

Health and Social Care Committee

Justice Committee

Oral evidence: Prison health, HC 963

Tuesday 10 July 2018

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[Watch the meeting](#)

Members present:

Health Committee: Dr Sarah Wollaston (Chair); Luciana Berger; Mr Ben Bradshaw; Dr Lisa Cameron; Rosie Cooper; Andrew Selous; Derek Thomas; Dr Paul Williams.

Justice Committee: Ruth Cadbury; Bambos Charalambous; David Hanson; Victoria Prentis.

Questions 121 - 262

Witnesses

I: 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.

II: 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 Eamonn 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.

Written evidence from witnesses:

- [Howard League for Penal Reform](#)
- [Royal College of General Practitioners Secure Environments Group](#)
- [Prison Reform Trust](#)
- [Department of Health and Social Care, Ministry of Justice, Her Majesty's Prison and Probation Service, NHS England and Public Health England](#)



Examination of witnesses

Witnesses: Frances Crook OBE, Dr Jake Hard and Ryan Harman.

Q121 **Chair:** Good afternoon. Thank you for coming to this afternoon's session of the Health and Social Care Committee on Prison Health. It is also good to be joined by David Hanson from the Justice Committee. Thank you for joining us, David.

For those who are following from outside this room, could you introduce yourselves and say who you are representing, starting with Dr Jake Hard?

Dr Hard: Good afternoon and thank you. I am going to start with quite a long introduction, if I may, just to say that—

Q122 **Chair:** Just say who you are representing and your name, and then we will come back to the questions, if that is all right.

Dr Hard: I am Dr Jake Hard. I am the chair of the Royal College of GPs Secure Environments Group.

Ryan Harman: I am Ryan Harman. I am the manager of the advice and information service for the Prison Reform Trust.

Frances Crook: I am Frances Crook. I am chief executive of the Howard League for Penal Reform, but I was also previously an NHS non-exec director of a primary care trust.

Q123 **Chair:** Thank you very much. To start with, can you set out for the Committee the key points that you would like to make today about prisons and healthcare, and what is affecting the health and wellbeing of prisoners? Jake, would you like to start?

Dr Hard: There are three key areas. Clinical leadership, in my view, is underdeveloped, remains variable and could be improved upon. There is no doubt that I have seen massive improvements in the 12 years' experience that I have in the prison setting, but, as I say, this is an area that could be further improved upon.

The second point is that this could be improved on through a well-resourced education and training programme, which would be multidisciplinary and would include both security and healthcare staff, with the aim of workforce development to improve retention and recruitment issues that we see within the setting. This would be a comprehensive educational programme for secure healthcare—I can go into more detail if you ask later for further details on that—the aim of which would be a rehabilitative environment, which we all recognise is an opportunity that could be built upon. From a whole-prison approach, I believe that that is a shared goal between healthcare and security.

Q124 **Chair:** It is about clinical leadership and continuing professional



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development. Those are the key points that you would like to make.

Ryan, would you like to come in?

Ryan Harman: The key point we want to get across today is the impact of overcrowding in the prison system and how that impacts on the health and wellbeing of people in prison. It is really evident from the people who contact us through our advice service, from the whole array of things that impact on their health, that overcrowding is a factor. We are talking about access to healthcare in its very basic form and access to external appointments, but also time out of cell, meaningful occupation, access to showers and speaking to your family. All those things impact on your long-term wellbeing.

We really believe that overcrowding is a key factor there and the impact of it has paved the way for the other problems we have seen in the estate, such as the use of psychoactive substances, the highest rates of self-harm and the highest rates of serious assaults. It all comes back to the number of people that we have in our prisons.

Frances Crook: I would like to get the Committee to look at prisons in a slightly different way: rather than looking at access to healthcare, or the problems in prisons, perhaps to look at what is a healthy prison, so it is a public health issue rather than an access issue. It is the duty of Government to provide those parameters and that support for their citizens. Prisoners and staff are citizens; they are still citizens, no matter where they live or work. It is looking at the population as a whole and at what could be a healthy establishment. To a certain extent, the Prison Service has started to do that. The smoking ban, for example, was a public health initiative, and, although there have been blips, it has been relatively successful.

There are other issues. I was in a women's prison recently where I was shocked to see that almost all the women were really grossly overweight—and I mean seriously overweight—because there is no exercise and the food is very poor. The budget for food is under £2 a day, so there are lots of carbs and sweets. It is looking at prisons as what could be a healthy environment for staff, who are incarcerated too, and prisoners. That is a very difficult but a very big question. I want the Committee to think about it in those terms rather than just getting to a doctor, a dentist or whoever it is that prisoners need to see. It is a much bigger and much more difficult question.

Chair: Thank you. Rosie, do you want to come in?

Q125 **Rosie Cooper:** The Justice Secretary recently spoke about the need to get the basics right in prison. What do you consider the basics to be and what does that mean for the health and healthcare of people in prison?

Ryan Harman: It is important to recognise that getting the basics right can mean different things to different people. For some, that will mean a return to the bread-and-butter basic imprisonment. We could come up



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with a very long list of things and debate that for a long time, but we are fortunate enough to have some recently updated and comprehensive expectations from Her Majesty's inspectorate that cover the sorts of things that people in contact with our service talk about every day, such as effective appointment systems, all prisoners having equal access to health, and being treated with dignity, respect and compassion. These are the basics. This document already exists and is something that we should be looking at to determine what we think the basics are.

Frances Crook: I am all in favour of basics, but isn't it disappointing that we even have to discuss that we should get the basics right? We have had prisons that have served for sentences for 200 or 300 years, and we are still talking about what the basics are. I agree that they should be clean, decent and safe, and that you should be able to access the basic treatments and care. You should not be experiencing violence or be faced with drug taking. If you have mental health problems, you should be able to get those treated.

I think we should be expecting more—and more from a public service that is very expensive, which is pretty much a monopoly, although they outsource some delivery. To take people's freedom away is the most horrific and awesome thing to do to somebody. If they cannot do anything or make any decision, we have to do more than get the basics right. I expect the basics to be right. I want much more than that, and I want a healthy environment for people so that they can be intellectually, morally, physically, emotionally and culturally healthy in every way. That is what our prisons should aspire to. If we are going to incarcerate people, we have to aspire to much more than the basics.

Q126 **Rosie Cooper:** I absolutely agree with that, but this year a young man died in Walton. He had not had the necessary health checks; he had not seen a psychiatrist for seven weeks; and he was begging the authorities for help. He was writing letters home to his mother. He was in a cell with broken windows; it had no electricity. It was described to me by a senior person as rat-ridden. How in a civilised society does that happen? Government and each of your organisations, and we as a society, have a role to play in that. You are all in position, so what did you do?

Frances Crook: The Howard League is also a law firm; we have legal representation of children and young adults in custody. We have, I think, about four or five judicial reviews outstanding against the Government at the moment. We are considering more, particularly for young adults.

For example, the conditions that you talk about in Liverpool are very similar to conditions where young adults in Aylesbury are being held today, which is a constituency of the former Secretary of State for Justice. In fact, I have written to him and I am awaiting a reply—five weeks later. There are young men in Aylesbury today and over the last few weeks who have been locked in their cells hour after hour in this heat. They get no education and no activity—nothing. That is not healthy. They may actually be able to get to a medical appointment; that is pretty



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much the only thing they are going to be able to get to do. It is outrageous that that happens.

We take legal action when we can, and I know my colleagues here do what they can, but don't forget that we are all relatively small charities, with relatively small and independent funding, which is very important. We do not take Government money, so we can be as independent as we like and do what we can. We do what we can.

Q127 **Chair:** Jake, did you want to come in on this as well?

Dr Hard: I would like to point out that, although I am from the Royal College of GPs and from a secure environments perspective, we look at this not just from a GP point of view but a whole-healthcare and security point of view. I go back to the point I made earlier about resourcing and incorporating sufficient training and education to the staff in a collaborative way between security and healthcare so that when somebody does come into prison those needs can be met and recognised at the earliest possible stage, just in reflection on that. That, to me, is the only way we are going to get a whole-prison approach.

I recognise the importance of the national partnership agreement and working together. I strongly believe, from the group's point of view, that that needs to be emboldened and defined in more detail as to how that will happen, and, as part of that, an education programme—a training programme—should come out of it.

Ryan Harman: To add to what Frances said, our service is very similar in the sense that we hear from prisoners on a daily basis, and, unfortunately, we hear stories not dissimilar from what you have described. We do our best both to guide people through the avenues they have and to raise that with governors to try to address those issues from outside. Again, it is very difficult. We are a small charity; we are not in the prisons.

Q128 **Rosie Cooper:** Who do you think should be in charge of healthcare in prisons—the governor or the lead clinician?

Ryan Harman: It has to be an element of joint work between the two. Neither of them can run effectively without the other.

Q129 **Rosie Cooper:** What if the governor does not have the resources? We are back to the real basics, not the view of a 21st century prison system, which I get. If we cannot get people to appointments and then they are undiagnosed—for example, we heard last week of a case of lung cancer—and patients die, that is not acceptable. Who actually pulls the levers of power there? If it is the governor, then untoward deaths are going to happen, aren't they?

Dr Hard: That is why I say there needs to be a collective approach. Both the head of healthcare and the governor need to understand from the patient's point of view precisely what the goal needs to be.



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Q130 **Rosie Cooper:** Do you mean that every governor and every head of healthcare does not understand that right now?

Dr Hard: I am not saying that. I am saying that maybe some further training and collaboration with the healthcare teams would further embolden that, because I am sure, as you recognise, there may be some clinical inconsistencies across the estate. I am sure there are some inconsistencies within the secure side of the estate in understanding, and I have seen that for myself. I do not wish to draw upon that particularly other than to say that it is an area of need.

Q131 **Rosie Cooper:** Do you think duty of candour should apply, so that those patients should know that they were prevented and therefore their families should take action against the Prison Service?

Dr Hard: Yes.

Q132 **Chair:** Do you see clear evidence and a link that you can point to where you do have that good collaborative working?

Dr Hard: I know that the prison that I work in at the moment has had its difficulties, but on the days that I work there I see an approach that tries to take safety at its utmost and works very closely with the prison officers. I see good morale within the healthcare staff and consequently within the security staff. That relationship is not something that you can simply foster by putting two different groups in one room. I have certainly seen prisons where there is a complete divide between those two. That is certainly the worst-case scenario, because neither is thinking about what the other is trying to do, and, of course, the person who loses out is the patient.

Chair: Thank you. David Hanson has a follow-up.

Q133 **David Hanson:** Following on from Rosie Cooper's question, in the Justice Committee we looked recently at Liverpool and the experience of what had happened there in relation to maintenance. It was very clear that there was no correlation between the national contract, regional management and the governor's control of the maintenance contract as a whole. It led to ill health, a range of medical conditions and to some potential problems for prisoners.

Are you aware whether in prisons healthcare staff are linking some of the routine healthcare problems that prisoners have with some of the physical maintenance problems in prisons? If so, who do they report it to and what action is taken as a result of those reports?

Frances Crook: Some years ago prison healthcare used to be directly commissioned and part of the Prison Service. It is put over to NHS commissioning now, which is a good thing, but it has created perhaps a dissonance, as I think you have both identified, between accountability. I think that could be got over, but you are absolutely right that there is a real problem with the way that prison health delivery is not treated as a priority for people. Two hundred and ninety-nine people died in a year,



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and you pointed out that some of them died unnecessarily and early, whereas in the community they would not have died; and it was not just suicides.

Q134 **David Hanson:** Let us give an example. If a prisoner reports to healthcare with chest infections, colds and other matters, and it is treating the prisoner for those conditions, is any check made by healthcare as to whether a window in the cell is broken, for example?

Frances Crook: Or whether they are getting a decent diet, ever had any exercise or whether they are getting out of their cell or anything—no, they do not have that.

Q135 **David Hanson:** The Justice Committee looked at the question of routine maintenance and found in Liverpool windows broken, toilets not working and infections as a result of that. What is the connection between the prison healthcare system in Liverpool and the governor, or indeed Amey, or Carillion, who have the contract for the prison maintenance work in Liverpool, because the governor originally had no decision-making powers over when the contract was completed for broken windows or for toilet repair?

Frances Crook: It is very easy to blame governors, and I think governors have—

Q136 **David Hanson:** I am not blaming governors. I am asking who has responsibility and whether that works.

Frances Crook: Responsibility rests with the Secretary of State. When we take legal action, it is against the Secretary of State, and that is where decision making is. That is who makes decisions about contracts, who lets out the contracts, who subcontracted out to Carillion and to Amey. It is the Secretary of State who makes the decision about how many staff there are and what the budget is, and the Chancellor of the Exchequer. Ultimately, it rests there. Then there is devolved responsibility, which must be shared. But over the past five years the prison system has been wrecked. It is only just starting to heal a little bit. We are seeing some green shoots—things are getting better—partly because the numbers of prisoners are coming down and partly because there are more staff. But the problems you raise with Liverpool are endemic across the whole system.

Q137 **David Hanson:** I suppose my final question is: do the Prison Service health staff, in your view, collectively, have any responsibility to report the factors leading to health as well as treating health in relation to the holistic approach to the governor?

Frances Crook: I do not think so.

Dr Hard: My view on that is that it is about appropriate, and with consent, sharing of information between healthcare and the security staff—custodial staff, whether it be a wing officer or a wing manager—so



that, for example, when you have a patient who is on an ACCT document, or who has a palliative care need, it is clear that people need to work together. It becomes less defined with a perhaps more common problem, such as somebody who has mobility difficulties, high blood pressure or a chest infection. When it is a significant need, it becomes a much better environment for closer working. That is why, going back to the training issue, if we are working together to educate staff to think collectively, as security and healthcare staff, we are going to be better able to serve the needs of the population out on the wings in the place where they live.

At the end of the day, healthcare is not responsible for putting the glass back in, but if it has a concern about somebody with a chest infection, having a communication with the wing staff—there is some dialogue there—I would say, with consent, is going to support that person better than it is currently.

Q138 Chair: Are you saying they would need to have the consent of the patient to report a broken window?

Dr Hard: No—the sharing of the medical information, “This chap has a chest infection.”

Q139 Chair: If they felt there were conditions in the cell or they were not able to access exercise, surely they should be able to report that directly.

Dr Hard: Healthcare, yes, would have a responsibility for reporting that up the line on to the security side, but I am talking about looking after the person in the place where they live, in their cell. It is about working collaboratively on an individual level rather than on an estate level.

Chair: Thank you. Rosie has a follow-up.

Q140 Rosie Cooper: Can I say on behalf of the healthcare staff in Liverpool Prison that they put Datix in and they begged the Prison Service to deal with the broken windows and to get people to psychiatrists? I have seen the Datix; I have read them; I have read pages and pages and pages of them. There is no lack of trying. They even set up an anonymous whistleblower email from which they emailed everybody—governor, MPs, the Secretary of State, chief executives, everybody. Nobody listened.

In talking about people acting collectively and training, this is about basic human dignity, and, if people can exist in the conditions that I saw, I am horrified. Genuinely, I accept what you say in good faith, but, frankly, people are speaking up and not being listened to. How would you get over that one? How do you get those healthcare professionals’ voices heard? How do you make that happen?

Ryan Harman: If I could come in on that briefly, I agree with your observation. Fairly regularly through our service, healthcare having made a recommendation about a provision—whether it is maintenance related or related to some item of clothing, or to their diet—we say, “This person needs this to avoid detriment to their health, and that individual is really



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struggling to get the prison to come forward and do anything about that.” There clearly is a problem about those voices being heard.

Q141 **Rosie Cooper:** But even the prison ombudsman cannot get his voice heard. It is a really big question here.

Ryan Harman: It is a very challenging environment for healthcare staff to get their voices heard. There has to be local communication between the head of healthcare and the No. 1 governor, who has to be raising these issues. We also need to make sure that the complaints processes for individual people in prison are transparent and effective so that, if that is not working locally, those issues are being properly raised to NHS England and we are aware of them and aware of the themes. At the moment, I do not think that we have complaints—

Rosie Cooper: NHS England was very clear about the problems at Liverpool Prison. I told them about the low-balling of contracts. An enormous amount of money has gone in there to put this right eventually. If even NHS England, knowing what it does, still low-balls contracts, what do we do?

Chair: This may be a question for the next panel.

Rosie Cooper: It is a question for the second panel; I get that.

Q142 **Dr Williams:** Coming on to not talking about the environment in prison, which I think we have heard is a very unhealthy one, but specifically talking about healthcare, should equivalence with healthcare outside of prison be an overriding objective of the prison healthcare service?

Dr Hard: Equivalence is a topic that I have been looking at for many years, and, as I said in the round-table, it is not currently defined, although I have recently written a paper on this topic with the College’s support, which I intend to publish next week on Nelson Mandela Day. I think, absolutely, equivalence is something to which we have to continue to aspire. It is a basic function of our society and critical that we continue to try to aim for equivalence where possible. Because there is no definition, it means that all the interested stakeholders in the prison setting do not have a basis for a clear understanding of what that means centrally. It is all individually orientated. Each organisation has its own view on what it looks like for them. Without a clear definition, it is very difficult to move forward with that.

By publishing our position statement, we hope that that will promote more discussion and debate on this topic of equivalence. But if we were to remove the notion of equivalence from the prison setting, I think we would be setting ourselves up for letting our society down as a whole—not just our prison population but the whole of society—because it is critical that we apply the standards of the NHS Constitution in the way that we do, that we serve everybody regardless of their age, race, sex, gender, and so on; and prisoners are no different.



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Q143 **Dr Williams:** Are there any other comments on equivalence?

Ryan Harman: I absolutely agree. Equivalence of care has to be central to our healthcare services in prison. People are sentenced to a loss of liberty; they are not sentenced to have poorer healthcare or a greater risk to their health. That should be a principle that goes right down from commissioning to delivery. It is referenced, as Jake made a reference, in the Nelson Mandela rules, so there is international expectation there as well. Although we recognise that there might be extra challenges to deliver that in prison, and there is also extra need, it really has to have an impact on the resources that we allocate, as opposed to a lesser quality and range of service.

Q144 **Dr Williams:** You are saying that to achieve equivalence we need extra resource put in. Do you have any notion yourself about how much resource there currently is put in to deliver healthcare for people in prison compared with the people who live outside of prison? Is there any data that you have on this?

Ryan Harman: I could not answer that, I am afraid.

Q145 **Dr Williams:** Is there anything else, Frances?

Frances Crook: No. Equivalence is a difficult thing, but I think you know when it is not there. I do not know what it is, but I know what it is not.

Q146 **Dr Williams:** Is it there now?

Frances Crook: No, definitely not. It may be in some patches, but you can't get to it. When I talk to healthcare staff, they say, "We have the appointments, we have the facilities, we have the dental surgery, but we cannot get the prisoners to it." So, even if it is there in theory, it is not there in practice.

Q147 **Dr Williams:** Are there any other examples of where we do not see equivalence?

Dr Hard: I think it is important to understand the notion of equivalence. It cannot be the same as what is delivered in the wider community, and, where it cannot be delivered the same as in the wider community, it must be at least equivalent or at least as good as what is available. For example, with the treatment of blood-borne viruses or substance misuse, extra skills of the staff—extra resources—have been put in to deal with the needs of those people as they come into prison or as they stay in prison. That is not something you would get in a normal primary care setting, as you know.

In other words, we have already adapted towards equivalence to try to achieve that for our patient group. That needs further development, further guidance and further evidence to support how we continue to escalate that, so that it spreads through the whole of the healthcare delivery within the secure estate, because, arguably, as has been



mentioned, there are patches where equivalence is working and where it is not working.

Q148 **Dr Williams:** If you could give one bit of advice to the national partnership board on helping to achieve equivalence, what would it be?

Dr Hard: The best place to start would be to understand and define what equivalence actually is, because, from that, if we have a collective understanding of what we are trying to achieve as providers, organisers, clinicians or security staff, then we can work together better and we can set out our health outcomes.

Q149 **Dr Williams:** Ryan, do you have any comments?

Ryan Harman: The point that Jake makes is really important. The important thing for us is that, if we do need to be stretching resources to meet the same outcomes that we get in the community, that is what we need to be doing, and, to pick up on a point that Frances made, it is clear when that is not being reached. If someone has waited six months to get a basic appointment with a dentist, that is not what we would expect in the community. If someone has had an external appointment for important surgery or other treatment cancelled three or four times, months in a row, that is not what we would expect in the community, but it does need further definition.

Frances Crook: I have been dealing with prisoners for many years, and you hear it so often said that you are considered old at 50 because prison is such an unhealthy environment. That is not equivalent. That is not the case anywhere in the community. The environment is so poor and the healthcare is part of that.

Q150 **Dr Williams:** Not only do we have people who are unhealthy going into prison—

Frances Crook: They are unhealthy already.

Q151 **Dr Williams:** We then create an unhealthy environment. In order to achieve equivalence, we have to both invest more in dealing with the underlying unhealthiness of the population and in changing the environment.

Frances Crook: Yes.

Q152 **Dr Williams:** It is going to take a significant change to achieve equivalence.

Frances Crook: They are unhealthy and they need a lot of healthcare, so it is expensive, but it is better to invest in that because they are all going to come out and you don't want them to be very unhealthy when they are out. You have an opportunity.

Dr Hard: That investment is an investment for our whole society, not just about that person inside HMP Liverpool or whatever. It helps their family; it helps everybody.



Q153 **Dr Williams:** Do you feel at the moment that there is that enthusiasm to invest in this particularly unhealthy group of people, when we have the opportunity to make that investment?

Frances Crook: It is getting better—slowly, a little bit. I am not getting overenthusiastic, but it is getting better.

Dr Hard: I have seen significant progress in 12 years. When I started in prison, we were working from paper records. We now have an IT system and so on, so we are moving in the right direction and I wholeheartedly support that.

Frances Crook: There are more staff, which helps.

Q154 **Ruth Cadbury:** We have been covering basic health expectations around appointments and so on, and I want to go back to the point Frances made earlier about what makes for a healthy environment. Are there, or should there be, any basic minimum standards of minimum nutritional expectations in the diet, regular checks on weight, targets on smoking cessation and those sorts of things? Should there be those sorts of things, and, if so, what would that look like?

Frances Crook: Can I give you an example? Wearing another, different hat, I was on the board of the school food trust, which was set up by a previous Government to look at school food and set nutrition guidelines for lunchtime for school children. I tried very hard to get that adopted by prisons so that they would use the school nutritional standards so that at least one meal a day would conform to that basic minimum standard. That is the sort of equivalence that you could have. It is difficult to deliver on £2 a day for all meals, but it is possible and there are variations. It is that sort of thing.

If we look at nutrition, you cannot expect people to behave well if they are hungry, if they are badly fed and the only way they can fill their bellies is by buying some extra sweets and crisps with the £8 a week they have earned by cleaning the wings. Basic food standards would be a good start, I would say.

Dr Hard: From an evidence point of view, we do not have enough clinical evidence to support what the nutritional standards should be, so we have been working with—

Frances Crook: That is not true.

Dr Hard: I do not think we do in terms of the health needs of our patient population; I do not think we have sufficient information to say what the correct diet should be. We have been working with a couple of dietitians who have an interest in, and have been doing research into, this area to try to establish what should be more appropriate in a secure environment.

Q155 **Mr Bradshaw:** Can we go to the example in this context that you cited



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earlier about the prison where all the women were obese? Did you have a conversation with the governor there and make any suggestions?

Frances Crook: Yes.

Q156 **Mr Bradshaw:** What were you suggesting that they should be doing in terms of physical exercise to tackle that?

Frances Crook: When the women were moved out of Holloway, they lost a very important resource—a swimming pool that they used to use. Then they were shipped out and dispersed across the country, and there is now not a swimming pool in any of the women's prisons. There is a gym, but women do not go to pump iron, so all they do is walk—saunter very slowly—backwards and forwards. There is no exercise, the diet is very carbs heavy, and there is very little fruit or fresh vegetables. It is a really serious problem. I had a conversation with the governor and she said she was aware of it—and she is an extremely good governor—but with limited resources it is not a priority.

There are real conflicts in prisons. The overwhelming consideration is always security—not safety, not wellbeing, not outcomes, but security. That means that there are all sorts of strange decisions being made that counter and sometimes damage things such as safety and wellbeing, and this is an example of that. There are huge walls and barbed wire and everything. You have to go through gates and gates and gates. These women are not going anywhere. They don't have helicopters to get them released, and yet that stops them from being able to walk around properly or getting any exercise. Put swimming pools into women's prisons—simple.

Q157 **Andrew Selous:** Can you each give me an example of the healthiest prison environment that you have come across in your work and tell us why it is good? Then perhaps we can think about how we might spread that as best practice. What is the best that you have seen? Frances, you have been around this area for years.

Frances Crook: I have.

Q158 **Andrew Selous:** You have been into loads of prisons and have told us that quite a lot is not where we would all like it to be, but in your travels have you seen anything where you thought, actually, this is really good and if we could have it everywhere we would be a step ahead? Perhaps, while you are thinking, we can get everyone else in.

Frances Crook: You have stumped us there.

Q159 **Andrew Selous:** Frances, you are not normally lost for words. We will pass on to Jake first and then to Ryan. I just think it is important. We all get the fact that there are some prisons that are good, but if there is one somewhere or even a couple of them doing it really well, could we learn why and try to spread it? That is my question.



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Dr Hard: From a clinical point of view, the organisation that I work with, which is a GP surgery that delivers care to five prisons in the south-west, has the right approach. From a clinical point of view, when I first started working with them, I left the prison feeling that I had done a good job and felt safe in terms of the clinical safety of my patients, because they had systems and structures that allowed you to do what you needed to do without the chaos of a disruptive system behind you.

Q160 **Andrew Selous:** To make sure I understand this, are you saying that the healthcare in prisons was provided by a GP practice?

Dr Hard: Yes.

Q161 **Andrew Selous:** Is that very unusual? I thought it was normally large trusts that provided prison healthcare.

Dr Hard: It is variable. There is no specific standard as to what the right way is to do it, and of course we know that a significant proportion of the GP delivery is done through locums; in some cases, you have regular doctors; in others, you have salaried doctors and, in some, GP surgeries who manage.

Q162 **Andrew Selous:** To press you on that, was the healthcare better because this was just a particularly good GP practice, or was there something about having a GP practice provide healthcare in prisons that meant the outcomes were better?

Dr Hard: I would say both, because you have that collective responsibility and people who are also working regularly in their community GP surgeries. They are constantly looking at the conflict between, "Why am I doing this for patient A inside the prison different from patient B out in the community?" I think they challenge themselves on that level because they are interested in, and keen and enthusiastic about, the topic. There are a significant number of doctors working in the prison system—far fewer than there used to be—who are not interested in the topic. That is again why I go back to the education and training, because there are a lot of doctors out there who would find secure environment stuff an interesting topic and would like to learn more, but we do not have the structure in which to deliver that.

Q163 **Andrew Selous:** That is very interesting; thank you. Ryan, is there anything to which you would draw our attention?

Ryan Harman: I am hard-pressed to think of one prison where I think they have got it right. People obviously approach us to report poor treatment as opposed to good practice. When we have gone out and seen what prisons are doing, there are pockets of good practice—sometimes very simple things. In a couple of places, they have employed currently serving prisoners as healthcare reps to help co-ordinate appointment systems and manage the communication between healthcare and the prison. There, you get something that is much more effective, because



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not only do you have communication and investment from healthcare and the Prison Service, but from the community—the prisoners themselves.

Q164 **Andrew Selous:** How widespread is the appointment of healthcare reps in prisons? Is it quite isolated or a reasonable number who do that?

Ryan Harman: I see that in a fairly wide range of places, but it is used in different ways. I have seen a really involved system where you are not only communicating with people on the wings as to when they get appointments, but you are feeding back as to why people might have missed appointments, and therefore making the appointments to rebook quickly. I have only seen a really well-developed system in two or three places, although that is not to say that it is not more widespread.

Q165 **Andrew Selous:** Frances, we will come to you.

Frances Crook: Open prisons is the answer to your question, I think, where there is a healthier environment. We have a lot of very good open prisons. We do not use them sufficiently; we are slightly concerned about using them. Category C prisons used to be much more open. Places such as Blantyre House, a cat C prison, had a very healthy environment with a lot of creativity and artistic activity where there was a whole-prison approach. Healthcare was built into a healthy environment. Our open prisons are very good at that, and also people go out to work and so on. The more you can get out, the better.

Q166 **Andrew Selous:** Changing the subject, because I am watching the clock a bit, we heard from the chief inspector last week that in some cases 15% to 20% of prisoners who went into prison clean—that is, free of drugs—become addicted to drugs while in prison, which is a pretty appalling state of affairs. What can we do to try to prevent drug use in prisons and, in particular, prisoners becoming addicts while there?

Ryan Harman: Picking up on the point that we raised at the beginning around overcrowding, when you keep people locked in their cells for 23 hours a day, you provide no meaningful occupation for them and limited access to speak to their family, it is no surprise that something that is easily available on the wings becomes more attractive. That is the thing we really need to tackle. We need to be talking about demand as much as about supply.

Dr Hard: My personal view on this is that I do not recognise the use of psychoactive substances and the black market of illicit substance misuse in prison settings as a standard defined addiction that we see of opiate and alcohol misuse in the community. It has changed. Back 10 or 12 years ago, we were seeing heroin addiction and alcohol misuse in a much more consistent way with what was going on in the community. What has happened in the last few years with psychoactive substances is very different, and I am not sure that it can necessarily be approached in the same standard context of dealing with it in addictive terms. It is a real curve ball.



Frances Crook: I do not think you can punish your way out of it. I agree with what Ryan said about overcrowding and would add relationships to that. It has to be relationships with staff. You have to have not only sufficient staff but a stable staff group, so that it is the same people working on the same wings day after day and you get to know them. That is the way that you can get to know what is going on. I do not think you will ever get rid of hooch and drugs completely in prisons, but you can certainly reduce it quite considerably. You cannot punish your way out of it, because these are people who are punishing themselves. These drugs are really dangerous. People know they are risking death when they take them. There is nothing you can do to frighten them even more, so it has to be about offering hope, positivity and good relationships.

Q167 **Andrew Selous:** For the uninitiated who may not know this, hooch is home-brewed beer.

This is the final question from me. We have the Minister and senior officials in the next panel. What are the key questions that we should be putting to them?

Frances Crook: My question is that they should take on board that prisons should be a healthy environment for staff and prisoners, and they should see it as a whole-institution thing that involves healthcare and getting to healthcare, but also it is about being a healthy environment. It is not just about the basics. It is about being positive. It should be a healthy environment emotionally, intellectually, artistically and with creativity, so that when they come out they can be an active citizen in a healthy way, and not a drain on the taxpayer and the community—and for the benefit of staff too, which is terribly important. They keep getting forgotten and they are the key to so much.

Dr Hard: I have a simple question. What does your organisation require in order to achieve and develop the delivery of equivalent healthcare? That is the question I would put to the panel.

Andrew Selous: Right.

Ryan Harman: I made it clear that we think overcrowding really sits in the middle of this issue in terms of access to services. We would like to know what the plan is to address this in the strategy of improving people's health and wellbeing.

Chair: Thank you all for coming this afternoon. We really appreciate it.

Examination of witnesses

Witnesses: Jackie Doyle-Price, Kate Davies OBE, Dr Éamonn O'Moore, Edward Argar and Digby Griffith.

Q168 **Chair:** Good afternoon; welcome to our second panel and congratulations to Edward Argar on your appointment. Thank you for joining us this afternoon. For those following from outside the room, could we start by



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you introducing yourselves and who you are representing, starting with Digby Griffith?

Digby Griffith: Thank you. I am from HMPPS. I am executive director for rehabilitation and assurance, which looks after interventions, health, education, work, litigation for national offenders, and a few other bits and pieces as well.

Edward Argar: I am Edward Argar MP, relatively—three weeks ago—newly minted Parliamentary Under-Secretary of State at the Ministry of Justice responsible for offender health.

Kate Davies: Hello, everybody. I am Kate Davies. I am a national director for NHS England. I am the director responsible for health and justice, which is the commissioning of healthcare within our prisons, immigration removal and children's secure, and also major programmes such as liaison and diversion, police custody and courts. I also have responsibility for armed forces and sexual assault.

Jackie Doyle-Price: I am Jackie Doyle-Price. I am Minister for Mental Health and Inequalities at the Department of Health and Social Care, and in that regard I am responsible for offender health.

Dr O'Moore: I am Dr Éamonn O'Moore. I am a medical doctor by background, a public health consultant and the national lead for health and justice with Public Health England. I also work as director of the UK collaborating centre for the World Health Organisation's health in prisons programme.

Chair: Thank you. Dr Paul Williams is going to open this panel.

Q169 **Dr Williams:** I have a simple first question: what do you think a healthy prison environment looks like?

Edward Argar: I will attempt to answer that, three weeks in, and relatively succinctly, Dr Williams. The key aspect is that it must be a safe and secure environment, but, as we heard in the previous panel, that is only a very basic definition.

What must come with it, I believe, is an environment that is clean, which also effectively offers and indeed encourages the opportunity for rehabilitation, because our prisons and our custodial estate, in my view, serve three key purposes, one of which, which we should not forget, is that custody is a punishment and acts as a deterrent. It is also used to protect the public by those who have committed serious crimes being in custody.

Finally, if we do not use it to take the opportunity to rehabilitate those who are in there, we simply risk perpetuating the cycle of reoffending and we are not actually protecting society in the long term. It must address all of those things, and in that context addressing some of the underlying drivers of offending around health has to be a key part.



Q170 **Dr Williams:** Which drivers are you thinking about?

Edward Argar: There are a whole range. Some are around substance misuse; some are around mental health issues, which I know Ms Berger has raised on a number of occasions in the House. There are a range of those factors, and, depending where the Chair takes the questioning, we may look at the female offender strategy. Some of the issues there that we noticed in female prisoners involve historical domestic abuse and a whole range of other factors. It is looking at all those factors that have played a part often in someone ending up in a custodial institution.

Q171 **Dr Williams:** The evidence suggests that many of those factors begin at birth, or even from conception—the impact on the likelihood of somebody ending up in prison, yes. Can I have your comments on a healthy prison environment?

Digby Griffith: If I can add a few thoughts, a healthy prison has a specific meaning for us because the chief inspector of prisons applies a healthy prison test, which looks at safety, respect, purposeful activity and resettlement. That is a very specific set of criteria that the chief inspector looks at.

In general terms, what the Minister said is absolutely right. We would also look for a positive culture—a rehabilitative culture, a culture in which prisoners and staff are collaborating, a culture in which there is sharing of information and knowledge between different participants, which could be prison staff, education staff, health staff and various contractors who come into the prison. We see many good examples of that in the system, as well as all the other things that the Minister described.

Q172 **Dr Williams:** Do you see some places where it does not happen as well?

Digby Griffith: From time to time things go wrong, undoubtedly. One risk in our system is that of siloed working. We have a range of partnerships in place in every prison. Where that is working well, there is shared prioritisation, shared obligations, shared information and shared intelligence. Where that does not happen, we can see the security department, for example, keeping hold of its information, not sharing that with healthcare, and healthcare saying, “This is confidential information; I cannot share it with the senior management team at the prison.” I think that is beginning to be broken down, giving proper regard to confidentiality of patients and the privacy of information, but I think we are seeing much more collaboration within the prison system—within prison and across the system—to offer protection towards prisoners and their families.

Q173 **Dr Williams:** As a commissioner, what, for you, is a healthy prison environment?

Kate Davies: I have been working in and out of prisons for many decades and I do not think I have been in any prison where I would say that it strikes me as a healthy environment. I think prisons are exactly



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what they are designed to be, but what I would absolutely advocate is that 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. The most important thing is getting our residents, our inmates, our patients, to feel part of that environment, to be part of influencing that environment, along with the staff, the healthcare teams, and obviously along with the governor.

It is really important for us as NHS England commissioning healthcare in that definition to see prisons where there is much more involvement and activity, particularly from inmates, staff and healthcare, and that certainly gives a better outcome for the individuals. Also, people want to work there at the end of the day, because, as I say, I have been in and out of prisons for many decades. If I get complacent about going in and out of prisons, then I need to be concerned. Prisons are designed for the element of punishment, but I completely agree with the Minister to my right that they absolutely need to invest more in rehabilitation.

Q174 Dr Williams: You started out by saying that no prison is a healthy environment. Do you think that it is a necessary part of punishment to create an unhealthy environment? What we have heard as we have taken evidence and visited prisons is that it is an environment that has all types of impacts on people's health: the environment of drugs in prisons; the fear that many people have, and many prisoners are spending all their time in fear; the lack of exercise; the poor nutrition; and time spent in isolation. All those things contribute. Do you think those things are all a necessary part of a prison environment or things that we should be aiming to eliminate?

Kate Davies: Absolutely, the element of health, wellbeing, dignity and respect is what a prison environment should be. In order to achieve that element, which I know you were discussing with the panel before around equivalence, it is not just equivalence of healthcare but of the standards of approach and individual care, which goes outside the clinical care and is absolutely important.

The bit that is really important in the context of this question—and I know this is a very experienced panel in front of me—is that we have many different reasons why we have different types of prisons, from open prisons to high security prisons, which are working in different ways with different men and women and different age groups. There is a lot of work that is happening at the moment to explore and change the policy of how those prisons have a better flow, and how we make prisons make sense to the kind of sentence and the kind of rehabilitation that we need for individuals.

Going back to your question, the reality with prison environments not necessarily always being healthy is that we have a large number of men and women who are there on very short sentences. We have a churn



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within our prison environments, and a churn that means that, in healthcare terms, it is quite difficult at times to maintain that level of healthiness and planning.

Q175 Dr Williams: We have seen that as well. Minister, have you visited any prisons as part of your role as Minister with responsibility for prison health?

Jackie Doyle-Price: No. I have visited the high secure hospitals. That is where the Prison Service and health service meet at the highest level, but, clearly, we are maintaining an overview of how prison services are working.

Coming back to your original question about health in prisons, by definition, depriving someone of their liberty is going to be poor for their health. For me, a healthy prison is one where health professionals and the prison staff have good ways of collaborating in terms of how they deliver services, with an objective outcome of ensuring that all prisoners have access to the healthcare that they need. Within that, although we have seen transformation over the last decade in how we commission services going into the NHS, and then obviously now into NHS England, there is still a variety of performance and that is something that we need to do better. But the direction of travel is positive.

Q176 Dr Williams: What is a healthy environment for you in a prison? What kind of environment would you like to see created in prisons?

Jackie Doyle-Price: It is one where prisoners feel safe; it is one where, as I say, there is good collaboration between prison staff and any medical staff, and one where prisoners needing access to healthcare get it. One serious issue with which I am grappling is the fact that many prisoners do not get access to healthcare because they are not accompanied to attend appointments; so that, for me, is a big issue.

I also think a lot of this is set by the culture of the prison. We have seen, for example, in Liverpool, where we are going through a necessary transformation, that the role of the governor has been absolutely key; so that is always important. Also, there is generally just care around the environment in a prison.

Q177 Dr Williams: In terms of the culture of the prison, we have heard that in some prisons there is a practice of using things such as exercise, showers, family contact and recreation time as rewards for good behaviour or sanctions that can be taken away. People get the chance to exercise, the chance to have a shower or to have family contact taken away when behaviour is poor. What do you think about that in terms of creating a healthy environment in prisons?

Jackie Doyle-Price: They are very much the tools that affect people's behaviour, so, in that sense, they do—

Q178 Dr Williams: They affect people's health as well.



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Jackie Doyle-Price: Rather than rewards and sanction, we have found that time spent in cell can have a very significant impact on health. Equally, the environment within the prison needs to be safe for the staff who work there, so there needs to be an appropriate balance within that.

Q179 **Dr Williams:** As to taking away things that have an impact on people's health, do you accept that in order to control behaviour sometimes you have to make somebody a bit less healthy?

Jackie Doyle-Price: I would not quite put it in those terms. We know that is what contributes to good health and time spent out of cell generally, but, equally, these are environments that are necessarily meant for punishment.

Q180 **Dr Williams:** Thank you. Dr O'Moore?

Dr O'Moore: Shall I speak?

Digby Griffith: I would like to come back on that issue. People should be receiving all those things that you mentioned. Some of them are not always beneficial to the individual. We would all hope that contact with family is a good thing. For some people it is not; it is a negative issue in their lives. For some people, doing exercise with lots of other prisoners is not necessarily a thing they want to do. So, I think we need to be careful; it is not one size fits all. We have to try to tailor the regime and the availability of things that is beneficial to the individual.

Q181 **Dr Williams:** But we have heard about these things being used as punishments or rewards in some prisons. Dr O'Moore, back to the environment.

Dr O'Moore: Thank you. We are helped in this by international standards of what a healthy prison looks like. The WHO has helped us to think about this in a document called "Good governance for prison health in the 21st century", which also advocates the idea of a health-promoting prison. It talks about a whole-prison approach to health and wellbeing. We also have the Mandela rules—the UN international standards for prison—which include definitions of what good health looks like and good healthcare.

But we go further. We talk about prison as an opportunity to address previous health needs that have been unmet or underserved in the community. We talk about the principles by which we approach the development and delivery of healthcare as being person-centred, supported by peers and also informed by partnership work. But it should be delivered as an evidence-based programme; it should support ideas of continuity of care, so that what happens in prison is informed by what the experience of the person prior to incarceration has been and thinks about what is going to happen to them next.

It provides an opportunity to address things such as the diagnosis of infections. We heard from Jake Hard about some of the work around



blood-borne virus testing. There are opportunities within prisons to address previously unmet needs that I think we can positively exploit in terms of addressing health inequalities. A healthy prison has to be more than healthcare services. So, we come back again to the idea of the interaction between health services and the ability for people to address the wider determinants of health, whether it is about mental or physical health. It needs to think about all those aspects that we know are promoting of health, protective of good mental health in the community and what we call the “prisonification” of that. What does that look like and mean in a prison setting, where you have to do things differently but can achieve some of the same health outcomes that we would like to seek in a wider community?

Q182 Dr Williams: Do you think we achieve that with our prison environment and prison health service?

Dr O'Moore: There are many challenges within the prison system and it would be naive to say there were not, but there are exemplars of good practice. If I may briefly mention one, we have just accomplished a really important public health goal with the implementation of smoke-free prisons. We now have the largest smoke-free prison estate in Europe. We started off with a population where 80% of people in prison smoked. This was a real health issue for the people who live and work there. This is a good example of a programme that takes account of the environment, takes an opportunity to address a significant health inequality and addresses a health improvement opportunity that we hope will continue into the community. That is about recognising opportunities to do something while not being blind to the real challenges about delivering those sorts of programmes in a prison setting in England.

Q183 Chair: We have heard from previous panels—not today—that, although you might technically have a smoke-free environment, in fact people are smoking other substances. So, it might be cigarette free, but it is not smoke free, and you accept that.

Dr O'Moore: I know that there is still an issue with other substances being used as a substitution, but there is no doubt—no doubt—that we have significantly improved the situation with regard to exposure to tobacco and the second-hand smoking exposure issues. We have significantly supported people to make healthier choices that we would support as PHE in moving people to less harmful behaviour, and things like vaping devices have helped.

There are always going to be challenges that are specific to the environment in prison, and this is one aspect of it. I was in the Prison Service College yesterday at an event that was looking and reflecting on the implementation of smoke-free prisons. People are very aware of the challenges and very aware of the needs of prisoner populations with this, but there is no doubt that this is a significant public health achievement that has been delivered through partnership work, taking account of the needs of the population in prison.



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Chair: I have a lot of colleagues who want to come in—Derek, Ben, Luciana and Andrew—so could I ask you to keep your questions and answers brief?

Q184 **Derek Thomas:** I have one question. We have talked about the healthy culture that we aspire to, but can I talk about an individual's health? Presumably, consideration of an individual's health and healthcare needs to begin at the start of their sentence. We heard earlier in the first panel that it is important that prisoners' needs are met and recognised at the earliest opportunity.

Is it the case today, or is it an aspiration, that when an individual turns up to start their sentence, however long that might be, consideration is given to their health, their mental health, their wellbeing, their need for family contact, exercise, meaningful activity, education and effectively a plan to leave? Is this assessed on arrival? Are all those things that you plan to do—and I guess there are other things that could be considered?

Jackie Doyle-Price: I expect everyone to be screened for both their physical and mental health on arrival. It is commissioned on that basis, yes.

Kate Davies: I would say it goes before then, and that is why I am really pleased that we are commissioning particularly criminal justice programmes in courts and police custody, and as soon as possible.

I would also encourage looking at alternatives to custody, because there is quite a lot of work going on between departments in looking at how we can maintain that level of the right number of people in prisons for the right reasons, and that we can make those enabling environments, because we also look at it before people enter.

But you are quite right. When someone is either on remand or they may be moving around prisons, because we have a lot of people moving around prisons as well at any one time, it happens at that point too. Every individual should be getting a same-day entry screening; that is what we monitor and commission our healthcare services on.

I think we have to accept that 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. As part of that clinical requirement, we also require 72-hour follow-up, self-referral and targeted response. That has been something that we have initiated recently in the last 18 months. We are monitoring it very closely to see how that reduces things like self-harm, but particularly deaths in custody, and improves the uptake of immediate understanding of people's needs, particularly a high level of learning disability, medication needs and continuity of medication management.

I could go on, although I know that it would be too long an answer. To get the essence of your point, yes, it has to start then, but it is about



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whole-system planning for that individual, and some of them are only there for weeks and months.

Q185 **Mr Bradshaw:** Do the Ministers think they could feed themselves healthily on £2 a day?

Edward Argar: I think I could feed myself, but whether or not it would be healthy is a different matter. However, the point I would make about that, Mr Bradshaw, is that when you are catering in bulk for a large number of people, as we have seen, the direct suggestion that it is £2 a day for an individual does not exactly work, because for a large sum of money put together you can cater for that, as schools and others do. I would suggest that the comparison is not an identical or easy one to make.

Jackie Doyle-Price: I have very little to add to that, but that is—

Q186 **Mr Bradshaw:** You think it is possible to feed somebody a healthy diet, even if it is a group of people, on £2 a day per head, do you?

Digby Griffith: We try very hard to do that. I think the chief inspector of prisons has commented both favourably and unfavourably in terms of what we do. The buying in bulk keeps the cost down. We try to commission the five a day, less sugar and less salt, and we try to commission two opportunities to eat oily fish per week. All of that is available. What we cannot guarantee is that the prisoners will always make the healthy choice.

Q187 **Mr Bradshaw:** Do you think it is impossible, even in some of our old Victorian, restricted-space prisons to ensure that there is the opportunity for physical exercise to meet the prisoner's individual needs? Is that an impossibility?

Digby Griffith: We try very hard to do that. I think it is possible in many circumstances to do that—in fact, most circumstances. I would point to Durham Prison, which is an early 19th century prison, so one of our older prisons that you would traditionally see a picture of. It has a very healthy culture, a very collaborative and healthy approach to the provision of healthcare, exercise and diet in the prison, and it is one of the places that we look at that is very good. I was listening to the conversation earlier on with the previous panel. The circumstances of the fabric of the building do not necessarily indicate that it is a very unhealthy prison.

David Hanson: It is in Liverpool.

Digby Griffith: It is in Liverpool, I agree.

Q188 **Luciana Berger:** Can I clarify with the Health Minister what you said before? You said you had visited a secure hospital, but have you not visited any prison healthcare services?



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Jackie Doyle-Price: I tried to visit Liverpool after the report but was rejected by the governor and deputy governor, so you can read into that what you wish.

Q189 **Chair:** Did they refuse you access?

Jackie Doyle-Price: Yes.

Q190 **Chair:** Did they give you grounds for that?

Jackie Doyle-Price: It was that they were not around, which again tells you everything, but I visited Ashworth and Broadmoor. My priority is to look at the secure accommodation from a health perspective, but I did try to visit Liverpool following the Kirkup report.

Q191 **Luciana Berger:** Minister, obviously the secure accommodation is very important, but you have been a Minister for over a year. Your first two responsibilities are quality and safety of mental health services and vulnerable groups. You sit on the national prison healthcare board on behalf of the Department of Health and Social Care, which has responsibility as the commissioner for prison public health services. How can you sit in front of us and have us ask you questions about prison healthcare services when you have made one request to visit one prison and you have not been to any others, of which there are countless numbers that you could visit across the country?

Jackie Doyle-Price: That is a fair question, but I do have a wide-ranging portfolio and I am answering honestly where I have visited.

Luciana Berger: I think that it is unacceptable.

Q192 **Rosie Cooper:** I have to say to the panel that I am flabbergasted at some of the answers I have heard. They are very high level and divorced from on-the-ground reality.

Kate, we went to Liverpool together. You know that same-day screening did not happen; you know 72 hours did not happen; prisoners do not get a lot of choices; they did not choose to be in a rat-ridden cell with no lighting; and you were in that guy's cell, as I was, who died.

These answers are so high level that they are not dealing with the issues. Contracts are being low-balled. Kate and the Minister, I would say to you: what opportunities do you have to evaluate the low-balled healthcare contract that you are associated with having commissioned that led to the appalling state of healthcare in prisons such as Liverpool?

Digby, the question to you is: how did it happen under your watch?

Minister, why was there no money? Why were there windows that were not fixed? Why was that estate so appalling?

David Hanson has talked about Amey. Neither the prison governor nor the staff could get them to come and fix the windows. Saying that there is a lot of choice is wrong. However, the current governor, Pia, is doing a really great job, but I will say this now about Spectrum and Mersey Care.



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Spectrum, for those who do not know, is a not-for-profit company, the chief executive of which is a GP, and it is in there working really hard. That is now. How did all this happen on your watch? How did it? This is a—

Chair: Who is the question to, Rosie?

Rosie Cooper: Let us start with Kate, and then the Ministers, because the real question is this. They are high-level answers. I have heard should have, would have and want, but I have not heard how you let this happen.

Kate Davies: As you are aware, I visited Liverpool on a number of occasions, as I have other prisons. Liverpool is not the only prison that has issues and problems as regards the environment being appropriate or giving the right level of healthcare that we would like to commission and provide. There is no way that we want to be commissioning the public purse into an environment where we cannot deliver the right level of healthcare.

We monitored Liverpool. I was in front of a Select Committee just for HMP Liverpool, so I do not want to rehearse that, but we monitored and changed the healthcare provision in Liverpool over a number of years, a number of times, in order to improve and in order to react. We did that with good faith and quite a lot of monitoring. In the end, as you know, NHS England terminated the contract in order to be part of a catalyst of change. We are also putting in additional resource and additional money, because we absolutely recognise that it is quite an uphill struggle to get some of this right a lot of the time.

We have some excellent staff, Chair, and excellent nurses and GPs providing healthcare in some very difficult environments. I was in HMP Chelmsford only last week¹ for the same reason—to monitor an improvement situation within a prison. It is absolutely important that we do that, as you were saying, when we are commissioning contract by contract, by having a very hands-on, collaborative approach with our healthcare providers, commissioners, service users and our governors. That is the only way that we will get some change.

Lastly, if it is not possible to maintain a level that we are content with and that is equivalent as part of healthcare standards—and I have certainly spoken to my Minister, who has been incredibly supportive—that is a point we would have to look at.

Q193 **Chair:** Can we have shorter answers, because we have a lot to get through? Minister?

Edward Argar: I will endeavour to respond on the basis of three weeks' knowledge of this. While in a sense it was not on my watch, it was on the

¹ Note by witness: The visit to HMP Chelmsford actually took place three weeks prior to the hearing.



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Government's watch, of which I am a member, so I am happy to endeavour to answer the point.

You are absolutely right, I think, in your criticism and analysis of Liverpool. I do not disagree with or dispute that. It is different now, and, as you say, there has been significant change made. I was hoping very much last week to be able to go to visit Spectrum. I think Dr Harris heads it. I am afraid that at the last minute I ended up having to respond to an Adjournment debate in the House, so my trip was cancelled.

However, I am hoping to reschedule, and I am going to try to get round the 12 female prisons, seven YOIs and STCs in another part of my portfolio over the summer, so that will give me an opportunity to see some of the healthcare that is in place. It is not a perfect dataset, as it were, because it will not include all the adult male prisons, but I will endeavour to go to Liverpool as part of that and speak to Spectrum. Perhaps the honourable lady might be around as well to accompany me.

Rosie Cooper: I would be delighted to. I have said that I would go back in six months.

Edward Argar: I appreciate your point about high-level answers, and I apologise for that, but I hope perhaps that I might be back before this Committee before too long, by which time I will have been here for more than three weeks.

Q194 **Rosie Cooper:** Great. When you are looking at it, just look at how contracts are evaluated and how you get commissioned contracts that you cannot change.

Edward Argar: As has been alluded to, in the contracting model, which you will be aware of obviously, the commissioning sits with NHS England and with the NHS, and I have responsibility for the overall provision within an MOJ context. I have worked very closely already, just in these three weeks, with my equivalent in the Department of Health and Social Care. But I think the key to this comes back to what was mentioned at the beginning about collaboration, the new partnership agreement and the co-commissioning with governors being part of that process, which I think is hugely important. If you get a good governor who understands it and works well with that commissioning process, you will get better outcomes.

Q195 **Rosie Cooper:** The bottom line is that prisoners may not be No. 1 on the hit parade, but the truth is that they are human beings and we have a duty to—

Edward Argar: At the risk of incurring the wrath of the Chair, I will very quickly respond to that. You are absolutely right. I set out at the beginning what I see as some of the core purposes of our prisons and custodial estate, but within that—and we may come on to it later—around equivalence, the role of that custodial estate is to protect society, to reduce reoffending and to punish. That does not include impacting on



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people's health, and therefore we have an obligation to provide equivalent healthcare. I know we heard from Dr Hard that there is a discussion about how you define that. There are elements in the expectations documents set by HMIP and in others. I look forward to reading his paper on the definition of equivalence.

Q196 **Chair:** Minister, we have heard from previous panels that these things are reported and no action is taken. How are you going to set about making sure that there is a proper governance process in place so that, when things are reported, action is taken, and who would then be responsible if no action is taken?

Edward Argar: Can I clarify, Chair? Are you talking primarily about where something emerges perhaps in the context of a health issue in relation to the physical environment, be it broken windows, for example, or other factors?

Q197 **Chair:** Well, exactly. If you have a prisoner who is living in a, frankly, unacceptably poor environment, which is being reported by the healthcare staff, and everybody knows that there is an issue but nobody seems to be held to account for no action being taken, how are you going to put in place a process so that, when people report basic problems, action actually follows?

Edward Argar: At a very basic level, a very high level, people are held to account, because I hold Mr Spurr and Mr Griffith to account, who in turn hold governors to account, and he will be able to set out perhaps in more detail how that filters through in terms of a request being made within an establishment, to what the expectations are and to what reporting mechanisms are to check that something actually happens.

Q198 **Chair:** What are the consequences that will follow if nothing happens?

Digby Griffith: I can expand on that a little bit. The governor is responsible for what is happening in his or her prison. If there is something that needs outside help, such as the repair of the fabric of the building, they would look to their managers to help with that perhaps. We have just changed the whole tier of structure above governors to give that tier essentially fewer prisons to look after so that they can take a closer interest and have a closer sense of supervision over what is happening in those prisons. I would hope that Liverpool would not be happening again in that kind of scenario, because the challenge towards the governor should be revealing what is going on far better than it did before.

We then get into what the issue might be: is it policy, is it an issue of funding, or is it an issue of operational control? That is where accountability may change. Ultimately, it is the Secretary of State, and beneath that it is the chief executive of my organisation, Michael Spurr. We are held to account on performance. The chief inspector of prisons—

Q199 **Chair:** What are the consequences that follow when you say that you are



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held to account?

Digby Griffith: Using Liverpool as an example of that, it is a change of governor, if there is a reason to change a particular governor, or it may happen above the governor level.

Rosie Cooper: How many prisoner deaths have to happen before somebody listens—for goodness' sake?

Q200 **Victoria Prentis:** In Liverpool, quite a lot of the prisoners were removed, so, of course, the system had a great deal more capacity immediately within it to deal with its issues. Would you agree that you would anticipate the situation to be much better in Liverpool now, as we know that it is, but we should be more concerned about the other prisons on the watch list, and how can we be sure that energies and follow-up are properly being directed to them?

Digby Griffith: It is difficult to talk about this without talking about the history of the last four or five years, where we have had an organisation that was under immense pressure for a number of different reasons. We took about £1 billion out of the organisation over five years due to the need to live within a much smaller allocation of funding. That was on the back of prison forecast: they were forecasting a much-reduced prisoner population. That bounced back up, probably for two reasons specifically: the civil disorder of 2011 and historical sex offenders coming into prisons. We were faced with having shut 16 prisons, taken out a great deal of staff and a great deal of money, and the prison population bounced up.

At the same time, we began to see the emergence of new psychoactive substances—new types of drugs in prisons, synthetic drugs, which appear to have a different effect on people. They can make people extremely violent towards themselves and others, and they also seem to give rise to a new supply market in prison.

The combination of those factors meant that prisons were facing significant challenges with too few staff and new challenges and risks to manage. That is why, at the same time, we managed to get money for new staff. We have put in place 3,100 new staff over the past 18 months to try to get staffing levels up again.

The Secretary of State has just announced some more money today going into prisons to deal with the fabric of the estate to deal with drugs issues. Gradually, we are getting on top of some of the challenges that were proving extremely difficult for us. Liverpool is a lovely example where, if you just eased the pressure a bit, by taking some prisoners away from the prison, you would give staff a chance to get back on top of things.

Q201 **Chair:** Are there any other powers that you feel you need? You mentioned that you have had more resource and more staff. Are there any other powers that you feel need to be in place that you would like to see coming out of an inquiry such as this in order that you can respond



effectively where problems are arising?

Digby Griffith: I think we know what the answers are and we probably have the powers that we need. Money is always an issue—I would be lying if I said it was not. There is something about good fortune sometimes. Being hit with those two big issues of more prisoners and new psychoactive substances at about the same time was a major challenge for us. I think we can see what the answers are.

Having got on top of some of the really difficult issues, we are beginning to put some stronger foundations down in terms of, for example, using HMIP recommendations, using recommendations from IMBs to try to ensure that we are doing those things and making the best use of the expertise that is looking at what we are doing.

Q202 **Chair:** Thank you. Minister, are you still committed to the principle of equivalence, which you referenced before but which is not in the national partnership agreement? Do you want to make any further comments on that?

Edward Argar: No. I think it does underpin how we should approach healthcare in a custodial environment. I take the point, I think made by Dr Hard earlier, about the definition, and I think he said he was going to publish a paper next week on that, which I will read with interest.

There are two parts to this. There is the equivalence of what any of us receive in the way of access to healthcare and health outcomes and healthcare in the community, and what can be provided in a custodial environment. I think equivalence is very important there.

There is another layer—I could be wrong, but it may be Dr Williams who was referring to it—that there are particular other factors that may have a higher prevalence in a custodial setting and elsewhere. For example, of the £400 million spent that was referred to, I think, in the PAC hearings, the suggestion from Simon Stevens was that £148 million or so was spent on what could be evidenced as mental health care services; it is about 37%. That is higher than in a normal community setting outside of a prison in some cases; you can probably take it up a little bit more because GPs treat both mental health and physical health in a custodial environment. So how do you classify it? I would argue that in some areas there is more spent, probably to reflect greater need.

Q203 **Chair:** But I think the point being made to us is that there are higher needs and so—

Edward Argar: That is the point, so there is equivalence, but then you adapt that to the needs of the population that you are seeking to help and assist with their healthcare.

Chair: Thank you. Paul.

Q204 **Dr Williams:** The difficulty is that, as the panel earlier said, in some



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places we are not even doing the basics. The Independent Monitoring Board report into a prison near my constituency, Holme House Prison, said that it takes between eight and 12 weeks just to get a GP appointment. That demonstrates that we are nowhere near providing equivalence.

Chair: Or the facilities might be there but no one can get to them.

Jackie Doyle-Price: Can I follow up on that? The issue there now is consistency. In some facilities it is working better than others, as I have said before. It is equally the case that in some settings prisoners will be getting better healthcare than before they went into prison. Quite often you are dealing with people at the edge of society, with very complex needs and a high instance of substance misuse. One advantage is that because they are there we can make sure they are getting access to treatment.

Equivalence is clearly the objective. We would all recognise on this panel that we have a way to go to deliver prisoner health across the board in a way that we are all happy with, but the direction of travel is positive and the picture is very mixed.

Q205 **Chair:** I have a question for you, Dr O'Moore. The average age of death for prisoners is 56. In your public health role, and you have referred to smoking already, where do you see that you can make the greatest change?

Dr O'Moore: Thank you for that. I think this is one of the real challenges within the prison system. In the previous panel we heard reference to the chronological age and the biological age of people in prison being 10 years different, but it 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.

We have, as a public health agency, recognised that big concerns about cardiovascular disease and preventable deaths due to earlier detection of cancer must be part of the approach to address the 184 natural deaths in the prison estate last year. We recognise that there is an ageing cohort in prisons, so there is an expected increase in mortality within the prison estate consequent to that, but for the premature mortality this is not an acceptable situation.

We have been working very closely with our partners to modify the NHS health check programme, in which you or I might be invited to participate in the community, to take account of prison. We now have the prison health check programme, which will go some way, we think, to identify earlier modifiable risk factors that may allow us to intervene more.



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There is something absolutely about the quality of access to primary healthcare services within prison that allows us to recognise signs or symptoms of disease that might be associated with a risk of morbidity or mortality.

Then there is also the very important element of working with the prisoner population themselves. There is a real issue about health education and how we ensure that we take opportunities to engage with people in prison who may not have had the exposure to or engagement with primary healthcare systems or preventive systems that we would hope.

There is a lot of work to be done. This is the point the Minister was making about prison being a health opportunity, which I would entirely endorse. There is an opportunity from that point to engage with people and engage them in screening, prevention and diagnostic programmes, but it is part of the work that we are engaged in together to make sure that programmes of identifying patients and supporting them work, and that, particularly, recognition of acute care needs is met effectively.

Q206 Chair: What about the point that Dr Hard made on the previous panel about not really knowing what constituted a healthy diet in a prison? Is that—

Dr O'Moore: I was a little confused about that point and I think you expressed a similar confusion, because in fact we have good international standards of what healthy prison diets look like, and the WHO and UNODC published this guidance not long ago—a couple of years ago. We also have, and I am pleased to say published on International Women's Day, evidence-based standards for improving health and wellbeing of women in prison this year. PHE published that, working with others. That has a lot of evidence-based advice about what constitutes healthy and nutritious diets for women in prison, which I think is extrapolating evidence for what a healthy diet looks like. It also addresses some of the issues about exercise. So, I think we do have some evidence of what a healthy diet looks like in prison.

The application of that advice to the real system is a challenge. Digby has already mentioned some of the challenges about the ability to cater to that healthy dietary advice, but we have improved that. There is work to be done. Again, I come back to the point about working with the people in prison themselves, to enable them to make healthier choices too when it comes to diet and to support them in that sort of activity, not only when they are in prison but, importantly, when they return to the community and bring those new skills to—

Q207 Chair: Essentially, it is not that we do not know; it is just the challenge of putting it into practice.

Dr O'Moore: That is how I would see it, yes.

Q208 Victoria Prentis: I have a very specific and slightly niche question about



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footwear for women prisoners trying to do exercise. I understand that trainers are only available in size 6 and above in the prison-issue trainer world. Does anybody know if that is true and if smaller women's sizes are available to women prisoners in particular, and, of course, to men with smaller feet, I suppose?

Digby Griffith: I do not know the answer to that. Some people can use their own trainers, obviously, but I can find out whether we supply sizes less than 6.

Q209 **Victoria Prentis:** That would be very helpful. An extremely knowledgeable source told me that this was really a barrier to women exercising in prison.

Kate Davies: I am very aware of that particular issue now and we have brought it up with colleagues in HMPPS. One thing that is absolutely crucial to getting this right is working with service users. As you know, in the women's estate we have been working with a lot of women who are current-serving prisoners as well as women who have left. I am avoiding using this word, but some of those basics around trainers, sanitary products or healthcare products, if you are a black African Caribbean woman and so on, are part of the need for the whole-environment approach to not only health and wellbeing but changing someone's perception of themselves, changing someone's perception of their offending behaviour and maybe other options as they leave the prison. So, yes, the footwear issue came up as part of a consultation we were doing with women.

Q210 **Chair:** A final public health point from me is to the Minister. We heard on our visit to Thameside the prison governor telling us that, as long as he has been in the service, he has been hearing time and again about the impact of housing outside prison contributing to the revolving door—coming back into prison. Is this something that you are going to get a handle on—about providing better housing for prisoners as they come out of prison?

Edward Argar: It is not something over which I have direct control, as you will be aware, Chair, but, just as I work closely with my opposite number in the Department of Health and Social Care, I have at this stage an initially strong, but hopefully continuing to be strong, relationship with my opposite numbers in MHCLG. Just as I have regular bilateral meetings to discuss continuing both care for offender health within the custodial establishment and beforehand, and after release, with Ms Doyle-Price, similarly I will have exactly those same conversations about how we improve resettlement opportunities to build on what we do, hopefully, in the custodial environment with health and everything else when people are released.

Q211 **Chair:** You can assure this Committee that that is going to be—



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Edward Argar: I will assure the Committee that I will discuss it with my opposite number in MHCLG. I have no direct lever over that, but I will happily discuss it with the Department.

Q212 **Chair:** But in the sense that we heard very compellingly that it is a key factor in people coming back into prison—

Edward Argar: Yes, along with—

Q213 **Chair:** That is surely on your agenda to reduce prison populations.

Edward Argar: It is, but I have no direct lever to control that in terms of resettlement or housing provision once someone has left custody. Similarly, just as I will work with MHCLG, who will in turn work with local authorities and others, I would equally work with DHSC on other factors that can impact on reoffending around access to continuing social care and other services once someone is released. It is about smoothing that pathway when someone is released.

Q214 **Chair:** You would accept that it is not just the impact on reoffending; it is the impact on life expectancy. Digby, you are nodding here. What do you feel is the impact of this?

Digby Griffith: It is an absolutely fundamental issue, but it is not the only one. There are connected issues here as well. Housing is one that is so important, as is having a job in order to pay rent perhaps, or having access to benefits—knowing how to access the benefits system—and having some kind of peer or family support.

There are a range of things that are absolutely crucial to resettlement. We try to work with other organisations, other Government Departments and community rehabilitation companies, to try to do as much as we can in prison and at that really crucial point on release to try to make sure all these things are lined up. It is extraordinarily difficult. There is no set housing stock for people leaving prison, and it is very difficult to make a convincing case that ex-prisoners should be the highest priority for the housing stock that exists. It is a perennial problem.

Chair: Thank you. Derek has a quick follow-up point and then we will move on to Rosie.

Q215 **Derek Thomas:** When I asked my question earlier, the point was that prisoners often move quite quickly and then fall through the net. When we talk about housing and connection with the family, jobs and everything else, is that something that is considered for prisoners the minute they arrive or is it thought about at some stage later on? Is there a plan to leave with all those things included, or do you aspire to that, so that when prisoners arrive there is a plan to make sure they carry on life after release?

Digby Griffith: It depends on the length of the sentence, essentially. If someone has been sentenced to 20 years, clearly you do most of that kind of stuff towards the back end of their sentence. If someone is



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getting a very short sentence, as soon as they come in we will be thinking about what we need to do to prepare them for release and working with the national probation service, community rehabilitation companies and charities to try to ensure that there is a proper resettlement plan in place for that individual. Otherwise, often, we are wasting the work that we try to do with people inside prison because things just fall through a hole when they become released. It is an absolutely crucial point.

Chair: We will come on to deaths now within the prison estate.

Q216 **Rosie Cooper:** I was going to ask you about how you are going to plan to stem the rise of incidence of deaths during post-release supervision and custody, and this is to the Minister and to HMPPS. Putting it in context, Dr O'Moore suggested that you had prisoners with complex vulnerabilities. You talked about engaging with the various healthcare and screening programmes while they were prisoners. To me, that sounds like having a bus pass when there are not very many buses.

Using Liverpool as an example again, Mersey Care, having taken over the contract recently, has established, shockingly, that 60% of the prisoners have an IQ of around 75. In that context, they are not getting enough screening and the information that everybody thinks they are getting, and they are actually now leaving prison. How are you managing the deaths that occur straight afterwards?

Digby Griffith: Shall I try to pick that up? This links to the question about the resettlement work that we do. We try to ensure that there is a proper resettlement plan where as much as possible is done to try to tackle the issues of housing, employment, access to benefits, peer or family support and ongoing healthcare. It is not easy; at times it is failing to happen, and people are leaving prison without an adequate plan that is realistic and achievable after release.

Q217 **Rosie Cooper:** If you accept that there is that big gap there, what are you doing about it? When those deaths happen, do you investigate and is there clinical learning? Does the death of a prisoner mean anything to anybody?

Digby Griffith: Are we talking about deaths of prisoners or people released into the community?

Q218 **Rosie Cooper:** I am sorry—people who have recently been released from prison.

Digby Griffith: I have the statistics here if it is any help. In 2016-17, 370 people died under probation supervision, so under our supervision; 31% of those were self-inflicted; 38% were natural causes; 4% were homicides; and 4% were accidents. We do look at the particular circumstances of each one of these to see whether we could have done more.



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I think we are talking about a group of people who are often incredibly vulnerable. They are vulnerable before they come to prison and they remain vulnerable on release. We have tried to ensure that the national probation service and community rehabilitation companies do as much as possible to point those people in the right directions, to involve other bodies such as charities in their support, but there is a limit because they are not looking after people 24 hours a day.

Q219 Rosie Cooper: If you know a prisoner is leaving prison and maybe do not know what they are doing about a job or accommodation, family and all the rest of it, how do you make sure they get the health and mental health assistance that they need? How do you make sure that we are caring about them?

Digby Griffith: In some ways, the answer is that these people are part of the community, as you and I are, and in the probation service—my own organisation—there is a limit to how much it can do to ensure that that provision of care takes place. We would always signpost people into healthcare; we will always signpost people into the right kind of support.

Q220 Rosie Cooper: Do you link in to those mental health trusts or things like that? Do you actually link in?

Digby Griffith: There is proper signposting into those. There are two issues. One is that it is voluntary, so the individual has to want to go and do that, and we cannot always force people to go and do that. Secondly, there has to be the availability of that provision in the community: sometimes there is and sometimes there is not.

Edward Argar: I would endorse what Mr Griffith has said there, and I think the key point is his last one. We endeavour, when people leave a custodial establishment under probation or are moving back into the community, to see that they do once again take particular treatments, but they are no longer in custody, so we cannot force or compel them under normal legislation, save in extremis.

There are two key parts, and I would add a third element to this, if I may. One is the signposting; the second is that there needs to be the availability within the community and the context into which they are moving; the third part is about information sharing. You may have seen in the Public Accounts Committee hearings the work that has been done—I think it was late last year—on the contract around, I think it is called, Spine, which will allow much greater sharing of healthcare data between the NHS and a custodial establishment, and HMPPS, when people come into that custodial environment, but will also allow greater sharing of that with the community and the health service in the area to which someone subsequently goes. You can do all of that.

Ultimately, as Mr Griffith says, you can do everything you can to ensure the service and information is there, and they are signposted, but there still has to be a voluntary acceptance of or engagement with those



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services, which I would suggest will happen in many cases but may not happen in all.

Q221 Victoria Prentis: To clarify the figures, when I was engaged in conducting inquests on behalf of the Prison Service—we had too many, of course, but we had much smaller numbers than we have today—we were very aware of how all those people died. Now we often refer to deaths as being of natural causes or we are not quite clear which category they fall into. Could you perhaps set out—I do not know who is right for this—what those most common natural causes are? Are they drugs overdoses, for example?

Dr O'Moore: Do you mean in post release?

Q222 Victoria Prentis: Both in pre and post release; I have seen confusion with both sets of figures.

Dr O'Moore: Let us start with the early data—

Victoria Prentis: In prison.

Dr O'Moore: Natural causes deaths are those causes that we would normally ascribe as causing death due to natural processes, so a drug-related death is a different category. We would look at things like cardiovascular disease, cancer and so on. It is not always entirely self-evident if it is a self-inflicted death, so you may note that in some of the data produced by the MOJ it will talk about a number of deaths for which the cause is undefined as yet. What is really interesting is the number of those—that fraction—has gone up and up.

Victoria Prentis: It is enormous.

Dr O'Moore: That tells you some of the challenges that there are about understanding the nature of the problem. In the post-custody period, it is really important in this conversation that we have concerns about the number of people who have drug-related deaths in that period as well as those who have had self-inflicted death. That correlates with a concern about the lack of continuity of care for drugs services.

People might be aware that PHE published a report on the follow-up of people post release. We looked at data on people leaving prison, and we found consistently that only about a third of people leaving prison on a structured-drug treatment programme are picked up by drugs services. The point about that is that it is not just the drugs services that are the issue; it is the fact that you are in a structured-care programme that has benefits beyond the specific reason for engagement. We know this from other areas of healthcare.

We have been doing some work thinking about what are the elements that enabled that successful continuity to happen for the third that it does and what are the reasons why people are falling off the care pathway. Of course it is complex, but one thing that came out of a pilot piece of work



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done in London, which has now been extended as a national audit, is the engagement “through the gate”, as we say.

The thinking about the preparation for release is really crucial. The role that community rehabilitation companies and the probation service can have is really important. We have been talking in recent times about some of the work that we do currently focused on pre-entry, such as the liaison and diversion work that NHS England commissions. It is interesting to think about that work happening post release. It is one thing that we need to do as a system approach to support people leaving custody. The truth is that it is a complex issue.

In fact, just on the point you made about the level of need among people in prison, I totally understand that. We work really hard to make the work we do accessible, but people in prison are higher consumers of primary healthcare than their peers in the community, which tells me something. If you provide a service that is accessible and appropriate to their needs, people will use it. We need to think about what the reasons are for people falling off their care pathway, and that will get us into some of the complexity about that. It is a complex reason that needs a collaborative approach to support people when they are particularly vulnerable in that movement from custody to the community.

Chair: Thank you. We are going to go more on to mental health with Luciana.

Q223 Luciana Berger: I have a question for the Ministers. You all know that we have seen self-harm in our prisons go up by 73%. The figure provided by the National Audit Office rests at over 41,000 people self-harmed in our prisons, and the number of suicides in our prisons has increased significantly; it is just under the record high, but it is still over double what it was in 2012, with over 100 self-inflicted deaths in the past year. How do you explain that?

Jackie Doyle-Price: The environment within prisons does not help. It is important to look at suicide and self-harm together.

Q224 Luciana Berger: Yes. I am asking the question together.

Jackie Doyle-Price: Absolutely, but people are taking comfort from the fact that suicide has declined. I do not, because obviously self-harm has gone up. It illustrates that we are dealing with people at the very severe end of mental health and it is very important that we make sure they have access to those services.

Again, it remains the case that we are also dependent on the wider environmental factors within that prison. We are doing our best to keep these people safe. We can commission the services to support them, but the other issues—for example, drug use and substance misuse—are issues that obviously lie with the prison. I do not know if you want to add anything there.



Q225 **Luciana Berger:** On that in particular, we had an opportunity during our visits to prisons just the other week—or I had an opportunity—to speak to people in segregation. They did not have access to drugs, and some of them had chosen to be in segregation for their mental health, to look after themselves. I met one person—I will call them N—who said he had not had any psychiatric input for over two weeks, and he was in segregation, where he had previously had it at another prison. Another person in segregation told me that they had self-harmed in order to get some medical attention.

Jackie Doyle-Price: That is clearly unacceptable. Obviously, I am happy to go into that and challenge it.

Digby Griffith: Can I offer a few thoughts here? The self-inflicted deaths figures that we have had over recent years have been absolutely awful. There were 115 self-inflicted deaths the year before last. I am happy but cautious that the figure has come down to 69 last year. The reasons for the increase since 2013 are probably complex and multilayered. I do not think it is a coincidence that the self-induced deaths went up at the very time when we were struggling with staff numbers. I do not think it is a coincidence that it went up when we were struggling to understand and get on top of the proliferation of new psychoactive substances and the harm they cause in terms of bullying, intimidation, drug markets and the rest. I think 95% of our prisoners are male, and self-harm and suicide in the community of that group has become higher.

There are a number of factors that have contributed, and I do not think there is any doubt that prisons became a less safe place for many people. I am embarrassed to say that, but I think that was true. That amounts to it being less safe for staff and for the people we are looking after.

Edward Argar: I come back, if I can, on the segregation point and mental health needs in that context.

First, I would agree with the points made by Mr Griffith, but segregation is not and should not be normally used to manage mental health issues. Prisoners suffering from mental health issues should not normally be held in a segregation unit, save where it is for their safety or for a reason linked to that. In that context, where that does happen, HMPPS is very conscious of the potential impact of that on individuals. Segregated prisoners have to be seen daily by healthcare chaplaincy segregation unit staff, the governor and by a member of IMB during visits, and every three days have access to a doctor. Clearly, the situation you outlined that you were told about is not acceptable.

Luciana Berger: Okay. I am happy to share the details of that.

Edward Argar: Yes. I am very happy outside this Committee, if you think it is helpful, to have that conversation.

Q226 **Luciana Berger:** Indeed. One issue that has been raised on a number of



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occasions—and I know the Justice Committee has raised this—is about the delays in transfer out of prison into mental health services. Again, on another visit to a prison, prison officers told us that they were waiting around eight weeks to get their transfers from prisoners into beds.

If I reflect on the figures that we have most recently of those delayed transfers that are available, over 66% of transfers were not completed within the 14-day period. I understand that you have some plans to address that. Can you share a bit more with the Committee what they are?

Jackie Doyle-Price: I think that was the first conversation that you and I had when you were appointed.

Edward Argar: It was.

Jackie Doyle-Price: Clearly, the performance is not good enough and we have to get down to that 14-day standard. We both recognise those issues on both sides, which we are tackling. It needs to be noted—and it comes back to the point you made earlier, Chair, about what the role is with regard to housing solutions for these things—that when we look at our medium and low-secure accommodation, which is where we need to be moving these patients to, quite often we have bed blockage because there are not step-down services at the other end for people who are not detained under the criminal justice system. That is something we definitely need to tackle with colleagues in MHCLG, but we recognise that, basically, there is a lot of shaking up to be done to get much more fluidity into the system so that we are moving people into care situations that better suit their needs—and back again. It is essentially about getting the machine moving much better.

Kate Davies: An important point related to your last question as well around deaths in custody and suicide and mental health transfers is that they are not unrelated. We often have very vulnerable people, particularly on remand. I would welcome the Committee looking at the new model of reception prisons as part of how the healthcare models are appropriate to supporting probably what will be the highest number of men and women, but particularly men, about whom there are questions around mental health transfer. It is not good enough. There are too many people who are waiting too long.

The good news is that the work and the plans that we are putting in place between our colleagues in specialised commissioning and mental health in the community, but also within prisons, are showing some benefits. We have an 8.6% reduction as an improvement in the decrease in numbers awaiting mental health transfer. The work that we are doing is also targeting individual prisons and looking at the needs of individual prisoners who often have been in that situation, as you say, for a long period of time, and are also maybe blocking up the whole healthcare flow within that prison, and particularly quite often within the segregation unit.



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There is also a discussion about how particularly those men and women—and they are predominantly men—on mental health transfers are also maybe being remanded and/or sentenced when that is not the most appropriate thing to do. At the moment, the Mental Health Act review, which Sir Simon Wessely is overseeing, is a great opportunity to look at some of those baselines and standards around not using prisons, in inverted commas, as a place of safety in the way that we have done exactly the same kind of work with our police custody colleagues.

To give you absolute confidence, this is an issue that we take very seriously and are putting a lot of time, energy and resource into, but we are also doing a lot of individual patient care pathway work. We have recently done that in HMP Woodhill, Exeter and Liverpool. Again, in some of those areas we are seeing big decreases and also at the same time improvement in healthcare flows.

Jackie Doyle-Price: Following on from that, I think it is very clear from my perspective that there are some people who are in prison when it is not the best place for them. If you look at the prison population and the rate of people with learning disabilities, for example, that is not going to be the place where we are really going to give them the best care and stop them reoffending. The whole programme of liaison and diversion service is extremely important to make sure that we are capturing people and giving them the right support in the right setting.

The distressing thing is that, because again we are talking about people at the edge of society, quite often people's first interaction with organisations that could help them is when they become a nuisance to society and break the law. Unfortunately, we do not have an influence on sentencing policy, which is where things end up. Anecdotally, we do know that sentences are being used to put people in a place of safety, as Kate has just alluded to, because, when it comes to making a sentence, there is probably more confidence that the support pathway is there rather than outside.

Kate Davies: Can I come back on the transfer question because transfers is also about transfer and remissions, so it is also about the flow of patients coming from stabilisation or appropriate support and healthcare, particularly in low and medium secure, back into the prison setting to serve their sentence and also to leave? There is a piece of work that we are doing collectively about moving that particular block as well where we need to execute warrants from the Prison Service to get those remissions back in and people back to serve the rest of their sentence.

There are new remission and transfer standards currently being developed, both for immigration removal centres and prisons. They go out for consultation in September. Those will be absolutely key to ensuring that we get the most urgent cases at the right place at the right time and with the right care, but we also get the right flow of assessment, because some of those patients are not getting, necessarily,



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the right assessment at the right time in their pathway within the criminal justice system. I will be very happy to come back and answer questions on that.

Q227 Luciana Berger: Thank you. The CQC has said that services focus on meeting the needs of prisoners with moderate to severe mental ill health, with insufficient provision for those whose needs are mild to moderate. That certainly came up during the course of our Select Committee visits. Will your priority to improve the mental health of the prison population address the needs of adults with those mild to moderate mental health needs?

Kate Davies: I was lucky enough to hear, and we work very closely with, Dr Jake Hard. An absolutely key issue is also getting primary care healthcare services commissioned and right as part of the integrated provision of mental health between primary care and secondary care. As many people on the panel know, that is also a priority in the community, and it quite rightly should be a priority within the prison setting.

The other element that we are doing more of, both in terms of capacity and quality, is integrated healthcare between substance misuse and mental health services. For too long, quite often mental health services and substance misuse work in silos or do not work as part of an integration on one patient's needs. So, a lot of our models of review of our mental health and substance misuse service specifications within the prison and secure settings is about how you get primary care and integrated substance misuse and mental health services for those who are low, moderate, mild and severe. That is also what patients absolutely want as well. It links back to the point about continuity of care.

I could not agree more with Rosie's question. We absolutely need to prioritise how we mirror that model as part of how that is delivered pre-release but also in the community, because that element will also pick up a lot of people who are coming through the system on a very regular basis.

Q228 Luciana Berger: Finally, in the evidence that we received—and I take on board all the points you made about what you need to focus on—an additional point that was raised with us is that clinicians who are responsible for carrying out initial assessments on prisoners believe that they need improving, particularly in the area of mental health, because they say there is only very limited screening of prisoners' mental health needs. Would you agree with that and is that something that you would look at?

Kate Davies: That is one reason why the new health and justice information system and the whole ability to get the patients' records and the clinical standards around what is called a clinical template is absolutely crucial. We have done a review with the secure environments group, with our clinical colleagues, in how you get a range of improved standards for clinical assessment, for mental health, substance misuse,



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and on transfer and discharge; that also happens now at screening. We have a new, improved clinical template around screening that also looks at transfer and discharge, which is really important when you have a lot of people serving under a couple of weeks, and also around deaths in custody and suicide.

The new mental health specification, which went live in April, was reviewed by stakeholders, clinicians, service users and our colleagues in the prison system. One priority is about getting a rolling model of mental health continuity of care for whoever commissions it. For NHS England, I commission dentistry, physical healthcare, mental healthcare, substance misuse, podiatry, a big increase in speech and language therapy services as well currently, and older people services. That model must have an integration of mental health all the way through it. That is part of our approach with the new improved specification.

Chair: Thank you. We have a quick supplementary from Paul and then Ruth and older prisoners.

Q229 **Dr Williams:** This question is on the same topic, Kate. When will a GP record in a prison be able to be transferred to a GP record outside a prison and vice versa? When will that be one continuous record?

Kate Davies: As the Minister has said, we are really pleased after many years of deliberation and really onerous work to get the equivalence of NHS digital systems for our patient group in and out of secure. We signed that in November. It has gone live now. Those clinical templates and the position of personalised information is now rolling out across the system. I think we are actually up to 81 of the 102 establishments that are implementing that first stage.

The direct answer to your question is February 2020, which is a long way off when we are sitting in this Committee today in 2018. That is the full roll-out date for the GP-to-GP transfer of information and how that will work around the primary care records and transfer. Obviously, that process has started now and is moving out now. We are doing a full pilot in North Yorkshire, which we will be very happy to talk to you about, on the whole-systems approach to do a systems-benefit analysis in order for that to be safe and appropriate for the full roll-out across England. That is absolutely crucial for public health, as well as mental health and physical health, and cancer screening.

We have improved massively the amount of blood-borne viruses, hepatitis C, testing and screening. We want to have a button, to put it bluntly, that pings that straight to the GP's records so that, when, hypothetically, the inmate who leaves Holme House goes to their GP, it will be waiting for them. For many of those people, it will be the first time they have a named registered GP as part of that system as well.

Q230 **Dr Williams:** That is the other part of the question. Are you making sure that as people leave the prison gate they are registered with a GP as



well?

Kate Davies: That is absolutely one of the priorities and benefits of this system. It will affect not only the transfer of GP records that are already part of a named practice when you are asked that question at screening, but if you are asked that question at screening and you do not have a practice, or you are transient, then it will also be about how you enable a clinical record to support you on release. That is absolutely crucial as part of this new system and approach for digitising a patient coming in and out of the criminal justice system. Quite often, we hear also that community GPs are saying that they are prescribing quite high levels of painkillers, for example, and that is following that patient in. The first thing we hear is a patient saying at screening, "By the way, I am on a massive dose of pregabalin," for example. What we want to do is follow that through, so the liaison and diversion service is key to that patient pathway too.

Digby Griffith: I would add quickly that those clinical inputs have to be seen in the context of us trying to put in place a much more positive prisoner environment, with a much greater rehabilitative culture, introducing more educational and work availability for prisoners.

The Secretary of State introduced the new futures network a couple of months ago. There is a great deal of work taking place to try to reduce the availability of illicit drugs in prisons, which will make prisoners safer. All of those things will contribute to a more positive mental health approach in the culture of the environment.

Q231 **Ruth Cadbury:** We have a growing ageing population in prisons for a number of reasons, and the older the prisoners are, the more complex their health conditions. We had a useful contribution last week from Restore, which is an organisation that supports older prisoners.

What is your response to the prison and probation ombudsman's concern about a lack of a strategic grip on the health implications of the ageing prison population?

Digby Griffith: I will start off with that and my health colleagues may want to comment on the particular health issues. We are very aware that we have an ageing population. That is for a number of reasons. People are living longer, which is a good thing. We are also seeing a large number of historical sex offenders coming into our care who seem to be over 50.

We are very aware of that, and we are taking that into account in the design of new prisons. There may not be a strategy, but we have a model for the operation of prisons for older prisoners. We introduced this just a couple of months ago, to advise governors about just how to approach what is a growing number of older prisoners.

We also have some very good elements of good practice. Exeter is doing very good things in the south-west in acting as a cluster for social care



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for older prisoners and other prisoners needing social care. We are very aware that the numbers have grown, and all the prisoner projections are suggesting that we will have another 1,500 or so of over-50s by 2021. We are taking the environment into account in terms of the design, where people are held and where they might be held. Some older prisoners feel safer in a wing of older prisoners. Some older prisoners do not want to go near other older prisoners; they want to be near the general population. We are also conscious that older prisoners can have a calming effect on the younger, more volatile parts of the prison population.

We try to take into account individual need and also what the environment looks like as a matter of course.

Dr O'Moore: I would like to add something to that conversation. We worked with Restore last year to publish a useful health and social care needs assessment toolkit for commissioners, service providers and policy makers to take an evidence-based approach to understanding and meeting social care needs. That takes a really important element of how to ensure that you meet the needs properly into the place where we are designing services to meet those needs.

We talked to a number of people who run services for older prisoners. An excellent example of that was in HMP Whatton, where the governor there has led an exemplary service which has developed a very empowering model that takes account of the health and social care needs of a complex population, many of whom have a history of sexual offending.

In fact, the work that we have been doing in the UK has also informed international work, because that governor and I took part in work a year or so ago with the International Committee of the Red Cross, who have also been looking at this as an international problem.

Finally, we had a conference with our colleagues in the Royal College of GPs in Glasgow last November to think about this with people who work in prison and deliver healthcare. There is a clustering of work around this, and it is also referred to in the national partnership agreement as a population of particular interest. It also brings into the discussion the social care needs issue and the relationships we have with local government in providing social care to people in prison, and the mutual understanding of the needs of that population and the ability of local government to meet those needs.

I think there is a huge amount of work going on, and we are very sighted on those population needs and have done a lot of work.

Chair: I am very conscious that we will be having a vote shortly. Ruth, did you have any further questions? I am keen to bring Andrew in and also David on some points as well.

Q232 **Andrew Selous:** The Secretary of State for Justice talked about the



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importance of drug-free living today. Whose responsibility is it, or who is held accountable, within either health or justice for the proportion of prisoners who leave custody drug free? Does anyone take an interest in that?

Jackie Doyle-Price: We would obviously make a substance misuse service available to them while they are in prison.

Q233 **Andrew Selous:** I am not talking about substance misuse. It is a very specific question. I want to know who is accountable for the proportion of prisoners who leave prison drug free. That is different from providing a service. I am talking about the outcome of that service. Does anyone care? Is anyone held accountable?

Digby Griffith: I think we are, in HMPPS, very clearly. Most people who arrive in prison for the first time, or for the latest time, have been using some kind of substance. Our task is to try to get them off those substances by the time they leave. We have had some success in that. Sometimes that success is qualified because they will then go and take drugs as soon as they leave. We know that happens; that is failure on our part. We invest quite heavily in terms of trying to remove drugs from prisons.

Q234 **Andrew Selous:** I am sorry to interrupt. I understand some of the processes, but I am after the outcome. I know that lots of people are drug users when they come into prison. The Chief Inspector told us last week that sometimes 15% to 20% of people become drug users in prison to add to that. Is there drug testing on release? When one leaves prison, are they drug-tested as they go through the gate?

Digby Griffith: At times they may be drug-tested.

Q235 **Andrew Selous:** But not regularly.

Digby Griffith: Not as a matter of course in every prison.

Q236 **Andrew Selous:** So we do not actually know the proportion of prisons. I am thinking of governor A who might be really on this, who gets people off drugs and stops people going on them. With a similar population, governor B is not really on this. It sounds like no one has the management information to know that governor A needs a pat on the back and governor B maybe needs some help.

Digby Griffith: We do have some management information. The mandatory drug-testing regime that we have shows the rate of drug misuse to a certain extent. That is a random system we have that measures people every so often in each prison.

Q237 **Andrew Selous:** Is drug testing on release something that HMPPS or you, the Minister responsible for prison health, might consider? There is a sense that these people are literally a captive audience. We know that being on drugs is really bad for your health. It alarms me enormously that 15% to 20% of people, according to the chief inspector, who go into



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prison drug free become drug users in prison. If we are not having regular testing, Minister, is it an area that you would be prepared to look at?

Edward Argar: In responding to a distinguished former holder of my office, I will certainly explore with officials and colleagues from the Department of Health and Social Care what the opportunities might be around what you suggest.

Kate Davies: One of the things I have really welcomed in the last couple of months, Minister, is the new taskforce at HMPPS that the MOJ have now put in place around demand reductions—

Q238 **Andrew Selous:** Forgive me, I have a couple of other questions. How many drug-free wings do we currently have in prisons in England and Wales?

Digby Griffith: Gosh. Off the top of my head, I do not know exactly how many. They are dotted around the country. I am willing to find that out and come back to you.

Q239 **Andrew Selous:** Is the evidence that they work? Reading the Secretary of State's speech today, I am not sure if that is part of what is proposed. I have visited drug-free wings. It is a slightly odd concept in a prison. You would think that the whole prison would be drug free, but I understand why they are not. What is the evidence on drug-free wings from the ones that we have?

Digby Griffith: We have two advantages. First, the people who can go into drug-free wings are those people who have never taken drugs, do not want to take drugs and do not want to be near them. Secondly, those people who have successfully given up drugs, have successfully come through treatment and do not want to go back on drugs will also go into drug-free wings.

The indications are that they are very successful. We do not find so many illicit drugs in a drug-free wing because the demand is not there. The system that we have, and the system we are trying to strengthen in the taskforce, is about reducing both supply and demand. There is no point in concentrating on fences, searching and scanners if the demand is still there. That is why the drug-free wings are so important; because they are a group of people who have made a conscious choice not to take drugs.

Q240 **Andrew Selous:** Do you anticipate that there will be more of them given what the Secretary of State said today?

Digby Griffith: Yes, undoubtedly.

Q241 **Andrew Selous:** How many enabling environments are there in prisons in England and Wales? There is one in Aylesbury, which did not get a very good report from the earlier session, but I visited an enabling environment in Aylesbury, the memory of which is still with me. It was



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very positive, not least on health outcomes. I know it is quite a process to go through with the Royal College of Psychiatrists. The sense behind my question is, do you have an evidence base on outcomes? I thought that the ones I saw were excellent. Are you looking to have more? Can you do it more speedily with the Royal College of Psychiatrists? What are your plans on enabling environments? My experience was very positive.

Digby Griffith: I do not have the number at the moment. I would like to think that every prison has an element of enabling environment within it, in terms of having a very positive rehabilitative culture.

Q242 **Andrew Selous:** But this is a particular kite mark, if you like, from the Royal College of Psychiatrists, which is positive. Again, I might put that as a suggestion in your inbox for summer reading.

Edward Argar: A suggestion well and gratefully received.

Q243 **Andrew Selous:** I just want to go on to the area of smoke free. Dr O'Moore, earlier you were talking about the seminar you visited at the prison college, and you talked about smoke-free prisons. I presume that was referencing tobacco.

Dr O'Moore: Yes.

Q244 **Andrew Selous:** The chief inspector last week told us about visiting a prison and smelling enormous volumes of smoke coming out of a cell. He asked to go in and there were two prisoners smoking substances that were not tobacco. He was concerned that this seemed to be almost a normal occurrence on the wing.

In terms of cracking down on general drug taking within the prison environment, is there anything today in the drugs taskforce that is going to speak to that issue? Often you go on the landings and the smell is strong with all sorts of things that should not be smoked—not just tobacco.

Digby Griffith: Smoke-free prisons have been a success because that has been tackling the legal consumption of tobacco. The smoking of illicit substances is something that we are trying to tackle. The taskforce is looking both at supply and demand. We are looking at the use of scanners and the availability of treatment. I would hope that we would see a reduction in demand and a reduction in supply.

As you will know—given your former experience—there are multiple routes to get drugs into prisons. In recent years we have seen the proliferation of the use of drones for getting drugs into prisons. We have a specialist team dealing with that now. I think we are doing the right things. The Secretary of State's announcement today gives a little bit of money to do a little bit more on that, but the key is trying to do both things at the same time. We need to reduce supply through attacking the methodologies and reducing demand through education, treatment and a positive environment, by giving people other things to do—getting educated, working and having a positive culture in the prison.



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Q245 **Andrew Selous:** I agree with you.

Moving to a different area and touching on some of the Chair's earlier questions on governance, the Chief Inspector who was before us last week expressed his frustration that his recommendations, and indeed those of the ombudsman, have not been implemented in the way that should have been the case. What is the governance mechanism now within the Ministry of Justice to make sure that inspectors' reports and ombudsmans' reports within the health sphere are acted on?

Digby Griffith: I will pick this up again. I meet with the chief inspector of prisons every quarter along with Michael Spurr. He has been very vocal about his own frustration that he makes recommendations, we accept them and then we do nothing with them. I think we have to concede that that has been true—not for everything, but for a number of recommendations.

What is changing? First of all, the governance above the governor—the supervision above the governor—is tighter. We have put in place a new range of deputy directors above governors, and they will be looking to see specifically what has been done with the chief inspector's recommendations. These are the recommendations from the ombudsman and recommendations from IMBs. I would expect those deputy directors to be going into a prison, sitting down with the governor and asking what is happening.

Q246 **Andrew Selous:** Will there be a public checklist that someone could see against the prison: IMB, inspector, ombudsman: tick, tick, cross, cross, still waiting?

Digby Griffith: Yes. In addition, with the assurance team in the HQ of HMPPS we are visiting prisons and trying to determine whether people really have implemented what they say they are going to be implementing. We are now publishing our action plans in terms of what we are doing in response to Peter Clarke's recommendations. Our inspectors are being much more transparent about what happens with them. Certainly, Peter Clarke will continue to make it known whether we are doing that or not.

Edward Argar: If I may pick up on that, Digby's final point was important about publishing the action plans. I have also taken a close interest. As you will be aware, I see every IMB, HMIP and ombudsman report as the Minister. I keep track of what the recommendations are, and, as I go forward in this role, I will be making clear that at regular intervals I get the red, amber and green against each of those until we are satisfied that they have been met. Hopefully, as the Minister, I will also drive that continued focus right through the organisation.

Q247 **Andrew Selous:** It is very good to hear about the traffic light reporting system.

Mr Griffith, in relation to staff you gave us some good news on new staff



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coming in at the bottom end, but there were some concerning figures released last week on the number of prison officers leaving. I think, from memory, it had doubled from the year before. You will know as well as I do that it is no good getting bright, keen, young prison officers in at the bottom end if you are losing at a rate of knots your experienced officers later on.

What are you doing specifically on the retention issue? This is key, as we have heard repeatedly today, to good healthcare. We cannot take people to healthcare if they are not going to get it. What is the plan to keep the prison officers that we desperately need to keep on doing this vital work?

Digby Griffith: It is a really important point. We are trying to expose new recruits to prisoners before they sign up—before they complete the process. What we have been very conscious of is that people are applying to join the Prison Service in quite large numbers, and we are getting very good recruits through, but once they find out what the job is about they sometimes think it may not be for them. We are trying to expose them to the environment before they join.

Also, as we make prisons safer and more positive, they will become a much more attractive place to work. It is already attractive for many people, but we have had problems and we are addressing those.

There are also issues about understanding the culture of some younger people who are coming into our system. Whereas 20 years ago people may have been joining for a 10, 15 or 20-year career, for younger people these days it is more of a portfolio-type approach. They do not expect to be staying for 10 or 15 years. They might do two, three or five. We have to change our expectations of what is going on.

The combination of all these three things should see us understanding this a bit more. Probably we will also see fewer people leaving at an early stage in their career as it becomes safer and as we sift people out of the process for whom we do not think, or they do not think, it is a career. I think we will see the figures getting better.

Q248 **David Hanson:** I have a few questions on the drug taskforce in the short time we have. A simple question: who is on it?

Digby Griffith: This is a combination of staff from prisons, from health—

Q249 **David Hanson:** At what level?

Digby Griffith: Individuals?

Q250 **David Hanson:** Seniority.

Digby Griffith: It is led by an executive director of HMPPS who has nothing else in his portfolio except to run this taskforce.

Q251 **David Hanson:** Who else is on it?



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Digby Griffith: It has people on it who are from security departments across the organisation and from healthcare, who are contributing.

Kate Davies: I am on it.

Q252 **David Hanson:** What is the remit?

Digby Griffith: To reduce the availability of drugs and to reduce the demand for drugs.

Q253 **David Hanson:** You have mentioned extra funds. How much and what is it likely to be bid against for?

Digby Griffith: I think the amount of extra funding that was announced today by the Secretary of State is £7 million.

Q254 **David Hanson:** That is for enhanced security in prison. That is for security as opposed to a health issue. How much of the £6 million or funding is on the health side of drugs as opposed to the security side of drugs?

Digby Griffith: That would all be on the supply side. On the demand side I do not know whether Kate can help.

Kate Davies: There are three objectives to the task group. There is supply and demand reduction, but it is also about recovery. The third one is about recovery, which has been mentioned a few times.

Q255 **David Hanson:** Is any extra resource being given to manage outputs?

Kate Davies: It is a very important question. Holme House is a Pathfinder drug recovery prison and we have put an additional £3 million into that particular prison, which is one of the taskforce's objectives from the health side in order to look at a whole-systems approach. We are increasing, as part of our allocation and review of prisons, substance misuse and mental health services, as I have said in previous questions. None of the identified resource that came from the announcement today is targeted at the demand or recovery side. We have seconded a full-time member of staff from NHS England who is very experienced into the staff team with Ian Blakeman.

Chair: To clarify the record, we understand that it was £6 million to enhance security.

Q256 **David Hanson:** I am going quickly. Which 10 prisons and why?

Kate Davies: That is for the MOJ.

Digby Griffith: I do not have a list with me. We are working through exactly which prisons as we find out where the bigger problems are. That is something on which we will probably have to write to the Committee to confirm.

Chair: Yes; that would be helpful.



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Q257 David Hanson: The Secretary of State indicated today that lessons from these 10 will be applied across the estate. What is the timescale for evaluation, and at what stage would lessons be transferred across the estate?

Digby Griffith: I would like to think that we would learn lessons as we go along and apply those immediately, as opposed to waiting for a fixed point to do an evaluation and then to introduce the learning points.

Q258 David Hanson: Again, I just want to tie this down. There is £6 million for enhanced security. That is presumably £6 million for the 10 prisons. There is no money identified for the healthcare element of prevention, so, if there is a roll-out, presumably at some point there has to be an additional assessment of what the cost is of any lessons learned on the 10 for both security and for health.

Kate Davies: I spoke to both Michael Spurr and Ian Blakeman last week. There is a clear focus on the first year. That is why there is a diagnostic of those 10 prisons. We will have interim findings in September. What is really important to us—and we have pushed from the health side, Chair—is to have some of those interim findings because of commissioning cycles within the NHS. That is part of one of the early lessons, as Digby says. As one of the members of that taskforce, we are also asking to look for that.

Q259 David Hanson: Even at an optimistic level, if the lessons and the funding for the 10 prisons are transformed across the estate at some point over a year, 10 prisons would mean 12 years before every prison had the assessments made potentially on the first 10.

Kate Davies: It is important to say as part of the taskforce that, from a demand and recovery perspective, substance misuse services are a priority in every prison. It is also about a better use of current resources. That is absolutely crucial, going back to the questions about models of care, models of recovery and models of treatment, both clinical and therapeutic.

I am not in a position today to give any overview of what that would mean around increased resource, but that is something that we obviously look at continually as part of what that means. The Holme House part particularly will be incredibly important. One of the things about that model—I visited it recently and please come with me when I go up shortly—is about care co-ordinators. It is following through the position of what you start with in Holme House and what you continue in North Yorkshire, Tyne Tees or where the prison population tends to come from.

Q260 David Hanson: So, at the end of the first year that we have just indicated for the 10 prisons, will there be an evaluation published that is open to scrutiny?

Digby Griffith: I do not know, but I can take that away and we will give it consideration.



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Q261 Luciana Berger: Following on from my colleagues' questions about drugs in prison, I am by no means an expert, but I listened very closely to what the prison officers told us during our two visits. It is very clear to me that, if they did have access to drug detection dogs and the scanner machines, that would have a massive impact on the supply of drugs in both the prisons that we went to.

To what extent, if at all, will this money outlined today go to funding things that prison officers told us that they thought would make the greatest differences?

Digby Griffith: I think the prison officers are absolutely right, but I will come back to a small but important caveat to that. We have introduced 300 sniffer dogs specifically to try to detect new psychoactive substances. There are more dogs available for a wider range of drugs.

We are losing scanners as part of the taskforce and using those in other prisons. We have to be a little bit careful though, because there is no simple solution to this. There are multiple routes for drugs getting into prison. If you close off one route, people will try to exploit the other routes. You have to have a very holistic approach to keeping drugs out of prison, which has to include reducing demand, but it also has to include very strong intelligence about the routes that are being used at any one time and about the people who are using those routes—both inside the prison and outside—to tackle the routes themselves.

What you have heard is absolutely right, but I think there is a wider backdrop. Closing off one route will not necessarily stop drugs coming into prison.

Luciana Berger: Thank you.

Chair: Did you have a final question?

Q262 Dr Williams: Yes. It is something that came from the CQC, who we had here last week. We were talking with them about the difficulty they have in inspecting prison health services, particularly because sometimes a service, as seen by a prison, is provided by three or four different providers. For those providers, the prison element of their service may only be a tiny element of the service that is actually inspected. I wonder if you have any thoughts about whether or not the CQC should have the power to inspect the health services provided to a prison.

Jackie Doyle-Price: Yes. I have had exactly the same conversation, because obviously the CQC inspects providers, so for that reason you cannot necessarily do it. We have had conversations with the CQC and HMIP about doing some thematic work on where the risks are, and that work is being undertaken.

Kate Davies: We are really pleased. We were part of negotiating, along with Public Health England, to get the CQC as part of those processes of quality of healthcare and inspections; and we take the recommendations



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very seriously. We have a number that are obviously being implemented at the moment.

I think you are right. There are elements of the practical process of the inspection that can be improved as part of the accountability of the organisations that are being inspected. Does that make sense, above the bell?

Dr Williams: Yes; thank you.

Chair: We have had our final question, and here is the bell. Thank you very much for coming this afternoon.