described as a nuisance. I have heard prison staff on the wing stating they wish people would kill themselves more efficiently. 'Let him hang for longer', 'let him cut up,' and 'I used to gut fish for a living so I can show him how to do it properly' is just some of the dialogue I have personally heard."*

67. We received reports of flippant and dismissive attitudes among prison staff and healthcare staff to prisoners experiencing an urgent health or mental health problem. The Prison Reform Trust told us prisons have refused to speak to them, and families of prisoners, when they have sought to report urgent health concerns about detainees.[95]

90 Prisoners Advice Service (PRH0044),Prison Reform Trust (PRH0038)
91 Prisoners Advice Service (PRH0044)
92 Prison Reform Trust (PRH0038)
93 Prison Reform Trust (PRH0038)
94 Prison Reform Trust (PRH0038)
95 Prison Reform Trust (PRH0038)

68. **Prisoners experience problems getting medicines they need.** Prisoners can experience delays in getting access to medicines, including medicines they've been prescribed before they enter prison or when they are transferred to another prison. The Prisoner Advisory Service (PAS) informed us that prisoners can be left without vital medication including "beta blockers, insulin, mental health medication and pain relief."[96] According to the PAS, this problem is "endemic in certain prisons" and has resulted in hospitalisation on occasions.[97] Like illicit drugs, there is a market for prescription medications inside prisons. This can result in prisoners being bullied for their medicines. Healthcare professionals, wary about the possibility of bullying, choose not to prescribe medications.

> *Another prisoner who wrote to us said "last week I was told by the doctor that while he understands I might need pain relief, he can't prescribe tablets to me, as I might be bullied. So the doctor is doing the bullies' job now by denying me them."*

69. **Prisoners often struggle to see a dentist, GP, speech and language therapist or an optician.** User Voice found that over 70% of prisoners reported finding it difficult or very difficult to see a dentist, with just over 50% reporting similar problems accessing a GP and an optician. We heard of cases where prisoners waited many months to access specialist dentistry services or optical care. For example, the PAS informed us of prisoners waiting months for urgent dental treatments, such as a tooth extraction, or specialist treatment for eye conditions.[98] On the latter, prisoners who are unable to access treatment for eye conditions can be left feeling very vulnerable, particularly because of high levels of bullying and violence in prisons. Dentists, according to the User Voice survey, were reported to offer the lowest quality of service. Over 40% of prisoners who accessed dentistry services reported these as being poor or very poor.[99]

> *The Prisoner Advisory Service informed us that they "recently assisted a prisoner who was denied contact lenses, although he was partially sighted and his condition meant he could not wear glasses. He could hardly see on the prison wing and felt very unsafe. The matter was resolved but not without months of anxiety and distress for the individual concerned."*

96 Prisoners Advice Service (PRH0044)
97 Prisoners Advice Service (PRH0044)
98 Prisoners Advice Service (PRH0044)
99 User Voice (PRH0031)

70. **Prisoners report problems when making a complaint**. Prisoners' complaints often go unanswered, as do complaints made on their behalf. The Prisoner Advisory Service told us it is not sure whether unanswered complaints are recorded in the first place. This concern was also voiced by prisoners who responded to our advert in Inside Time. As such, prisoners often end up making numerous complaints about the same problem. Prisoners are often unware that healthcare services have a different complaints procedure, so, as well as being ignored, they report being passed from pillar to post between different agencies.[100]

> *One prisoner told us that he can prove the head of healthcare at his prison puts prisoners' complaints in the bin. He describes that when prisoners complain, and their complaints are not binned, the response they get from the NHS is a "fob off", which leaves them back at the point they started at. According to the prisoner, there is a rogue doctor operating within the prison. He goes on to say that hundreds of prisoners have complained about his treatment of them, but the head of healthcare just gets rid of them.*

Medical appointments

71. Missed appointments, either in or outside prison, are common. Non-attendance for internal appointments, based on reports by Independent Monitoring Boards, is on average around 20–30%.[101] HMIP provided examples of similar trends in the prisons it visited. For example, at Brixton, HMIP found that between November and December 2016 the 'did not attend' rate for the GP clinic was 28% and that 25% of hospital appointments between October and December 2016 had to be rescheduled. In both cases, it was restrictions in the regime that was the underlying cause.[102]

72. Getting an appointment can be difficult in the first place. For example, it is common for staff to fail to pass on messages or for applications made electronically to go missing.[103] Waiting times can sometimes be excessive, according to HMIP. For example, waiting times to see a GP ranged from 8–12 weeks in Holme House.[104] This is due to staff shortages, high demand, high rates of non-attendance, prisoners not being unlocked for, or escorted to, appointments or prisoners choosing to use the time for other activities if there is only limited time out of their cells.[105]

73. Similarly, prisoners can also wait too long for external appointments, as people detained in closed prisons require a prison escort, usually a prison officer. HMIP told us they 'found some prisoners waited too long for external appointments as a result of too few escorts to meet demand and also cancellations due to a lack of escort staff'.[106]

74. Medical emergencies within prisons also affect pre-arranged appointments. For example, increases in emergencies, such as those fuelled by the use of novel psychoactive substances, mean escorts are allocated to those in most immediate need rather than someone who may have an appointment, such as a cancer investigation or treatment

100 Prisoners Advice Service (PRH0044)
101 AMIMB (PRH0043)
102 HMI Prisons (PRH0039)
103 Prison Reform Trust (PRH0038)
104 AMIMB (PRH0043)
105 HMI Prisons (PRH0039), para 27
106 HMI Prisons (PRH0039), para 31

appointment that is urgent but not immediately life threatening .[107] We were also told that further follow ups may then be cancelled or simply not rearranged as a result of poor communication.

75. **The Government in its response should set out how it intends to drastically reduce the number of missed appointments both in and outside prison across the prison estate to ensure that clinical need is always met.**

Drugs

76. Cannabis, opiates, steroids, other diverted medicines, synthetic cannabinoids and other novel psychoactive substances are heavily misused in many establishments.[108] These substances, and the internal market for them, compromise the safety of prisons by fuelling high levels of debt, violence and self-harm. The Independent Advisory Panel on Deaths in Custody note that drug-related deaths in prison appear to have been increasing and argue for clear recording of such deaths, to highlight the extent of the problem.[109]

77. Many prisoners report having a drug problem on arrival (42% of women and 28% of men). Worryingly, 13% of men and 8% of women reported they had developed a problem with illicit drugs while in prison.[110] However, from our oral evidence it was clear that without mandatory drug testing prisons do not, and cannot, know the extent to which people have a problem on arrival or develop one during their sentence.[111]

78. The widespread use of novel psychoactive substances over recent years, we heard, has presented a major challenge to an already overstretched service. Dr Jake Hard, a GP and Chair of the Royal College of General Practitioners Secure Environments Group, distinguished NPSs from other illicit drugs, describing their rise as a "real curve ball."[112] These substances have unpredictable and severe physical and psychological effects (changes in blood pressure, seizures, reduced drive to breathe and extreme strength, agitation, paranoia and psychosis). The psychological effects can sometimes be severe or enduring enough to require intervention under the Mental Health Act.[113]

79. These substances also negatively affect staff, diverting health and prison staff away from their usual roles, leading to assaults and regularly draining NHS resources, especially ambulances and emergency services."[114] The Royal College of Nursing told us that their members "report suffering the effects of inhaling the drug" being used by those they are treating, including at least one case where a nurse was taken to A&E by ambulance after being knocked unconscious by the psychoactive fumes.[115]

80. **We agree with the Independent Advisory Panel on Deaths in Custody that drug-related deaths in prison should be clearly recorded. We recommend that in the Government's official response to this report the Ministry of Justice set out the steps it intends to take to ensure that happens.**

107 AMIMB (PRH0043)
108 HMI Prisons (PRH0039)
109 Independent Advisory Panel on Deaths in Custody (PRH0040)
110 HMI Prisons (PRH0039), para 43
111 Qq112–116
112 Q166
113 Royal College of GPs (PRH0023), para 30
114 Royal College of GPs (PRH0023), para 30, Prison Reform Trust (PRH0038)
115 Royal College of Nursing (PRH0037), para 2.5

81. **We recommend the approach to health screening is modified to enable prisons to get a much more comprehensive understanding of people within their prison who have a pre-existing substance misuse problem. The approach to screening should also enable prison healthcare providers to identify, and assist, those who develop such a problem during their sentence.**

82. **The National Prison Healthcare Board's Partnership Agreement states that it will "continue work at all levels to reduce the impact of substance misuse (including from the use of psychoactive substances), to address the risks of misuse and resultant harms, and to ensure the right help is available at the right time." This statement of intent is very vague. In its place we recommend the National Prison Health Board commit to reducing substance misuse in prison, as well as its impact, and set clear and ambitious targets for:**

a) **reducing the supply of, and demand for, illicit drugs in prisons; and**

b) **improving the recovery, and associated health outcomes, of people in prison with a substance misuse problem.**

Mental health in prisons

83. Numerous concerns have been raised with us about the demand for, and provision of, services catering for people with all severities of mental health need in prison. The environment, culture and conditions within prisons frequently compromise the mental wellbeing of prisoners and staff alike. For example, in men's prisons, over the last two years, the vast majority of HMIP's inspection reports (90% in 2017/18 and 75% in 2016/17) have been critical of the establishments response to one or more of the key factors that contribute to self-harm and suicide. One fifth of reports in 2016/17 and a third in 2017/18 included a main recommendation relating to these issues.[116]However, the inspectorate's latest annual report notes that "despite similar recommendations in the past, prisons had made insufficient effort to help prisoners in crisis."[117]

84. HMIP recommended improvements in the provision of mental healthcare in just over half of all prisons inspected in 2017/18.[118] To begin with, there is a gap in mental health services commissioned in prisons, particularly services catering for people with mild to moderate mental health needs (e.g. psychological services, counselling etc).[119] This point was reiterated in CQC's evidence to us.[120] There is also a difficulty with ensuring continuity of mental health care when prisoners are transferred to other prisons.

85. For those with severe mental health problems, guidelines introduced in England and Wales following the Bradley Report stipulate that prisoners should be transferred to a mental health unit within 14 days of the first medical recommendation for transfer. A second medical opinion and all administrative tasks, including finding a bed, should also be completed in those 14 days. However, this is rarely the case. Instead, in England and

116 HMI Prisons (PRH0039)
117 Her Majesty's Inspectorate of Prison for England and Wales, Annual report 2017/18, July 2018, HC1254
118 HMI Prisons (PRH0039)
119 HMI Prisons (PRH0039)
120 Care Quality Commission (PRH0004)

Wales in 2016–17, only 366 (33.7%) of the 1083 transfers from prison to hospital were completed within 14 days. 717 (66.3%) took longer than 14 days and 76 prisoners (7.1%) waited 140 days or longer.[121] HMIP found excessive delays in 27 male prisons in 2017/18.[122]

Self-harm and suicide

86. Rates of self-harm in custody have reached record highs over recent years and continue to rise.[123] In 2017, there were 44,651 reported incidents of self-harm, up 11% from the previous year. The number of self-harming individuals increased by 6% to a new record high of 11,630.[124] Self-inflicted deaths in prison also remain at very high levels.[125] The Prison and Probation Ombudsman told us that:

> We have seen a very welcome reduction in self-inflicted deaths in 2017/18, although numbers started to increase in the second half of the year. It is important that we work together to understand the reasons behind this. We should all recognise that levels remain unacceptably high and that it is far too early to conclude that "our work here is done". Combating self-harm and self-inflicted deaths must remain a key concern.[126]

87. Every death by suicide is a tragedy with appalling long-term consequences for loved ones, those around the individual who has taken their own life and staff. Suicide must be regarded as preventable.[127] Risk of suicide is dynamic: anyone can become at risk of suicide at any time during their sentence.[128] However, it is unacceptable that deaths by suicide continue to occur for people who are known to be at high risk and for whom appropriate action, including the removal of all ligature points, which could have saved their lives, has not been taken. Particular attention also needs to be paid to periods of greater risk, including on entry to prison, on release from prison, while in segregation and while awaiting transfer to a secure mental health hospital.

88. **There are well known risks relating to suicide and self-harm for people in prison. While rates of self-inflicted deaths in prisons have fallen since reaching a peak in 2016, there is no room for complacency as incidences of self-harm remain at a record high. We expect to see a concerted effort from Government to reduce suicide and self-harm in prison, supported by ambitious targets and a clear and credible plan for achieving them. The newly identified role of a minister with responsibility for suicide prevention is welcome, but we expect the Government within its response to report on how this role will extend to suicides and self-harm within prisons and on release.**

89. **The National Prison Healthcare Board's agreement states that between 2018–21 it plans to "continue to work collaboratively to improve practice to reduce incidents of self-harm and self-inflicted deaths in the adult secure estate, by strengthening multi-agency approaches to managing prisoners at serious risk of harm and further**

121 UK National Preventive Mechanism (PRH0030)
122 Her Majesty's Inspectorate of Prison for England and Wales, Annual report 2017/18, July 2018, HC1254
123 Ministry of Justice, Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to June 2018 Assaults and Self-harm to March 2018, 26 July 2018
124 INQUEST (PRH0027) para 10
125 Q28 Rebecca Roberts
126 Prisons and Probation Ombudsman (PRH0017)
127 House of Commons Health Committee, Suicide prevention, Sixth report of Session 2016–17, 16 March 2017, HC1087
128 Clinks (PRH0005)

embedding shared learning." Like the reference to substance misuse described above, this is too vague. The Board should set clear reduction targets and measures of success for this period, including improving access to psychological therapies, especially for those with mild to moderate mental health needs.

90. We are deeply concerned that the majority of people requiring treatment in secure mental health facilities are not transferred within the 14-day target and that a small minority wait over 140 days. The most cited reason for delays is a lack of access to secure hospital beds.[129] We were informed of aspirations to increase capacity, but that this will not be achieved for some years.[130] Currently, the National Prison Healthcare Board is working hard to reduce waiting times by improving the flow through the system, thereby using the current capacity more efficiently.[131]The question remains to what extent the 14-day target is achievable within the current capacity of secure beds. **In response to this report, we recommend that the Board set out the level of reduction in waiting times for transfers to secure mental health facilities it plans to achieve in each of the remaining years of its partnership agreement (2018/19, 2019/20 and 2020/21). We also recommend that the Board set out its plans for expanding the number of secure hospital beds, including dates by which extra capacity will be operational and the contribution this extra capacity will make to reducing waiting times.**

Social care in prisons

91. There is an underserved need for social care in English prisons due to high prevalence of learning disabilities, autism and other difficulties with communication. People with these difficulties often fall below the eligibility criteria for state funded social care support.[132]

92. For those who may qualify for social care, there are pockets of good, even excellent, practice across the prison service, although overall the identification, assessment, commissioning and provision of social care in prisons varies significantly. Where problems with social care arise, they may be the fault of local authorities (e.g. failing to commission services or delays in local authorities carrying out assessments) or of providers (e.g. inadequate staffing, poor care planning and communication).[133] However, the majority of the issues reported to us were with the prison service.[134]

93. Referrals to local authorities for assessment of an individual's social care needs vary significantly between prisons. For example, in 2016/17 six prisons generated over 100 referrals, while eight prisons did not generate any.[135] These variations may stem from differences in the ability of prison staff to identify people in need of social care and/or a lack of contact with social care staff and a corresponding lack of knowledge about the local authority's role and how to contact them.[136] In addition, very few areas, 7 out of

129 UK National Preventive Mechanism (PRH0030)
130 UK National Preventive Mechanism (PRH0030)
131 Q226
132 Association of Directors of Adult Social Services (ADASS) submission (PRH0051) and Revolving Doors Agency (PRH0046)
133 Care Quality Commission (PRH0004)
134 Care Quality Commission (PRH0004) and Association of Directors of Adult Social Services (ADASS) submission (PRH0051)
135 Association of Directors of Adult Social Services (ADASS) submission (PRH0051)
136 Association of Directors of Adult Social Services (ADASS) submission (PRH0051)

50, have a memorandum of understanding in place between the prison and the local authority, despite the inclusion of such an MoU being stated within official Prison Service Instructions.[137]

94. Prisons add to the cost of providing social care in two critical ways. Firstly, in a sector which already experiences a high staff turnover (30%), the long waits for security clearance often mean prospective employees have found another job before their vetting is completed. In addition, the time taken to get in and out of prison doubles the cost of providing social care in prison compared to the community, according to ADASS.[138]

95. **We recommend a target should be introduced for all of the 50 local authority areas with prisons to have a memorandum of understanding on the provision of social care in place with each prison in their area in the next year.**

Release from prison

96. Release from prison is a challenging time for prisoners, associated with significant risks to their health. During this transition the risk of suicide increases and those who misuse substances are at risk of overdosing.[139] We heard that "healthcare provision at present is often disjointed between prison and the community" and that "uncertainties at the time of release, for example regarding future home address, can make communication between integrated and community healthcare services more difficult".[140]

97. Problems arising upon release from prisons include prisoners leaving without or with the wrong medication, without being registered with a GP in the community, and without an assessment of their social care needs, despite receiving care in prisons. Dr O'Moore from Public Health England also told us only a third of people on structured drug treatment programmes in prison are picked up by drug services when they leave.[141] In addition to problems with continuity of health and care, many prisoners are also released homeless.[142]

98. We were particularly concerned to hear from INQUEST about the number of people dying during post-release supervision in the community. INQUEST informed us that almost 1,400 people died during post-release supervision in the community between 2010/11 and 2016/17. 554 of the 1,378 deaths were of natural causes, 401 were self-inflicted and 229 await classification. Analysis by INQUEST of official data from the MoJ showed the increase in deaths post-release (274%) has been far in excess of the increase in caseloads (62%).[143] We share INQUEST's concern that "there seems to be a complete absence of any form of investigation and follow-up when something happens to somebody on post-custody supervision."[144]

137 Association of Directors of Adult Social Services (ADASS) submission (PRH0051)
138 Association of Directors of Adult Social Services (ADASS) submission (PRH0051)
139 Royal College of Psychiatrists (PRH0014)
140 University of Manchester (PRH0003), para 1.9.1.
141 Q222 Dr O'Moore
142 On our visit to HMP Thameside we were informed that 45% of prisoners are released to no fixed abode.
143 INQUEST (PRH0027)
144 Q56 Rebecca Roberts

99. A lack of continuity of care on release and problems securing provision for ex-offenders may be caused by a poor sharing of information between services, disputes, for example between commissioners, over who is responsible for the ex-offender's needs, and scarce resources in the community (e.g. a lack of social housing).[145]

100. **We recommend that the Government undertake a thorough investigation of deaths during post-release supervision in the community, including the reasons for the rise in death rate that has been described. We further recommend that the Government clarify where responsibility for oversight of such deaths should lie and set out a plan to reduce this death rate.**

145 Q214 Digby Griffiths

5 Breaking the cycle of disadvantage: a whole system approach

101. Prisons are an opportunity to identify and treat the health and care needs of people who often live on the edge of society and who have faced a lifetime of disadvantage. In many instances, people who end up in prison have health and care needs that begin in early childhood, but remain unrecognised and/or underserved, and exacerbated by social problems. It is sometimes only when, as the Parliamentary Under-Secretary of State, Jackie Doyle-Price MP, told us, these people become a "nuisance to society and break the law" that these needs begin to be addressed.[146]

Whole systems approach

102. The challenge of providing a safer and healthier prison environment begins by managing the number of people going into prison. We agree with CQC that this requires "a whole system approach that has its roots in sentencing and release."[147]

103. A more strategic, coordinated whole systems approach, we have heard during our inquiry, would provide a much more effective way of supporting the needs of people in contact with the criminal justice system and protecting the public. Such an approach, as CLINKs argued, could resemble some of the aspirations in the Government's recent strategy for female offenders, with a particular focus on "pooling budgets and redesigning some of the systems and services around individuals."[148]

104. Kate Davies from NHS England told us that there is a lot of work going on between Government departments, and their arms-length bodies, looking at how services outside of prisons can help manage the prison population, ensuring that there are the "right number of people in prisons for the right reasons" and that prisons are enabling environments that help people maintain their health and wellbeing and prepare for better life once they're released.[149]

105. In the Female Offenders Strategy, the Government states it wants to see the "the spread of multi-agency, WSA models, which bring together local agencies (criminal justice, statutory and voluntary) to take a joined-up, gender-informed approach to providing the holistic, targeted support that female offenders need, with shared investment and outcomes." The exact model is likely to vary to reflect the need and provision of services locally, but is likely to focus on an early identification and assessment of need (e.g. when offenders first come in contact with the police), a focus in court about the most effective means of addressing the offenders problem and targeted support from various agencies to address these problems, alongside a community sentence or on release from prison."[150]

106. **We recommend that the Government's evaluation of the female offenders' strategy should assess the merits of applying similar approaches to other parts of the**

146 Q226 Jackie Doyle-Price
147 Care Quality Commission (PRH0004)
148 Q15 Hazel Alcraft
149 Q184 Kate Davies
150 Ministry of Justice, Female Offenders Strategy, June 2018

prison population. In particular, we recommend that the evaluation should comment specifically on the extent to which a similar approach could be introduced for those with complex needs who would otherwise be given short custodial sentences.

Rehabilitative culture: narrative of care, health and wellbeing

107. Rehabilitation is one of the three core purposes of prison. Senior officials spoke of aspirations to bring about more positive rehabilitative and enabling environments inside prisons. Kate Davies from NHS England told us:

> the right approach for a prison setting is to have an enabling environment where healthcare is at the core of the needs and responsibilities of the individuals from the moment they enter the gate throughout whatever length of sentence they are serving and in planning for their release.[151]

108. A rehabilitative culture and enabling environment would, in our view, and the view of many of the organisations we heard from, be synonymous with, and supported by, a greater emphasis on health, wellbeing, care and recovery within prison. The way the Government talks about the rehabilitative purpose of prisons should reflect the fact that people in prison, and in contact with the criminal justice system, are among the most vulnerable groups in society, whose lives are characterised by a poor state of physical and mental health, social problems and early adverse experiences. It is important that the minister responsible for prison health has an understanding of the particular challenges and complexities faced by the prison population.

109. Putting greater emphasis on health, care, wellbeing and recovery does not mean diluting the role of prisons in providing public protection and justice. On the contrary, it acknowledges that the health, care, wellbeing and recovery of people detained in prisons is integral to reducing risk.[152] This includes current and future risks to people detained in prison, but also the safety of prisons and risks to the public when prisoners leave, including reoffending, but also health risks. The Royal College of General Practitioners told us:

> We support the development of a rehabilitative culture within prisons including initiatives that seek to improve the safety of the environment in which healthcare and security staff work and in which prisoners live. We expect an emphasis on effective treatments and working with prison staff to address prisoner behaviour and that this will not only improve individual health outcomes, but which will be likely to reduce reoffending and ultimately benefit society as a whole.[153]

110. We are encouraged by the language used in the Government's recently published strategy for female offenders. The underlying purpose of this strategy, and the language used, recognises that the vulnerabilities of female offenders, which are often a product of abuse and trauma, contribute to offending behaviour (chaotic lifestyles involving substance misuse, mental health problems and homelessness).[154] The Government's approach and

151 Q173 Kate Davies
152 Dr Emily Glorney (PRH0055)
153 Royal College of GPs (PRH0023)
154 Ministry of Justice, Female Offenders Strategy, June 2018

narrative on prison reform should recognise the trauma experienced by large parts of the prison population and ensure that training and guidance given to all staff in prisons enables them to identify and respond to signs of trauma in prisoners.

111. **We recommend that the Government's programme of prison reform, and the way it talks about its plans for reform, should place greater emphasis on health, wellbeing, care and recovery. Improving the health, wellbeing, care and recovery of people detained in prison will help improve the safety of prisons and reduce reoffending.**

Whole prison approach

112. Health in prisons, according to the World Health Organisation, "is too important to be left solely to the health team." The WHO recommend prisons adopt a whole prison approach to promoting and improving health and wellbeing. A whole prison approach is:

> a system-wide strategy aimed at creating healthy, supportive environments which engage at all levels of prison life and focus on promoting good health.[155]

113. The idea of a whole prison approach is not new. The WHO recommended its adoption in 1995 and Her Majesty's Inspectorate of Prisons has used the idea to underpin its approach to inspections.[156] However, the concept, while welcome and frequently used, still needs to be defined and developed so there is a clear, and shared, understanding of how such an approach should be applied in England. One of the National Prison Healthcare Board's priorities between 2018–21 is to "develop and apply a whole prison approach to health and wellbeing that ensures that the regime, activities and staffing facilitate an environment that promotes good health and wellbeing and reduces violence for all prisoners, including those with protected characteristics."[157]

114. We discussed the National Prison Healthcare Board's priority with representatives from 18 stakeholders across the health and penal system, including royal colleges, providers of healthcare, charities and representatives of prison staff and private prison providers. They noted that the National Prison Healthcare Board's priority is extremely complex to implement.[158] To begin with, there is no shared understanding of what a whole prison approach means. Reaching a shared understanding is critical as prisons often have a broad range of services, often characterised by clear cultural divides, operating within them. Cultural barriers between prison and healthcare staff, stakeholders told us, are common and frequently have a detrimental impact on the delivery of care.[159]

115. No one establishment stood out as a model of a healthy prison that could be replicated across the estate. However, we have heard of pockets of good, and even excellent, care across the prison estate where services have found innovative ways to address some of the difficult challenges facing prisons. Some examples may be found in the box below. A whole prison approach is likely to vary between different types of establishments. At our stakeholder discussion, the view was that a whole prison approach would be easier to implement in establishments with a more stable prison population. In contrast,

155 DHSC, MoJ, HMPPS, NHS England and PHE (PRH0032)
156 The Howard League (PRH0029)
157 National Partnership Agreement
158 Note on stakeholder discussion
159 Care Quality Commission (PRH0004), Annex 2 Prison Health Stakeholder Discussion, Q13 Sean Cox

prisons with a high churn in their population frequently struggle with staffing, including problems with recruitment and morale, although these prisons are also ones which see a high prevalence of complex needs.[160]

116. A whole prison approach to health and wellbeing is one where a focus on health, care, wellbeing and recovery is exemplified through the environment, regime and provision of services, and where these aspects of prison life actively support people to maintain and improve their health and prepare for their release. A whole prison approach begins with identifying and acting on people's health and care needs upon entry into prison, including needs that may have gone unrecognised and/or been underserved.

117. **The Board's intention to develop and implement a whole prison approach to health and well-being is the right one. We recommend this priority should be given much more prominence within its future plans.**

118. **In order to ensure that it is successful, much more work is needed to arrive at a shared understanding of what a whole prison approach looks like and how such an approach and best practice can be effectively implemented. The National Prison Healthcare Board, Her Majesty's Inspectorate of Prisons, the Care Quality Commission and National Institute for Health and Care Excellence should work with a group of national stakeholders over the next 12 months to define the core principles of a whole prison approach, together with guidance and resources to support prison governors and the appointed regional directors to develop more detailed plans for implementation at local level.**

Box 3: Examples of best practice

Her Majesty's Inspectorate of Prisons often find examples of good and excellent practice across the prison service, but they are rarely shared and adopted elsewhere. Below are some short examples of best practice that exist across the prison service.

Health promotion: Dovegate has a prison-wide approach to wellbeing. This includes health promotion days, healthy eating initiatives and 12 health champions who promote wellbeing through "physical health monitoring, peer information giving, and encouragement." We also heard examples of a few prisons that had started park-run.

Maternity care and childcare support: Birth Companions identified good practice in maternity care in women's prisons, including the appointment of a specialist midwife to design and deliver a pathway for perinatal women in prison (Low Newton); provision of counselling and support for women in crisis pregnancy and around the loss of a baby or child (HMP Bronzefield); 24-hour telephone access to the local labour ward, food packs, in addition to standard food, for pregnant women and breastfeeding mothers, and trained volunteers to support and advocate for women during birth (HMP Peterborough); a mother and baby unit providing parenting support, nursery provision and targeted intervention work (HMP Styal).

Family contact: From what we saw at Thameside, the social aspect of a prisoner's life was well respected. Prisoners have 7 events a month, which they can use to book family visits. There is a monthly family day, a homework club and other opportunities for prisoners to see their partners, children and babies.

Tackling the supply and demand of illicit drugs: On the supply side, Belmarsh piloted technology to detect contraband, including a new body scanner which had achieved encouraging results, according to HMIP. Elsewhere, Northumberland has worked with

160 Annex 2 Prison Health Stakeholder Discussion

prisoners to create and implement a drug supply strategy, in which peer mentors have been actively involved in "service delivery, service development and officer training," and have "contributed to drug strategy meetings." On the demand side, Preston, according to HMIP, provides an effective and supportive environment that encourages prisoners' recovery from addiction, with excellent partnership working between prison, clinical and psychosocial teams. Dovegate prison has run a voluntary NPS awareness course for prisoners who "tested positive for using NPSs."

Dentistry and oral health: Leeds provide a full range of dental services, equivalent to that provided on the NHS. These are provided at four sessions per week. There is also a dental hygienist clinic twice a month.

Long-term conditions management: Lindholme and Holme House have dedicated nurses, which ensure patients with chronic conditions or complex health needs are identified and reviewed promptly.

Mental health and learning disabilities: The National Audit Office's report on mental health in prisons identified a variety of innovative approaches to improving mental health provision, such as well-being courses, specialist gym classes and family counselling. During our visits, we also heard about the benefits of peer mentoring schemes for people suffering from mental health problems in prisons. Written evidence from the Centre for Mental Health also praised such schemes, saying they lead to positive benefits, and called for such approaches to be used more extensively.

NHS England's London Clinical Network on Health in Justice and Other Vulnerable Adults conducted an audit of support for people with learning disabilities in 8 London prisons and immigration removal centres. One of the main findings was the value of a learning disability practitioner or coordinator, as a source of expertise. In particular, the audit found "pathways for full assessment, reasonable adjustments and onward referral were most robust where there was a learning disability practitioner in post."

Social care: Usk has an excellent approach to social care. Social care staff see prisoners on their induction. Prisoner buddies, who are well trained and supervised, are allocated to prisoners in need of social care. These buddies follow a care plan, which is reviewed monthly with the social care team, and keep daily records.

End of life care: Dartmoor was praised for its end of life care. The prison has links with the local hospice and the Macmillan Cancer Care. The prison had a monthly clinic run by Macmillan which provided expert advice to patients with cancer and life-limiting conditions as well as patients receiving palliative care.

Release from prison: Life after prison was also taken into account at Thameside. Senior leaders informed us about a self-funded scheme which has helped 263 prisoners into full-time work and education, with recent leavers taking up positions at Pret-a-Manger and other well-known companies. Another prisoner we spoke to was studying with the Open University. We have also heard about resettlement schemes, such as Landmark, which support prisoners, and people at risk of going into prison, away from crime and into the community. For example, Landmark is a training project in which prisoners, or those at risk of offending, learn practical skills such as woodwork, construction, landscaping, cooking, vegetable growing and arts and crafts through an intensive training placement that replicates a working day. The project has supported 60 people since it began in 2013, over 90% of whom are in employment.

Sources: HMI Prisons (PRH0039),DHSC, MoJ, HMPPS, NHS England and PHE (PRH0032),Royal College of Midwives/Birth Companions (PRH0018) and the visit to HMP Thameside (Annex 1), Landworks website (https://www.landworks.org.uk/landworks-prisoner-training/prison-education-facts/), National Audit Office, Mental health in prisons, HC 42 Session 2017–2019, 29 June 2017, Centre for Mental Health (PRH0021), London Clinical Network for Health in Justice & Other Vulnerable Adults NHSE (PRH0042)

Workforce

119. A whole prison approach cannot work without a sufficient, well-trained, and stable supply of prison officers whose own safety and health is valued. The Care Quality Commission's written evidence identifies problems arising from the lack of a stable and well-trained workforce, saying:

> A well-recognised concern is prison staff turnover that has resulted in a reduction in welfare support and fragmented staff-prisoner relationships. In some prisons there is a low percentage of experienced staff who have the skills to identify risk and meet the complex needs of the population. Whilst there are some promising national initiatives to increase the staff-prisoner ratio, staffing is generally inadequate to effectively support risk management, relationship building, prisoner support and preparation for release.[161]

120. Prison officer numbers are now rising, but are still below 2010 levels and insufficient for the prison population.[162] The prison service is also struggling with low rates of retention, including among new recruits, and the significant loss of experienced officers. Her Majesty's Inspectorate of Prisons, the Care Quality Commission and the Prison Probation Ombudsman all identified significant gaps in the ability of prison staff to identify and respond appropriately to the health and care needs of people in prison, including their ability to respond effectively in emergencies.[163]

121. Healthcare services in prisons are expected to provide sufficient levels of suitably qualified staff, including an appropriate skill mix, to reflect the needs of prisoners. However, most prison healthcare providers struggle to recruit and retain health staff with the requisite qualities and skills.[164] For example, Her Majesty's Inspectorate of Prisons told us they "consistently observe acute staff shortages within prison health provision and this is often the primary reason for gaps in provision."[165]

122. The security clearance process for those applying to work in prison can exacerbate recruitment challenges. The length of time in gaining clearance results in successful applicants withdrawing their interest before starting. The use of agency staff is widespread in prisons, which, according to CQC, can make it "difficult to ensure a consistently adequate skill-mix to deliver community-equivalent services".[166]

123. Former prisoners have a lot of experience and insight that could be usefully deployed within prisons. However, we heard public sector prisons are often restricted from employing ex-offenders, whereas privately run prisons have more flexibility. A representative from G4S mentioned how ex-offenders have been employed in their prisons and are allowed to carry keys. Similarly, Craig Thomson, Director at HMP Thameside, run by Serco, told us that the company has employed 3 ex-offenders as apprentices across its wider business portfolio (e.g. supporting prisoners to find accommodation post-release). Mr Thomson

161 Care Quality Commission (PRH0004)
162 Ministry of Justice, HM Prison and Probation Service workforce quarterly: June 2018, 16 August 2018
163 Care Quality Commission (PRH0004), HMI Prisons (PRH0039)
164 HMI Prisons (PRH0039)
165 HMI Prisons (PRH0039)
166 Care Quality Commission (PRH0004)

believes there is an opportunity for ex-prisoners, once they are in a stable position, to be employed as peer mentors to support prisoners on release, as they have been through the process themselves.

124. **Workforce is fundamental to addressing the problems in prisons. We recommend that the National Prison Health Board should develop a workforce plan to underpin a whole prison approach. The plan should set out how it will ensure there are sufficient and stable staffing levels and how it will fill key gaps in the skills and skill-mix of the prison workforce.**

Oversight, commissioning and regulation

125. The prison service is poor at spreading best practice and learning lessons, both from serious incidents, including deaths, and from inspections. There are pockets of good practice across the prison estate, but such practice is not widely adopted. HMIP, CQC and the Prison and Probation Ombudsman stressed that the prison service frequently fails to implement recommendations following inspections and investigations, including ones which the MoJ, HMPPS and prisons agree with.[167]

Commissioning

126. Currently the model of provision in prisons varies considerably across the estate. Variation, in itself, is not a bad thing, but we heard that inconsistencies, particularly gaps in the provision in some places, has led to poor health outcomes.[168] We were particularly concerned to hear that contracts do not always reflect the prison's population need and that there are significant gaps in services such as dentistry, counselling and mental health services (particularly services for people with mild to moderate mental health needs), speech and language therapy and social care, including support for people with learning disabilities.

127. Health and care provision in prisons is delivered by a multitude of different providers specialising in different areas. This fragmentation of delivery can lead to a lack of continuity of care for prisoners. We are concerned to hear about the use of short-term contracts, in which providers frequently have to re-tender, since this can disrupt the continuity prisoners experience (e.g. as staff leave when contracts change hands) and acts as a disincentive for current providers to improve services. We are pleased to hear that longer-term contracts, informed by more robust data on needs, are beginning to address these problems. However, commissioners should remain vigilant and flexible to ensure contracts cater for changes in demand, which can be unpredictable. For example, Care UK told us that the contracts it has to provide care in prisons do not necessarily reflect the increase in demand its services have seen following the increasing use of novel psychoactive substances.[169]

128. Co-commissioning between NHS England and individual prisons is a welcome step, particularly in encouraging shared ownership of healthcare provision. The transfer of responsibility for commissioning healthcare to NHS England in 2013 has broadly been a

167 Care Quality Commission (PRH0004), HMI Prisons (PRH0039), Prisons and Probation Ombudsman (PRH0017)
168 HMI Prisons (PRH0039)
169 Care UK (PRH0025)

very positive change. However, it has created some dissonance between the priorities of different organisations responsible for prisoners' health and care, which co-commissioning can help address.

129. More broadly, the Care Quality Commission told us that the quality of strategic relationships between the prison service, commissioners and other services varies. These relationships are important as the governance arrangements covering prison services, including healthcare, creates barriers to making even small changes (see the note on our visit to HMP Thameside at Annex 1).

130. The commissioning of health and care in prisons, and for people in touch with the criminal justice system, should facilitate the whole prison and whole system approaches outlined above. It should do so first and foremost by reinforcing a shared ownership for the achievement of equitable standards and health outcomes among all services. An effective approach to commissioning would also ensure people in prisons have access to a broader range of health and care services that reflect their diverse and complex needs, and that they experience continuity in their care.

131. **There must be strategic relationships locally in which leaders have shared ownership of making prisons safer and healthier, with better joined-up decision making, for example when commissioning services. In response to this report the National Prison Healthcare Board should set out its assessment of the effectiveness of co-commissioning and whether, and over what timeframe, this approach could be spread more widely. As part of its future work plans, we recommend the Board include a priority to strengthen the quality of local strategic relationships, beginning with increasing the engagement and joint working between key bodies. Prison Governors have a crucial role to play, particularly since they have a duty of care towards prisoners. However, they currently lack the financial and other levers to drive improvement. In response to this report, we recommend that the National Prison Healthcare Board set out how it will foster shared ownership among local bodies, and how it will empower governors to make their prisons safer and healthier.**

132. **We recommend the Secretary of State for Health use Section 48 of the Health and Social Care Act 2008 to instruct the CQC to conduct a special review of the commissioning of health and social care in a number of prisons and report next year.**

Regulation and inspection

133. A whole prison approach and equivalency in standards and health outcomes for prisoners, as in the population as a whole, should be reinforced by a rigorous, respected inspection regime that supports the Government, prisons and providers of prison health and social care to improve. Such a regime needs to provide a robust picture of the state of health and care in prisons and drive up standards up ensuring best practice is shared, and, most importantly, lessons are learnt.

134. Unfortunately, the prison service frequently fails to learn lessons in response to concerns that are raised, including from inspections. HMIP, unlike CQC, does not have enforcement powers to take legal action against prisons. HMIP and CQC frequently find recommendations for improvements inside prisons are not achieved, or only partially achieved. HMIP note that effective implementation of its recommendations is an indicator

of performance on subsequent inspections. However, when HMIP return to prisons in most cases they have either remained the same or deteriorated. Over the last two years the percentage of recommendations judged as 'not achieved' has exceeded the percentage that has been 'achieved'.[170]

135. The Government has taken steps to ensure lessons are learnt following inspections. These include:

- extra capacity for HMIP to follow up inspections; Peter Clark, the Chief Inspectors of Prisons, told us that HMIP had been granted extra resource to increase the inspectorate's capability to "follow up and report outside the normal routine inspection processes."[171]
- the appointment of Regional Deputy Directors, sitting above prison governors, to monitor the implementation of inspection recommendations; and
- a new ministerial unit to track the implementation of recommendations.

These are welcome steps forward, but we are sceptical about whether they are sufficient to ensure lessons are learnt effectively.

136. Currently CQC's judgements inform the score HMIP awards to prisons under its 'respect' test. CQC told us significant breaches of fundamental standards may not receive sufficient attention as other aspects of a prison that come under HMIP's respect test are "disproportionately positive" and outweigh CQC's judgements.

137. In practice, while they claim to conduct unannounced inspections in prisons, CQC must notify the prison in advance, usually several days before. We accept there can be valid reasons for notice to be given in some circumstances (e.g. to ensure inspectors can visit the services and speak to the people they need to), but we believe it is in the interest of prisoners that an "unannounced inspection" is in fact unannounced.

138. **The voice of Her Majesty's Inspectorate of Prisons must be listened to and acted on. It is unacceptable that so many recommendations are not acted upon and that standards frequently decline between inspections. There must be greater accountability for these failures and in responding to this report the Government should set out who is accountable. We recommend that the Government should commission an independent evaluation of the new measures it has introduced to ensure the inspectorate's recommendations are acted on. This evaluation should inform a dialogue with the sector, including user charities, professional bodies and academics, about what further proportionate regulatory measures and enforcement powers are needed to drive up standards.**

139. **To help drive equivalent standards and health outcomes, we recommend greater prominence should be given to CQC's judgements in HMIP reports and that legal powers of entry into prisons should be granted to CQC inspectors.**

140. **We recommend that HMIP's inspection reports, which CQC contribute to, should provide a clear rating about the extent to which prisons enable prisoners to live healthy lives. A rating should include not only the quality of health and social care**

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provision in prison, but the extent to which all aspects of prison life enable prisoners to enjoy their fundamental right to health. A rating for each prison will support the implementation of a whole prison approach to health and care. We recommend, as part of the implementation of a whole prison approach, that CQC and HMIP work with stakeholders to develop a rating system.

141. **We recommend CQC should assess the range of services provided in prisons, including mental health, physical health (older people, adolescents), substance misuse, dentistry as well as the prison environment, against their five criteria (safe, effective, caring, responsive and well-led).**

142. **Where a health and social care provider delivers services in prisons, the Care Quality Commission's rating system should convey, as it does for other health and care services, the quality of care delivered to prisoners against each of CQC's five key questions, namely whether the service is safe, effective, caring, responsive and well-led. We recommend where a provider delivers services in prisons that these services are classified as a core service under CQC's rating scheme.**

Conclusions and recommendations

The state of health and care in English prisons

1. Governments, according to the World Health Organisation, have "a special duty of care for those in places of detention which should cover safety, basic needs and recognition of human rights, including the right to health." The Government is failing in this duty of care towards people detained in prisons in England. Too many prisoners remain in unsafe, unsanitary conditions that fall far short of the standards we should expect. The Government must urgently fulfil its special duty of care for prisoners. (Paragraph 9)

People detained in prison

2. We recommend that the National Prison Healthcare Board work with stakeholders over the next 12 months to agree a definition of "equivalent care" and indicators to measure the extent to which people detained in prison receive at least equivalent standards of care, and achieve equivalent health outcomes, as the population as a whole—in other words, to measure the health inequalities of people detained in prison. (Paragraph 35)

3. In the meantime, in all future iterations of its strategy and plans, including its national partnership agreement, the National Prison Healthcare Board should explicitly state its commitment to achieve equivalent standards and health outcomes for people detained in prisons, compared to the population as a whole—that is, to reduce health inequality. Its plans should include an explanation of how its action to improve access to healthcare and enable prisoners to lead healthy lives will reduce health inequality. (Paragraph 36)

People's journey through prison

4. We are disappointed that nearly a decade on from the Bradley report in 2009, liaison and diversion services do not yet exist in nearly 20% of the country. In the response to this report, the National Prison Healthcare Board should set out the remaining areas where it needs to roll out these services, the reasons for the delay and how the roll-out of these services to the rest of the country will be achieved. (Paragraph 40)

5. We are also disappointed by the decline in the use of hospital orders, despite liaison and diversion services identifying more people with vulnerabilities who may be more appropriately directed to other services besides prisons. The Board should set out the reasons for the decline in hospital orders, what action it is taking to reverse that decline, and by when that action will be completed. There must also be sufficient resourcing of community mental health services so that people are not sent to prison because of a lack of appropriate community mental health care. (Paragraph 41)

6. Imprisonment represents an opportunity to identify, effectively diagnose and treat health and care needs, some of which may be drivers of behavioural problems, which may have gone unrecognised and/or unmet. We recommend that over the next 12 months the National Prison Healthcare Board, in collaboration with stakeholders,

particularly those representative of health and care professions, develop a more comprehensive and robust approach to health screening in prisons, capable of testing for a broader range of health and care needs. Once a new approach is designed its implementation must be supported by a training programme for staff carrying out assessments. (Paragraph 47)

7. In its next annual report, we recommend that Her Majesty's Inspectorate of Prisons comment specifically on the quality of health screenings, including the extent to which prisons are conducting a second health screening within 7 days. (Paragraph 48)

8. In response to this report, the Government should set out what its plan is to ensure that all prisons are clean and sanitary all of the time and by when and how they expect to stop overcrowding. (Paragraph 53)

9. In response to this report, we request that the Government set out its future plans for the recruitment of prison officers, including a date by when it expects to have enough prison officers in post to ensure the overwhelming majority of prisoners can be unlocked for the recommended 10 hours per day. (Paragraph 57)

10. The Government's approach to prison reform emphasises the importance of harnessing incentives. Incentives should encourage prisoners to lead healthy lives. In addition, incentives should not deny prisoners regular access to facilities and activities that enable them to maintain basic standards of health and wellbeing. This point should be made clear in guidance on how prisons and prison staff use incentives. People in prison should not in effect be sentenced to a reduction in life expectancy or worsening health. (Paragraph 58)

11. The Government must urgently ensure that all prisoners have access to a reasonable quantity and quality of food which supports health and wellbeing rather than adversely affecting it. Public Health England should carry out an assessment to determine whether the daily food budget of £2 per person can realistically deliver this objective and review the national food standards in prison, which should be consistently implemented across the prison estate. (Paragraph 60)

12. The Government in its response should set out how it intends to drastically reduce the number of missed appointments both in and outside prison across the prison estate to ensure that clinical need is always met. (Paragraph 75)

13. We agree with the Independent Advisory Panel on Deaths in Custody that drug-related deaths in prison should be clearly recorded. We recommend that in the Government's official response to this report the Ministry of Justice set out the steps it intends to take to ensure that happens. (Paragraph 80)

14. We recommend the approach to health screening is modified to enable prisons to get a much more comprehensive understanding of people within their prison who have a pre-existing substance misuse problem. The approach to screening should also enable prison healthcare providers to identify, and assist, those who develop such a problem during their sentence. (Paragraph 81)

15. The National Prison Healthcare Board's Partnership Agreement states that it will "continue work at all levels to reduce the impact of substance misuse (including

from the use of psychoactive substances), to address the risks of misuse and resultant harms, and to ensure the right help is available at the right time." This statement of intent is very vague. In its place we recommend the National Prison Healthcare Board commit to reducing substance misuse in prison, as well as its impact, and set clear and ambitious targets for:

(a) reducing the supply of, and demand for, illicit drugs in prisons; and

(b) improving the recovery, and associated health outcomes, of people in prison with a substance misuse problem. (Paragraph 82)

16. There are well known risks relating to suicide and self-harm for people in prison. While rates of self-inflicted deaths in prisons have fallen since reaching a peak in 2016, there is no room for complacency as incidences of self-harm remain at a record high. We expect to see a concerted effort from Government to reduce suicide and self-harm in prison, supported by ambitious targets and a clear and credible plan for achieving them. The newly identified role of a minister with responsibility for suicide prevention is welcome, but we expect the Government within its response to report on how this role will extend to suicides and self-harm within prisons and on release. (Paragraph 88)

17. The National Prison Healthcare Board's agreement states that between 2018–21 it plans to "continue to work collaboratively to improve practice to reduce incidents of self-harm and self-inflicted deaths in the adult secure estate, by strengthening multi-agency approaches to managing prisoners at serious risk of harm and further embedding shared learning." Like the reference to substance misuse described above, this is too vague. The Board should set clear reduction targets and measures of success for this period, including improving access to psychological therapies, especially for those with mild to moderate mental health needs. (Paragraph 89)

18. In response to this report, we recommend that the Board set out the level of reduction in waiting times for transfers to secure mental health facilities it plans to achieve in each of the remaining years of the its partnership agreement (2018/19, 2019/20 and 2020/21). We also recommend that the Board set out its plans for expanding the number of secure hospital beds, including dates by which extra capacity will be operational and the contribution this extra capacity will make to reducing waiting times. (Paragraph 90)

19. We recommend a target should be introduced for all of the 50 local authority areas with prisons to have a memorandum of understanding on the provision of social care in place with each prison in their area in the next year. (Paragraph 95)

20. We recommend that the Government undertake a thorough investigation of deaths during post-release supervision in the community, including the reasons for the rise in death rate that has been described. We further recommend that the Government clarify where responsibility for oversight of such deaths should lie and set out a plan to reduce this death rate. (Paragraph 100)

Breaking the cycle of disadvantage: a whole system approach

21. We recommend that the Government's evaluation of the female offenders' strategy should assess the merits of applying similar approaches to other parts of the prison population. In particular, we recommend that the evaluation should comment specifically on the extent to which a similar approach could be introduced for those with complex needs who would otherwise be given short custodial sentences. (Paragraph 106)

22. We recommend that the Government's programme of prison reform, and the way it talks about its plans for reform, should place greater emphasis on health, wellbeing, care and recovery. Improving the health, wellbeing, care and recovery of people detained in prison will help improve the safety of prisons and reduce reoffending. (Paragraph 111)

23. The Board's intention to develop and implement a whole prison approach to health and well-being is the right one. We recommend this priority should be given much more prominence within its future plans. (Paragraph 117)

24. In order to ensure that it is successful, much more work is needed to arrive at a shared understanding of what a whole prison approach looks like and how such an approach and best practice can be effectively implemented. The National Prison Healthcare Board, Her Majesty's Inspectorate of Prisons, the Care Quality Commission and National Institute for Health and Care Excellence should work with a group of national stakeholders over the next 12 months to define the core principles of a whole prison approach, together with guidance and resources to support prison governors and the appointed regional directors to develop more detailed plans for implementation at local level. (Paragraph 118)

25. Workforce is fundamental to addressing the problems in prisons. We recommend that the National Prison Healthcare Board should develop a workforce plan to underpin a whole prison approach. The plan should set out how it will ensure there are sufficient and stable staffing levels and how it will fill key gaps in the skills and skill-mix of the prison workforce. (Paragraph 124)

26. There must be strategic relationships locally in which leaders have shared ownership of making prisons safer and healthier, with better joined-up decision making, for example when commissioning services. In response to this report the National Prison Healthcare Board should set out its assessment of the effectiveness of co-commissioning and whether, and over what timeframe, this approach could be spread more widely. As part of its future work plans, we recommend the Board include a priority to strengthen the quality of local strategic relationships, beginning with increasing the engagement and joint working between key bodies. Prison Governors have a crucial role to play, particularly since they have a duty of care towards prisoners. However, they currently lack the financial and other levers to drive improvement. In response to this report, we recommend that the National Prison Healthcare Board set out how it will foster shared ownership among local bodies, and how it will empower governors to make their prisons safer and healthier. (Paragraph 131)

27. We recommend the Secretary of State for Health use Section 48 of the Health and Social Care Act 2008 to instruct the CQC to conduct a special review of the commissioning of health and social care in a number of prisons and report next year. (Paragraph 132)

28. The voice of Her Majesty's Inspectorate of Prisons must be listened to and acted on. It is unacceptable that so many recommendations are not acted upon and that standards frequently decline between inspections. There must be greater accountability for these failures and in responding to this report the Government should set out who is accountable. We recommend that the Government should commission an independent evaluation of the new measures it has introduced to ensure the inspectorate's recommendations are acted on. This evaluation should inform a dialogue with the sector, including user charities, professional bodies and academics, about what further proportionate regulatory measures and enforcement powers are needed to drive up standards. (Paragraph 138)

29. To help drive equivalent standards and health outcomes, we recommend greater prominence should be given to CQC's judgements in HMIP reports and that legal powers of entry into prisons should be granted to CQC inspectors. (Paragraph 139)

30. We recommend that HMIP's inspection reports, which CQC contribute to, should provide a clear rating about the extent to which prisons enable prisoners to live healthy lives. A rating should include not only the quality of health and social care provision in prison, but the extent to which all aspects of prison life enable prisoners to enjoy their fundamental right to health. A rating for each prison will support the implementation of a whole prison approach to health and care. We recommend, as part of the implementation of a whole prison approach, that CQC and HMIP work with stakeholders to develop a rating system. (Paragraph 140)

31. We recommend CQC should assess the range of services provided in prisons, including mental health, physical health (older people, adolescents), substance misuse, dentistry as well as the prison environment, against their five criteria (safe, effective, caring, responsive and well-led). (Paragraph 141)

32. Where a health and social care provider delivers services in prisons, the Care Quality Commission's rating system should convey, as it does for other health and care services, the quality of care delivered to prisoners against each of CQC's five key questions, namely whether the service is safe, effective, caring, responsive and well-led. We recommend where a provider delivers services in prisons that these services are classified as a core service under CQC's rating scheme. (Paragraph 142)

Annex 1: Visit to the Greenwich cluster

As part of our inquiry we visited the Greenwich Cluster in South East London in June. The cluster is home to three prisons: HMP Belmarsh, HMP Thameside and HMP/YOI Isis. The following sections provide a summary of our visit to each prison.

HMP Thameside

Overview of the prison

HMP Thameside is a local category B prison in London run by Serco, which opened in 2012. The prison predominately serves the London boroughs of Newham, Lewisham, Greenwich and Tower Hamlets. There are 1232 prisoners and 191 prison officers.

Thameside, we were told, was originally intended to cater predominately for prisoners on remand. However, in practice remand prisoners only account for around 30% of the prison's population. Typically, the remaining 70% of people in Thameside have received a conviction, mainly for violent offences; around fifty-five per cent of Thameside's population, we were told, were serving time for violent offences.

Craig Thomson, the prison's director told us, Thameside is London's busiest prison. The turnover of the population is exceptionally high, with many prisoners only serving very short sentences of 5 to 10 days. At the time of our visit, the average length of stay was 38days. This average is dramatically increased by the other side of the prison's population, which is much more stable, consisting of prisoners serving 4–10year sentences alongside a small proportion of prisoners on life sentences or indeterminate sentences.

Sixty per cent of Thameside's population are from black or ethnic minority backgrounds. Eighty per cent have a substance misuse problem and 55% have a mental health problem. Autism and other learning disabilities, senior leaders told us, are also prevalent among Thameside's population.

Mr Thomson described how the prison's fluctuating population is in part linked to high levels of reoffending across London, which in turn is linked to wider social issues. A strong message is that the prison population mirrors and magnifies problems in the population at large. Perhaps the most shocking statistic we heard was that 45% of people released from Thameside are released homeless. In Thameside they get a warm bed, meals, access to healthcare and a television. For some, the alternative is sleeping rough. We heard that prisoners released as homeless sometimes deliberately go to one of the four London Boroughs served by Thameside to commit an offence, so they can come back.

Craig Thomson, alongside other members of Thameside's senior management team, have spent the vast majority of their careers in the prison service. The criminal justice system, senior leaders told us, operates is cycles. For many, the pressures currently on Thameside in many respects are longstanding challenges on the prison service, albeit with some notable exceptions. For example, levels of violence and the complexity of health needs.

One senior prison officer, who had served in many prisons including others on the cluster, spoke about a dramatic increase in the prison population over the last 24 years. When he joined the service in 1994, he mentioned there were 27,000 prison officers to 40,000

prisoners, whereas more recently the prison population has doubled to just under 90,000, but the workforce has remained the same. He described how in his view, there is a lot in the media about other public service professions: doctors, nurses, policeman, teachers. Prison officers, in contrast, he argued are largely forgotten.

In our discussion with the prison's senior management team, we were told that violence has always been a problem in prisons, but recent trends are particularly high. Prison officers at Thameside told us that gang violence is problem inside the prison. Officers described how they have to be aware of changes to gang culture in the boroughs they serve in order to manage the prison safely. The prison receives regular reports from Catch 22 about trends in gang culture, although they often have heard the information from inmates before these reports arrive. They have to be aware of these changes and take steps to segregate people from different gangs. This adds another complexity. New inmates, with particular needs and characteristics, can impact how wings are run, thereby having a knock-on effect on the regime, including healthcare.

Prison officers at Thameside

We spoke to a group prison officers, most of whom were relatively young, in their 20s and 30s, although one officer was in his mid-fifties. The needs of the prisoners they work with means they perform the role of a nurse, friend, parent, a social worker or even, on rare occasions, "a firefighter." If an incident occurs, officers are the first ones on the scene. They have to make snap decisions about the nature and severity of an incident. A code red indicates the presence of blood, a code blue that the injured party is not breathing. They then have to call the healthcare team who respond to all incidents. Prison and healthcare staff frequently negotiate to strike a balance between the need to provide immediate care to a prisoner and the need to ensure there are enough staff left to keep the wings safe. Night shifts we heard are often the most vulnerable time, as prisoners are locked up and the staff levels are therefore lower.

The prison officers at Thameside enjoyed their jobs. The officers, all bar one, did not hesitate to raise their hand when asked whether they had chosen the right career. Their roles are varied. The newest recruit had been in the job for only 5months, having had eight weeks training. She mentioned how one of the prisoners, who had ADHD, would not settle when she first arrived and frequently ran around and refused to return to his cell. She spoke with personal satisfaction about the rapport she had built with him in a relatively short time and the positive change in his behaviour. The value placed on building a rapport with prisoners, supporting them and making a positive difference in their lives was evident from the director right through to the frontline staff. The prison ethos, exemplified by the staff, was very much one of instilling a hope in prisoners.

Health and healthcare at Thameside

During our visit, we spoke to senior management, including a senior member of staff from the healthcare provider, about issues concerning health and healthcare at Thameside. We also met with five prisoners to discuss their experiences and those of their fellow inmates. All five prisoners made a clear distinction between their experience at Thameside and what they collectively described as HMP. While access to healthcare was sometimes hit and miss, and there were problems with the continuity of care, the experience at

Thameside was much better than HMP. There was a strong sense that the prison listened to the prisoners and gave them a voice. Prisoners and prison staff had a rapport and the prisoners described feeling listened too, rather than alienated.

The health and care needs of people inside Thameside

The health needs of people inside prison had become more complex, according to a senior member of staff. Demand for healthcare inside Thameside is high. 900 of the 1300 prisoners are on some form of medication. The prison administers 3000 scripts per month and 60 doses of methadone a day. There are 100 requests each day for an appointment to see one of the healthcare team. These are processed through an online system, which is accessible to all the healthcare professionals working in the prison, who then triage the calls.

Screening

All prisoners are screened upon arrival and then receive a secondary screening from a nurse. This not only includes examinations for communicable diseases such as Hep B, but also mental health and other healthcare needs. The senior leaders were very mindful of the significant impact the first few days inside prison can have for people, particularly on their mental health. The prison operates an early day's process, whereby new arrivals are on a separate wing for 5 days before moving on.

Mental health

The prison operated a peer mentor scheme in which prisoners are trained and paid to provide support to people potentially in a crisis. Prison Officers, responsible for the ACCT process, were clearly visible with bright orange ribbons. The last suicide at Thameside was in 2015. However, self-harm remained an issue. Common acts of self-harm were superficial cuts, but also ligatures.

Healthcare appointments

Prisoners acknowledged that some staff could be very busy and this had a negative impact on access to care. However, the prisoners themselves could also abuse the system. An appointment is an opportunity to get out of the cell, speak to one of your friends or at least someone else. One of the older prisoners mentioned that some prisoners "cry wolf" for these reasons. Access problems are often exacerbated by the lack of any pharmacy equivalent inside prisons. Prisoners need to make an appointment for even minor ailments like a cold or a headache, which outside are dealt with over the counter. Also, delays are also caused by the risks of giving some prisoners access to more than a day's worth of medication. For prisoners that could be trusted, they could access a week's supply, but for others this was not possible.

One problem at Thameside was backlog of prisoners waiting for external appointments. We heard that this, in part, was fuelled by a contractual arrangement in which Thameside is only contracted to provide 2 prison escorts a day. When prisoners arrive at hospital, some NHS trusts expedite their treatment, recognising the constraints these appointments make on a prison's resources. Some NHS trusts provide prisoners and prison staff with a private room. There was a strong sense from within the room that this is good practice.

Prisoners are clearly handcuffed, so a side room helps maintain their dignity. However, this is also hit and miss. Prison officers who have been injured are also rarely prioritised. We heard that prison officers have had to wait for long periods, up to 12 hours, for prisoners to be seen.

Prison environment and regime

In stark contrast to the conditions at HMP Belmarsh, the environment at Thameside appeared much healthier. The conditions in Thameside provided prisoners with the opportunity to live healthy lives during their incarceration. For example, walking from the entrance to one of the wings, we saw a modern 3G football pitch. Prisoners also have access to gym facilities.

We were told that prisoners at Thameside spent 7–8hours a day out of their cells. This is below the recommended 10 hours, but higher than many other establishments. One senior leader described how the regime is rotated to give prisoners time out of their cells. One wing is unlocked in the morning while the other wing is locked up. This is then reversed in the afternoon.

The prisoners spoke positively about the kitchen, particularly in comparison to, as they put it, HMP, although the options in the canteen were limited. This was another area in which the prisoners were listened too. For example, prisoners asked for hot meals for lunch and cold ones for dinner, instead of the other way around, which the kitchen now provides.

From what we saw at Thameside, the social aspect of a prisoner's life was well respected. Prisoners have 7 events a month, which they can use to book family visits. There is a monthly family day, a homework club and other opportunities for prisoners to see their partners, children and babies. The visitor's centre is welcoming with a small children's play area in the corner. One older prisoner with young children told us how these days enable him to see his family regularly and maintain contact, and he spoke with enthusiasm about this aspect of the prison's provision.

Life after prison is also taken into account at Thameside. Senior leaders spoke of a self-funded scheme which has helped 263 prisoners into full-time work and education, with recent leavers taking up positions at Pret and other well-known companies. Another prisoner we spoke to was studying with the Open University. His education prior to coming into Thameside had been very limited. He spoke fondly, and with gratitude, about the opportunity Thameside had provided.

Commissioning

Senior leaders of Thameside prison and Oxleas NHS Foundation Trust, the main healthcare provision for the cluster, had a positive relationship. However, the commissioning arrangements are very complex and cause problems. Thameside is PFI prison. The HMPPS' contract for the service sits with the special purpose vehicle holding the PFI contract, which then subcontracts Serco. HMPPS have a separate contract with NHS England who commission healthcare provision at Thameside from Oxleas. There were a few notable instances where these arrangements caused problems. One example was the provision of pharmacy services.

The duty of care for prisoners at Thameside, Mr Thomson told us, rests on his shoulders, yet he has little control over the delivery of healthcare services in the prison. Similarly, senior staff told us that prison governors have fewer levers at their disposal to incentivise good behaviour than they had in the past. One example, is that changes to a prisoner's sentences are now overseen by an independent adjudicator, whereas governors previously had some discretion that enabled them to shorten sentences in reward for good behaviour. The police are responsible for investigating assaults on prison staff by prisoners. However, we heard that frequently these investigations come back with no further action taken. This has a significant impact of prison staff as acts against them are not seen to be given sufficient concern.

HMP Belmarsh

Overview of HMP Belmarsh

HMP Belmarsh is a local prison serving the Central Criminal Court and Magistrates' Court in South East London and parts of Essex. The prison opened in 1991. Belmarsh was very different to the other prisons we saw. From the moment we entered, the security was much more stringent.

The population is very mixed, ranging from Category A to Category D prisoners. However, only the very high-risk prisoners are likely to stay for long, as offenders may come to Belmarsh before being moved onto other prisons. At the time of our visit, Belmarsh had several Category D prisoners, due to issues with placements, who are managed under the same level of security as the Category A prisoners.

Healthcare

The healthcare unit at HMP Belmarsh manages mental health, physical health and substance misuse issues. We were told that the health services had improved, but still have far to go. There is 24/7 nursing cover on the unit, which is more intense than on the prison wings. Staff reported that there are no telemedicine facilities at Belmarsh, despite the fact that this equipment was installed, as the service was never commissioned. The hardware is now sadly out of date. The prison is due to receive mobile MRI services, have scanners brought in, and to have orthopaedic services provided.

Screening

During the first day, upon arriving at the prison, prisoners will have an assessment covering physical health, mental health and substance use issues, with prisoners triaged to identify the most serious issues. On the second day, prisoners have a CBT-focused health and wellbeing assessment. We were informed that there is always a GP available for reception on the first night.

We discussed sexual health and were told that the prison have been promoting BBV opt-out testing and that they have a BBV/Hepatitis C day coming up. Hep B vaccination is offered to prisoners on arrival. Oxleas subcontract sexual health services to Lewisham and Greenwich and the prison has a dedicated GUM nurse. We were informed that condoms are available in the healthcare area and can be obtained from the nurse. We

were informed that screening for autism spectrum disorder forms part of the screening process. The head of healthcare raised the following points as areas currently lacking in healthcare provision at HMP Belmarsh:

- Tissue viability (healthcare ask colleagues to come in, but this is not a commissioned service)
- Wheelchair services
- Speech and language therapy (SALT). We were told there is no access to SALT services in Belmarsh and that this has been raised with NHS England.

Mental health

At the time of our visit to the First Night Centre, we were told that 31 prisoners were on an ACCT. We were informed that this number usually runs between 20 and 30. A senior leader explained that an ACCT is opened when someone has harmed or has threaten to harm themselves. The need for an ACCT can be identified at any point from reception. The prisoners on an ACCT when we visited were all on normal location (e.g. in their cells). However, we were informed that any prisoner assessed as being an imminent risk is put on constant watch and may be moved to the healthcare unit.

We were told that families would not ordinarily be informed if someone has been placed under ACCT, as this would need the prisoner's consent. However, if something does happen to a prisoner then the family will be informed within 72hrs. Dr Sarah Wollaston MP asked about the form of words around asking for consent to inform families about suicide risks. Oxleas stated that they are in the process of modifying the prison suicide strategy and will take this on board. Oxleas told us that they have started a families' forum and we also heard that the Samaritans run a listener's scheme at the prison.

One of the healthcare team, when asked about the transfer of patients to a secure mental health hospital, mentioned that the 14-day target is unrealistic. The process from assessment to getting a bed is long, although the prison has a transfer coordinator to help facilitate the process. While this improved the timeliness of transfers, it still takes between 6–8weeks to transfer a prisoner from HMP Belmarsh to Broadmoor. The main obstacle being a lack of secure mental health beds.

Prison environment and regime

Belmarsh's operational capacity is 910, with a certified normal accommodation of 760. The prison submits weekly stability reports. These reports include a traffic light system, in which the prison reports the level of regime they are currently offering. Red is the most restricted regime, where time out of cells is restricted to providing food and administering medication. A green regime, while a subject of debate, allows more time out of cell to engage in activities. The prison's regime goes in peaks and troughs, but over the last couple of years has consistently been at red/amber.

Prisoners, we were informed, are meant to be out of their cells for eight hours per day, but that the prison has had insufficient staff and a lack of space to manage this. Until recently, some prisoners were only coming out of their cell once every third day, when they might shower or use the phone, apart from time out to collect their meals or for a short period of

exercise. A lack of time outside of their cells, we heard, limits prisoners' access to fresh air and sunlight and their ability to remain physically active. If prisoners are unemployed, we were told, then they might spend 22–23 hours per day in their cell.

Restrictions to the regime are mainly driven by staffing levels. We were told that the prison had had a recruitment drive. One officer we spoke to informed us that the preceding weekend was the first weekend that he'd been on which was fully staffed for some time. He reported that the atmosphere was much better that weekend. For instance, he noted that it was relaxed, and prisoners were able to talk to their families. He emphasised that this is important for dynamic security in which officers pick up on issues early by talking to prisoners. We were informed that ensuring adequate staffing would 'absolutely' be their foremost recommendation for a healthy prison. A prison officer reported that it is 'painful' not to be able to do the basics of the job.

We were shown a three-bed cell, consisting of a bunk bed on the left-hand side and another bed up against the opposite wall. The gap between the two beds appeared to be about a metre wide. Room to move around the cell was limited; if all three men were standing there was not enough space for them to pass each other without touching. To the right-hand side of the entrance there was a sink, a plastic bin and a tiny mirror, about the size of a small paperback book. There was a toilet in the right-hand corner of the room. The toilet had a small door or screen with a small gap below and above. However, not all cells have screen or door. The main door to the room was not barred, but the wall on the other side had a fairly large window, providing some natural light in the cell. There were two cupboards either side of the window, both broken.

Insufficient workplaces restrict the amount of purposeful activity the prison is able to provide. The prison has between 800–850 prisoners, but the workspace capacity is just 50, with 40 additional workspaces for vulnerable prisoners (of whom there are currently 72). Often this work can be extremely tedious such as packing teabags. We were informed that the prison struggles to recruit workshop instructors due to low pay, noting that people would receive higher pay working in a warehouse down the road.

Deaths and serious incidents

At the time of our visit, we were informed that there have been two deaths in HMP Belmarsh so far this year, with one being a 'natural cause' death and the other resulting from suffocation. Staff reported that, in the latter case, the prisoner used substances and showed increasing spice use, but although healthcare offered him help he did not want to engage or stop using substances.

We discussed incidents of sexual assault in the prison and were informed that if these are reported then the police come in. Staff reported that they have only heard of a few incidents, but they suspect that it may be happening more than is reported. We were informed that there is a national HMPPS project, the Truth Project, around sexual abuse, where prisoners are invited to write to the team to have their case considered.

HMP/ YOI Isis

Overview

HMP/YOI Isis is a Category C training and resettlement prison. When it opened in 2010 it initially only held male prisoners from the ages of 18 to 25. However, the cap was removed in 2017 and the prison now accepts prisoners of any age. The Governor, Emily Thomas, informed us that, at the time of the visit, approximately 80% of prisoners were under the age of 30 and 40% were between the ages of 18 to 21. Emily Thomas reported that the certified normal capacity of the prison is 457 and that the operational capacity is 628. On the day of our visit there were 611 prisoners, two less than the day before. 156 of these prisoners were in double cells.

HMP/YOI Isis has an average length of stay of around six months, which means that it has a relatively settled population as compared to some other establishments. We were informed, however, that changes to the Home Detention Curfew (HDC) policy is resulting in an increase in turnover. We attended the morning staff meeting, which covered: current occupancy of the prison (611 prisoners), events over the last 24 hours, activity attendance, healthcare appointments, reports on prisoners on ACCT, and on those in segregation, and the findings of prisoner and staff searches.

The prison, we were informed, had been struggling with recruitment and retention. 80% of the prison officers are brand new. The prison recruited around 84 new officers last year, who have now been joining since February 2018. The prison is now reportedly fully staffed, but the staff are inexperienced.

Violence

HMP/YOI Isis receives prisoners from HMP Thameside and HMP Belmarsh, with only around 5% of the population coming from outside of London. HMP Isis has historically had a problem with violence. The Governor explained that the level of violence seen within the establishment fluctuates. However, current causes of violence inside Isis appear to be linked more to the illicit economy than gang rivalry. Prisoners aged 21 to 25 are statistically more likely to perpetrate violence inside prison. This was one of the reasons for lifting the prison's age cap. Emily Thomas informed us that in the quarterly survey, prisoners' responses were 50/50 as to whether they felt that violence was managed well, but that 80% reported that they currently felt safe. She explained that they have a new violence reduction policy and incentives policy, through which they are trying to tackle low level violence and antisocial behaviour to prevent escalation.

Drug use

Oxleas NHS Foundation Trust provide substance use services to the prison and we were informed that over half of the prison has engaged with them. HMP/YOI Isis does not tend have problems with Class A drugs. The Governor informed us the age range of the prison population means that they have not tended to see prisoners with engrained drug addiction. However, this has changed since the age cap was lifted; the number of prisoners prescribed methadone is now in double figures.

The use of spice within the establishment has increased, and is thought to be a driver of violence, although spice is not as big of an issue as in other prisons. Primarily, this, we were told, is because cannabis, rather than spice, is the community drug of choice. However, the healthcare manager informed us that there were currently around 20 prisoners whose use of spice was a concern, with around 10 of these being an acute concern. The officers reported that a lot of smoking of psychoactive substances happens overnight, increasing the need for nursing support. There had been spates of medical emergencies and violent incidents in Isis linked to spice, but these occurrences are not as common as in other prisons.

HMP/YOI Isis does not have problems with drones or people throwing drugs over the wall, as the prison is within the walls of HMP Belmarsh. However, we were informed that drugs tend to enter the prison through visitors, staff or in the post. Two members of staff had been arrested in the last two years for supplying substances to prisoners. For example, they had recently discovered that an agency nurse had been bringing substances into the prison. A search of every member of staff was carried out the day before our visit. The Governor told us that there was lack of drug detection dogs, but that they now have these in the prison. The prison is also due to obtain a machine to swab and test mail. The Governor reported that she feels their approach to managing spice use is punitive, as they struggle to get prisoners to engage, but that this approach does not seem to be working. She stated that they are trying to think creatively about how to approach the issue.

Healthcare at HMP/YOI Isis

We were informed that local prisons tend to filter problems before people reach HMP/YOI Isis. For example, all the prisoners in HMP/YOI Isis, at the time of our visit, had been to another prison. Personal and medical information collected at these prisons is then available to HMP/YOI Isis. As a result, Isis do not commonly pick up new diagnoses (such as ASD) and the problems they see tend to be less acute, although they do still see some complex cases. However, the healthcare manager stated that he thinks they may see an increase in prisoners with acute needs over the next 6–12 months as some Category B prisons, such as HMP Thameside, become more like reception prisoners with a high turnover.

Oxleas NHS Foundation Trust is the healthcare provider at HMP/YOI Isis, including substance misuse services. On arrival at the prison there is an initial reception screen and then there is a later, more in-depth, follow-up. The prison runs health and wellbeing sessions which include a health check, which is also part of the gym induction. The prison holds wellbeing days and there are clinics for long-term conditions. HMP/YOI Isis has 24hr nursing cover and are due to have an x-ray machine put in place. We heard of work within the prison around blood-borne viruses (BBVs) and that they have an upcoming event on hepatitis C, during which they are planning to offer testing to all prisoners and to have sessions around awareness.

The provider believes that they can provide more with the money available. We discussed the barriers to providing healthcare with the healthcare manager. These include:

- **the environment**. The security of the establishment is paramount and, therefore, healthcare have to work around the regime, although they reported that they have a good relationship with the prison;

- **staffing**. It is difficult to recruit nurses, there are always vacancies across the three prisons in the cluster. There is a push to move away from use of agency staff as they are so expensive. Clearance processes can take weeks or months and are completed locally and centrally, depending on the level of clearance. The prison's focus is on getting prison staff through and so clearance for health staff can take longer; and
- **engagement with prisoners**. Prisoners can have some indifference about their health.

We spoke to some of the prison officers who informed us that they think that healthcare in HMP Isis does not have a good reputation. They stated that they are not sure whether there are mental health nurses or healthcare assistants on the block, but that they do not seem trained to manage emergencies. They stated that there is only one response nurse for the whole prison, which they do not feel is enough. The officers stated that they think that a lot of hospital journeys could have been saved with a bit of first aid. We were told about the prison social care orderlies programme, through which prisoners are trained to provide support to other prisoners with physical and mental health needs. There is a new cohort ready receive training in July.

Mental health

There are 5 psychiatrist sessions per week and a full-time in-reach team. There are counselling and IAPT (largely providing cognitive behavioural therapy) services and from October 2018 they will be providing a primary care mental health model. To access counselling/IAPT prisoners have an initial assessment and then join a waiting list, which is around 4 weeks on average.

We were informed that there are occasional transfers to psychiatric hospitals, but that "transfers within 14 days do not happen–full stop", noting that such beds are in high demand. The healthcare manager stated that the inpatient facility at HMP Thameside is almost a de facto mental health unit, where there tends to be a lot of prisoners waiting for transfer.

We were informed that there has never been a suicide at Isis and that self-harm levels within the prison are low. It is rare to see double figures of people on open ACCT documents. We were informed that the prison has a high BME population, who also tend to be younger, and they believe that this group are less likely to be on ACCT. Officers noted that self-harm, like spice use, tends to happen at night, although they do not think they see as much self-harm in HMP/YOI Isis as they do in other prisons. One officer stated that he sees self-harm in HMP/YOI Isis as a manipulation tool.

Learning disabilities

There is a learning disability nurse that works across the prisons in the cluster, whose remit also includes prisoners with autism spectrum disorder (ASD) and learning difficulties. The nurse has a small caseload (around 4–5 prisoners) and works collaboratively with prison staff, education staff and peer support workers. We were informed that they do not

currently have any prisoners with acquired brain injuries in HMP/YOI Isis and that such prisoners do not tend to be placed in Category C prisons, but instead tend to be housed in local or specialist units with inpatient units.

Prison environment and regime

We were informed that the prison remains on a restricted regime. The prison is currently running an emergency restricted regime at weekends, in which one house block can come out at a time. The Governor's top priority when it comes to the regime is to move away from the emergency weekend restrictions. We were told that the prison is awaiting a new regime in October.

Purposeful activity

The prison report having space for over 400 prisoners to engage in activities, but that they are unable to use all of it. We were informed that all prisoners should be at work during the day and association in the evening, but that it is not possible to have association in the evening due to staffing levels. Therefore, during the day one block goes on association whilst the other block goes to work. On the current regime the prisoners eat at 5pm and then are locked in their cells from 6pm until 8am.

Segregation unit

On our visit to the segregation unit, one of the prison officers noted that the prisoners in segregation get more input than those on the wings, where it can be easier for people to go under the radar.

Healthcare across the cluster

During our visit to the Greenwich cluster we met with representatives of Oxleas NHS Foundation Trust (the healthcare providers), Change Grow Live (CGL) who provide social care, and NHS England who commission healthcare services in the cluster.

Oxleas NHS Foundation Trust took over the healthcare contract in April 2015. The contract was awarded for 5 years, but with the potential to be extended up to a total of 7 years. The provider tries to mirror interventions across the three prisons in the cluster. However, they also need to respond to changes, such as the new Category C houseblock in HMP Thameside and the removal of the age cap in HMP/YOI Isis.

One change on the horizon is that HMP Wandsworth is due to become a reception prison in the autumn. We were told that going forward this could cause problems as prisons will be receiving people with complex needs or complex medication regimes that they are not able to manage.

Oxleas informed us that 'very few prisons have 24hr healthcare cover', meaning that they have no out of hours GP cover and would rely on sending people to A&E. The provider reported problems when trying to transfer prisoners to other establishments. For example, they are unable to move a prisoner to another establishment if that prison does not provide a particular service or have/manage a certain medication that the prisoner requires.

We heard from Oxleas that it is quite common to have difficulty transferring people to appointments outside of prison due to a lack of escorts. This is an issue everywhere, but Thameside, Wormwood Scrubs and Belmarsh have particularly high Do Not Attend (DNAs) rates compared to other establishments in London.

Four escorts per day would be normal for a local prison. However, HMP Thameside are only contracted to provide two per day. Money has been put in by commissioners for 4 transfers per day, but that HMP Thameside do not have the prison staff to manage these. Only HMP Wandsworth, we heard, is likely to manage four transfers per day. NHS England, we were told, have a Task and Finish Group looking at how to resolve problems with prison escorts.

Healthcare staff informed us that clinicians and operational managers have to make decisions about who to prioritise for appointments. Priority is given to patients on dialysis as well as those requiring two-week-waits (e.g. urgent referrals) and cancer appointments, but other appointments may be deprioritised or cancelled. At the time of the visit, Belmarsh had two prisoners who required dialysis three times per week, which takes up a lot of the transfer slots. We also heard of one occasion in which clinicians and operational staff needed to choose between two prisoners who needed a two-week-wait appointment. The prison healthcare services are not always told that the prison has cancelled a transfer, which means that the healthcare team are not able to warn the hospital and the prisoner may need to be re-referred. We heard of various ways commissioners and providers are trying to address this problem, including:

- putting the provision of prisoner escorts out to tender.
- bringing services into the prison, such as ultrasound, orthopaedic, dental and hepatology services as well as mobile dialysis units.
- using telemedicine. A scoping exercise had concluded that dermatology and ear, nose and throat (ENT) services could be covered by telemedicine.

Oxleas noted that it is also better to have services provided within the prison as prisoners would prefer not to go out cuffed to an officer.

Annex 2: Prison health stakeholder discussion

The Committee held a stakeholder workshop on Thursday 21 June with representatives from across the health and penal systems, including trade associations and professional bodies, charities, NHS and independent providers of prison healthcare and providers of private prisons.

We discussed stakeholders' views on the main problems affecting prison health and healthcare, and on the objectives and priorities set out in the National Prison Healthcare Board's partnership agreement for 2018–21. This note summarises the key points stakeholders made on each of these points.

Key problems

Demand and funding

The system, we heard, is underfunded. Demand for healthcare, and other related needs, in prisons is massive. Services are trying to do as much as they can within the resources available. However, some services are operating on a shoe-string. One participant mentioned that there are historical disparities in the allocation of resources across the country. For example, some prisons, especially prisons in London, are better funded.

Staffing

Staffing is a major concern. This includes prison staff, but also health service staff too. During our discussion we covered the following issues relating to staff: staffing levels, recruitment, retention, training, working conditions and pay.

On staffing levels, one member of the group described that staff are currently firefighting, as staffing levels are not always safe. She emphasised the importance of safeguarding staff in prisons as well as prisoners. One participant referred to schemes in which prisoners are trained to care for other prisoners who are unwell. While encouraged, another participant stressed that such schemes need to be managed well, as it is not right for someone vulnerable to be looking after someone else who is also vulnerable. There was agreement within the group that clear lines need to be drawn on what is appropriate for prisoners to provide.

With regards to recruitment, it is widely acknowledged that there are workforce challenges across the NHS, but that these, we heard strongly, are amplified in prisons. Security clearance, which can take up to 12 months, makes it difficult to recruit new staff, although some prisons were reported to be quicker than others in clearing applications. Part of the problem is also one of capacity, as we heard from one participant that more people are needed to clear applications. As well as increasing capacity to clear applications, we also heard that prison governors could make greater use of their power to override clearance applications to speed up recruitment.

Retention is another important issue. There were two key issues raised here: access to training, including continuing professional development (CPD), and pay. In addition to investing in the workforce, the issue of training and CPD is also a capacity problem. For

example, one participant mentioned that nurses struggle to get away from the day job to engage in training and CPD. This is important as others noted a trend in many staff being unskilled in specific areas, which resulted in more care, particularly relatively basic procedures, being delivered outside of custody. For example, one participant mentioned that patients are often sent out of custody for stitches - a procedure that would traditionally have been done inside prisons.

One participant called for a comprehensive training programme for staff working within prisons, including prison officers and healthcare staff. Integrating provision is difficult, as professions are all trained differently. Forming trusting relationships between professionals working in prison, we heard is crucial to make sure that people don't bounce through prison service. An educational programme which seeks to breakdown these barriers could lead to substantial improvements.

Pay is another problem. The salary uplift for staff on the Agenda for Change contract means private contractors need to find a way to keep their salaries competitive, even though their income will not change. Another participant mentioned that the outsourcing of services had led to a reduction of resources. For example, most prisons do not have overnight cover and operational prison staff have had to make decisions that they shouldn't have had to make. Although there were numbers that operational staff can call for further help they do not always get the information they needed.

Hospital appointments

Escorting prisoners to appointments is a big challenge. In women's prisons this also includes getting babies to appointments for inoculations. We heard of a disparity between the funding allocated for escorting prisoners to appointments outside prison and the costs involved. For example, the funding allocated does not always change in line with changes in the prison population. We heard that some prisoners who need to go to hospital are not prioritised, as they are seen as having a bed in custody.

Prison environment, regime and diet

Overcrowding we heard is a major problem, which affects other aspects of prison life and in turn the health and wellbeing of prisoners. For example, spending 23 hours a day in cell, due to restrictions on the regime, means there is limited chance for people to even move, let alone exercise. There are examples of prisons that are trying to address these problems. For example, the group told us of one prison in Cumbria that is part of Park Run. The prison diet is another problem. For example, we heard that prisoners can sometimes be given their breakfast the night before. Catering for a large amount of people is not easy, especially when there is little money to do it. Talking about women's prisons one participant said it is the first thing female offenders in prison moan about.

The National Prison Healthcare Board's Agreement 2018–21

We heard that the partnership agreement is great as high-level rhetoric, but everything that needs to be put in place must be done from the ground up. If measures don't make a difference to prisoners then they aren't going to be implemented in any substantial way.

Many of the participants held the view that public opinion is important in creating the right environment in which to improve prison healthcare. Some raised the possibility of a positive media campaign to promote the positive work that happens in prisons.

Stakeholder engagement and representation

Participants raised several concerns about the National Prison Healthcare Board and the partnership agreement. Firstly, the Board as it stands does not have a provider or on-the-ground voice, despite those on the ground having important experience and insight. One participant mentioned that the problems at HMP Nottingham, which resulted in the use of an urgent notification by the Chief Inspector of Prisons, would have not surprised those working on the ground.

The group also expressed their disappointment about the lack of stakeholder engagement in the development of the agreement. It is not clear which stakeholders contributed to the agreement, although some believed a very small and selective group was consulted. However, there are no details on who was involved.

Objectives

The National Partnership Agreement set out the Board's three key priorities for the next three years. These are:

- To improve the health and wellbeing of people in prison and reduce health inequalities.
- To reduce reoffending and support rehabilitation by addressing health-related drivers of offending behaviour.
- To support access to and continuity of care through the prison estate, pre-custody and post-custody into the community.

On the first objective, the group discussed the concept of equivalent care between people in prison and the general population. The group saw equivalence of care as a desirable aim for government policy in this area. Equivalence covers all the key components of healthcare: access, quality and outcomes. However, the group considered the most important aspect of equivalent care to be equity of outcomes. In fact, many argued strongly that the people in prison may need enhanced service provision to achieve equivalent outcomes, given the poor health of the prison population. As such, an overarching message from the discussion is that services should reflect the level of need within prison.

On the second objective, we heard that transitions from prison into the community need to be better. Some of these issues relate to when and where prisons are released. For example, releasing prisoners on a Friday often leads to problems. Another issue is that prisoners are released in a different part of the country from where they live.

In general, one participant told us that it is important to distinguish between the delivery of the health service and healthcare objectives. One group emphasised that prison health needs more outcome measures, particularly around substance abuse, alcohol abuse and hepatitis B and hepatitis C testing. We heard that extending the use of Quality Outcomes

Framework into prisons might be a useful way forward here. One participant mentioned that there had been a loss of focus on rehabilitative measures. For example, the substance misuse specification does not include any reference to reducing reoffending.

Priorities

During our discussion we discussed the following key areas identified within the partnership agreement: the development and implementation of a whole prison approach, mental health, including suicide and self-harm, drug use in prison, including the impact of new psychoactive substances, and older prisoners.

A whole prison approach

The National Partnership Agreement set the following priority for 2018–21:

> Develop and apply a whole prison approach to health and wellbeing that ensures the regime, activities and staffing facilitate an environment that promotes good health and wellbeing and reduces violence for all prisoners, including those with protected characteristics.[172]

This was widely considered to be an extremely complex statement. For example, there is no clear definition of what this means. A whole prison approach demands engaging with stakeholders to get their buy-in. Given the number of organisations involved, the scale and nature of the engagement that needs to take place to define a whole prison approach should not be underestimated.

It is not clear from the way the priority is written how the Board intends to develop and implement a whole prison approach. It is also unclear the extent to which a whole prison approach will be defined and applied locally or defined nationally and then applied locally. In favour of the former, one participant mentioned that it is difficult to have a top-down approach to being healthy.

One group mentioned that prison service culture and health service culture are very different, often with a clear divide between the operational side and the health side in prisons, particularly in relation to their priorities. For example, a lack of prison staff on the operational side means that healthcare is often deprioritised. As well as cultural differences between services within prison, we also heard about an us and them mentality between prisons. Prisons also have different processes. For example, each prison, we heard, have separate screening documents and that when prisoners are transferred they undergo a different screening process.

Improving how prisons, and services within prisons, work together is widely considered to be worthwhile in helping to address problems affecting prison health and healthcare. However, health and care provision within prisons can be very fragmented, as different companies are contracted to look after different areas. For example, dentistry, general practice and mental health services in one prison may be delivered by different providers. The commissioning of prison health and care services is an issue. One problem is

172 HM Government and NHS England, National Partnership Agreement for Prison Healthcare in England 2018–2021, April 2018

inconsistencies in services commissioned within prisons, with huge variation across the country. For example, we heard that there can be critical gaps in services commissioned (e.g. dentistry). In addition, we heard the contracts do not always reflect clinical need.

When discussing a whole prison approach, prison service and health service representatives differed on what they considered to be realistic, with the prison service representatives more apprehensive about what can realistically be delivered. However, representatives from both services agreed that prisons with stable prison populations offered the most suitable environments in which to apply a whole prison approach. Prisons with significant fluctuations in their prison populations are much more complex to manage. For example, one participant made the point that those prisons which pick people up off the street often have the most needy populations. Consequently, these prisons also often struggle with recruitment, staffing and morale.

While prison populations vary between different types of prisons, a representative from the prison service, suggested that conditions in some prisons need to be stabilised before any healthcare priorities can be met. Reductions in funding and staffing have negatively affected the stability of some prisons to the extent that healthcare is no longer a priority. For example, why would any prisoner come out of their cell to go for their healthcare appointments if the environment is too dangerous to do so?

Mental health

The best way to prevent self-harm, one participant told us, is not to send people to prison in the first place. We heard that there were people who go into prison with mental health issues who should be in hospital, not prison. We heard that the Prison Reform Trust and Lord Bradley had been doing some work on liaison and diversion schemes to help address this problem. Instead of prison, someone with a mental health problem could be referred to a three to six-month wraparound service, which provides integrated support.

On the issue of stigma surrounding mental health, one participant mentioned that there is stigma outside prison, so it's no surprise it exists inside. The group discussed different ways to address stigma relating to mental health. Being informed about mental health (e.g. education provided within the prison) and having people (chaplaincy and peer mentors) and places to go to talk and share concerns was praised by the group.

Self-harm in prison, we heard, is a holistic problem. However, staffing is critical to addressing it. More officers equal less problems, while less officers equal more problems. However, this is not just an issue of capacity. Experienced officers, we heard, are better equipped to recognise problems.

On reducing self-harm, the group discussed work done by the World Health Organisation which emphasises the need to train prison officers effectively, identify prisoners that are having problems, including going beyond screening to do so, improving the prison environment and dealing with bullying. One participant mentioned that these interventions are well understood, the problem is that doing these things costs money. Ex-prisoners are seen to have valuable experience, which is an under-utilised resource, since they are often prevented from working in prison. However, we heard from one representative of a private prison provider that such restrictions are not the same in the private sector and that former prisoners can be employed and carry keys.

We heard about ways HMP Oakwood are tackling issues of mental health in prison. For example, prisoners are trained as peer mentors. We also heard about the importance of purposeful activity, as work provided for prisoners helps to focus their minds. Without this, prisoners can lack hope for the future.

One group discussed work done on suicide prisons, with a particular focus on allowing families access to prisoners when they are high risk. The extent of family involvement, at the end of the day, is the prisoner's choice. However, things such as not allowing prisoners to use Skype to talk with their families was seen as poor practice.

Drugs and the impact of substance misuse

One group discussed the National Prison Healthcare Board's plans surrounding the use and impact of drugs, including psychoactive substances in prisons. The group discussed different aspects of the problem of drugs in prison.

On demand inside prison, one participant mentioned that people used drugs in prison for all sorts of reasons, but generally those who are healthier are less likely to want drugs. Payment for drugs, the group told us, includes food, sexual activity and credit. Drugs we have heard during this inquiry are linked to violence and have serious effects on people's health. For example, the group told us that use of psychoactive substances is resulting in drug induced psychosis. These substances also pose dangers to staff.

The early response to the rise of psychoactive substances was not good, according to one participant. There was too much focus on tackling the supply side, which didn't work since there is only a supply problem because of the demand. Another representative told us that tackling drugs used to be a Government priority. There was a drugs strategy, but over the last 5 to 10 years joint meetings on drugs had drifted away.

One participant mentioned that Priority 2 on substance misuse, set by the National Prison Healthcare Board, focuses on outputs and processes rather than outcomes. A focus on processes can be a distraction. For example, one participant explained that Health and Justice Indicators of Performance include 210 indicators. In their view, much of this data is not useful and is not used by practitioners. Another participant explained that the National Drug Treatment Monitoring requirements were also very time intensive, including over 100 data items. Providers had to collect, collate and then send this information to Public Health England (PHE). Then two years later, the participant told us, PHE collated all this data and produced a six-page report. We heard that at HMP Wandsworth substance misuse staff are spending 40% of their time on data.

In discussing the approach that should be taken, one group member suggested that a whole system approach to supply and demand reduction, as well as a good emergency response, is needed to tackle this problem. A whole system approach, includes looking at meaningful activity and a healthy diet, which would likely have a positive impact on tackling drugs.

One member mentioned that drugs should not be accepted in prison, but that there should be support for people to come off drugs. Another mentioned that while an approach to reduce the supply of illicit drugs in prisons is important, it is also important to have realistic expectations about the extent to which the prevalence of drug use in prison can

be reduced. One member of the group suggested drug-free wings, as an area where people can be supported to come off drugs. However, another member mentioned that where such areas exist there could be an incentive to deal drugs on those wings.

The group discussed ways to prevent drugs coming into prisons. One member mentioned that there had been improvement in spotting these substances being brought into the prison estate. Technology had a role, according to another representative, but staff still needed to be part of the detection process. We also heard that some of the technology used to detect drugs can have repercussions, especially in cities. For example, mobile blockers can block signal provided in local areas.

Older prisoners

Addressing problems with the built environment is critical to improving care for older prisoners. However, one participant mentioned that this comes back to who is going to pay for this, saying that there is no capital funding around service need. We heard that there is demand for specific services around end-of-life care in prisons. HMP Dartmoor, we heard, is very good at end-of-life care. However, this is primarily because of the people working there rather than anything to do with the building. One participant called for there to be wheelchair-friendly cells.

Formal minutes

Monday 22 October 2018

Members present:

Dr Sarah Wollaston, in the Chair

Luciana Berger Dr Paul Williams

Dr Lisa Cameron

Draft Report (*Prison health*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 142 read and agreed to.

Annexes and Summary agreed to.

Resolved, That the Report be the Twelfth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Tuesday 23 October 2018

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Tuesday 3 July 2018

Sean Cox, Head of Development, User Voice; **Hazel Alcraft**, Development Officer, Health, Clinks; and Stuart Ware, Chief Executive Officer, Restore Support Network. Q1–23

Rebecca Roberts, Head of Policy, INQUEST; and **Elizabeth Moody**, Acting Prisons and Probation Ombudsman. Q24–59

Professor Steve Field, Chief Inspector of General Practice; **Jan Fooks-Bale**, Health & Justice Inspection Manager, Care Quality Commission; **Peter Clarke**, Chief Inspector of Prisons, Her Majesty's Inspectorate of Prisons; and **Paul Tarbuck**, former Head of Healthcare Inspection, Her Majesty's Inspectorate of Prisons. Q60–120

Tuesday 10 July 2018

Frances Crook OBE, Chief Executive, Howard League for Penal Reform; **Dr Jake Hard**, Chair, Royal College of General Practitioners Secure Environments Group; and **Ryan Harman**, Advice & Information Service Manager, Prison Reform Trust. Q121–167

Jackie Doyle-Price MP, Parliamentary Under-Secretary of State for Mental Health and Inequalities, Department of Health and Social Care; **Kate Davies OBE**, Director of Health & Justice, Armed Forces and Sexual Assault Services Commissioning, NHS England; **Dr Éamonn O'Moore**, National Lead for Health and Justice, Public Health England; **Edward Argar MP**, Parliamentary Under-Secretary of State, Ministry of Justice; and **Digby Griffith**, Director of Commissioning and Executive Director of Rehabilitation and Assurance, Her Majesty's Prison and Probation Service. Q168–262

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

PRH numbers are generated by the evidence processing system and so may not be complete.

1 MIMB (PRH0043)

2 Association of Directors of Adult Social Services (ADASS) submission (PRH0051)

3 British Dental Association and the National Association of Prison Dentists UK (PRH0024)

4 British Medical Association (BMA) (PRH0019)

5 Care Quality Commission (PRH0004)

6 Care UK (PRH0025)

7 Catholic Bishops' Conference of England and Wales (PRH0001)

8 Centre for Mental Health (PRH0021)

9 Clare Farm Ruth Bastable (PRH0045)

10 Clinks (PRH0005)

11 DHSC, MoJ, HMPPS, NHS England and PHE (PRH0032)

12 Dr Brian Docherty (PRH0020)

13 Dr Dennis Eady (PRH0011)

14 Dr Emily Glorney (PRH0055)

15 Dr Gerard Bulger (PRH0002)

16 Dr Jake Phillips (PRH0047)

17 Dr Jenny Taylor (PRH0056)

18 Dr mary Piper (PRH0022)

19 False Allegations Support Organisation (UK) (PRH0050)

20 FORWARD TRUST (PRH0058)

21 Gilead Sciences (PRH0016)

22 Hepatitis C Coalition (PRH0048)

23 Her Majesty's Inspectorate of Prisons (PRH0054)

24 HMI Prisons (PRH0039)

25 Independent Advisory Panel on Deaths in Custody (PRH0040)

26 INQUEST (PRH0027)

27 INQUEST (PRH0057)

28 London Clinical Network for Health in Justice & Other Vulnerable Adults NHSE (PRH0042)

29 Martindale Pharma (PRH0015)

30 Northampton Healthcare Foundation Trust (PRH0035)

31 Prison and Offender Research in Social Care and Health Network (PRH0010)

32 Prison Reform Trust (PRH0038)

33 Prisoners Advice Service (PRH0044)
34 Prisons and Probation Ombudsman (PRH0017)
35 Professor Jessica Woodhams (PRH0053)
36 RCSLT (PRH0026)
37 Restore Support Network (PRH0008)
38 Revolving Doors Agency (PRH0046)
39 Revolving Doors Agency (PRH0060)
40 Royal College of GPs (PRH0023)
41 Royal College of Midwives/Birth Companions (PRH0018)
42 Royal College of Nursing (PRH0037)
43 Royal College of Psychiatrists (PRH0014)
44 Secure Environment Pharmacy Group (PRH0034)
45 Serco, HMP Thameside (PRH0059)
46 The British Psychological Society (PRH0036)
47 The College of Podiatry (PRH0061)
48 The Disabilities Trust (PRH0049)
49 The Hepatitis C Trust (PRH0013)
50 The Howard League (PRH0029)
51 UK National Preventive Mechanism (PRH0030)
52 University of Manchester (PRH0003)
53 User Voice (PRH0031)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

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First Report	Appointment of the Chair of NHS Improvement	HC 479
Second Report	The nursing workforce	HC 353 (Cm 9669)
Third Report	Improving air quality	HC 433 (HC 1149)
Fourth Report	Brexit: medicines,medical devices and substances of human origin	HC 392 (Cm 9620)
Fifth Report	Memorandum of understanding on data-sharing between NHS Digital and the Home Office	HC 677
Sixth Report	The Government's Green Paper on mental health: failing a generation: First Joint Report of the Education and Health and Social Care Committees of Session 2017–19	HC 642 (Cm 9627)
Seventh Report	Integrated care: organisations, partnerships and systems	HC 650 (Cm 9695)
Eighth Report	Childhood obesity: Time for action	HC 882 (Cm 9531)
Ninth Report	Long-term funding of adult social care	HC 768
Tenth Report	Appointment of the Chair of NHS England	HC 1351
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