

Justice Committee

Oral evidence: [Prison governance](#), HC 2128

Tuesday 2 July 2019

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Members present: Robert Neill (Chair); David Hanson; John Howell; Gavin Newlands; Ellie Reeves; Ms Marie Rimmer.

Health and Social Care Committee Members present: Dr Sarah Wollaston (Chair) and Rosie Cooper.

Questions 139 - 311

Witnesses

[I](#): Dr Sarah Bromley, National Medical Director, Health in Justice, Care UK; and Dr Ian Cumming, Consultant Forensic Psychiatrist, Royal College of Psychiatrists.

[II](#): Digby Griffith, Executive Director, Safety and Rehabilitation, Her Majesty's Prison and Probation Service; and Michelle Jarman-Howe, Executive Director, Public Sector Prisons South, Her Majesty's Prison and Probation Service.

[III](#): Francesca Cooney, Head of Policy, Prisoners' Education Trust/Prisoner Learning Alliance; Paul Cottrell, Acting General Secretary, University and College Union; and Chris Emmett, Director of Strategy, Prison Education, Weston College.

Examination of witnesses

Witnesses: Dr Bromley and Dr Cumming.

Chair: Good morning everyone. Welcome to the Committee, Dr Cumming and Dr Bromley, and thank you for coming to give evidence to us. As well as members of the Justice Committee, we have Dr Wollaston and Ms Cooper from the Health and Social Care Committee. I am delighted to see both of them. They will join in some of the questioning as well, because it is a topic that overlaps considerably the work of our two Committees.

First, we have to go through the formal procedure of declaring our interests as members of the Committee. I am a non-practising barrister and a consultant to a law firm.

Dr Wollaston: My husband is the registrar for the Royal College Of Psychiatrists and a practising forensic psychiatric consultant.

John Howell: I am an associate of the Chartered Institute of Arbitrators.

Q139 **Chair:** That has dealt with that. Perhaps our witnesses would like to introduce themselves and the organisations they represent, just for the record, as we know a bit of the background.

Dr Bromley: I am Dr Sarah Bromley, a GP by trade, and I am currently the national medical director for Health in Justice for Care UK. We look after 43 prison healthcare contracts across the country.

Dr Cumming: I am a consultant forensic psychiatrist and have been one for over 20 years. I worked for about 19 years full time at Belmarsh prison, until about 2015, from the whole time before the NHS had any role or responsibility, so I have seen it through the various tendering and commissioning processes. I currently work at a national service for neurodevelopmental disorders with the Maudsley hospital, and I still work at magistrates courts.

Q140 **Chair:** What is the key change that has happened, Dr Bromley, in the governance of healthcare in prisons over the last few years?

Dr Bromley: I first started working in prisons in 2005, which was just at the changeover time when responsibility for healthcare in prisons was moving from the Ministry of Justice to the Department of Health. I joined right on the cusp of that change.

In the early days, healthcare was very underdeveloped in comparison with the community. Over that period of time, we have seen huge leaps and bounds in understanding what needs to be delivered in prison, and how we know what good looks like. It is very difficult to have good governance and understand the quality outcomes you are trying to deliver until you know what a good healthcare system looks like. The key change is that we have some understanding now of what good looks like,



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and are beginning to be able to measure that much more effectively, as well as understanding where there are issues with safety.

Q141 **Chair:** We have the regional health and justice teams, which effectively commission it, don't they?

Dr Bromley: Yes.

Q142 **Chair:** Then you have responsibility for care in the establishments. Do they join up sufficiently?

Dr Bromley: Between commissioning and provider?

Chair: Yes.

Dr Bromley: On a regional level they largely do, yes. There are very close relationships between, in our case, regional managers in other providers, or maybe the head of healthcare more directly. There are quite close relationships between commissioning teams at regional level and our operators on the ground. They are held to account for performance, both from a performance indicator perspective—some of the quantitative data that have to be collected—and from a quality perspective.

Q143 **Chair:** HMPPS is described as a co-commissioner of health services. Is it?

Dr Bromley: That is a trickier one.

Q144 **Chair:** It is a misnomer, isn't it?

Dr Bromley: Our experience of the tendering process over the last few years is that we have increasingly seen governors involved in the bidder presentations, for example, which are at the end of the tendering process. Being able to understand their perspective has been very welcome. Obviously, you would have to speak to HMPPS about whether they feel sufficiently involved in that process, but we have seen an increase.

Q145 **Chair:** That is through the local delivery boards, and the governor or, if it is the private sector, the director chairs them.

Dr Bromley: Yes.

Q146 **Chair:** Could you help me on this? Do you think it is an improvement? Why was there a move away from the situation we had in the past, whereby the governor had direct involvement and you had a governor-grade head of healthcare? A lot of people feel this has actually weakened the role of the governor.

Dr Bromley: I can give you my perspective on that, based on my experience.

Chair: Yes, and then I shall ask Dr Cumming for his.

Dr Bromley: One of the risks of the governor having overall control of healthcare in the prison is that a governor has many competing demands.



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As an independent healthcare provider—I do not mean independent sector healthcare—our job is to provide healthcare and to advocate on behalf of our patients. Where there is tension—for example, if somebody needs to go to A&E—we are independent from the operational management of the prison and can advocate for that patient to make sure that they get the right care. Obviously, everybody wants to do the right thing, but having that bit of grit in the system enables a better conversation and a better prioritisation of patient needs.

Q147 Chair: Dr Cumming, what is your take on it? You have seen the process change.

Dr Cumming: I think it has been a terrible loss. There was an intimacy between the governor and the healthcare provider in the past, and an opportunity to develop a relationship. They often had a service tailored much more to the needs of the population, because prisons are not uniform entities; they vary enormously.

The trouble is that there are three people in the process now: a governor, a provider and a commissioner. I often think that the dialogue moves around between the three. In the past, governors wanted to know about healthcare, and they wanted it to work. That was their main concern, and it remains their main concern; they want it to work. They do not necessarily want to be bothered, but they want to know that it is working and that it is safe. The trouble is that if there is an issue, the commissioner will say, "This is down to the provider," the provider will say, "We're delivering this," and it may not necessarily fit with what the governor is hearing on the ground from prisoners. In a lot of ways, the governor moving away from being more centrally involved has been a bit of a loss.

Governors had more flexibility in the past to develop things; they would look at resources in their budgets and say, "There's a gap here, so let's develop this and work with the provider to do it." A lot of the spirit of delivering services has been eroded. In the past, there were loose relationships between a provider and the governor, but it could work very well.

Q148 Chair: What about where ownership of risk lies? It is important that somebody in governance has ownership of taking decisions, because things may go wrong. Didn't that loose arrangement run the risk of there perhaps being lack of clarity as to who was accountable for actions and for the consequences of actions?

Dr Bromley: There is a shared approach to risk management. I would agree very much that where there is a close working relationship between healthcare provider and governor, the service works best. Where we see, across the country, local delivery boards up and functioning and having really good-quality conversations, there is shared ownership of risk and a shared strategy to manage those risks. Where local delivery boards are



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not functioning very well is where we start to see the divide happening, and it can be quite challenging.

Dr Cumming: In terms of risk, the most likely thing for people to focus on is deaths in custody; that is the most common thing. Sometimes it is wrong to use that as a barometer for what is going on in the prison, because the routes to self-harm and death in custody are not necessarily uniform. It is not necessarily a measure that if there are more deaths in custody, there is a paucity of, or problem in, the healthcare. A whole complexity of other issues might be behind that.

Q149 **Chair:** I understand that. I have just noticed that the Royal College of Psychiatrists has suggested that there ought to be separate clinical and quality structures in prisons to make sure that there is enough focus on healthcare issues. Do you agree?

Dr Cumming: Yes.

Q150 **Chair:** Why don't we have that, Dr Bromley?

Dr Bromley: Separate structures for clinical and quality?

Q151 **Chair:** Yes. It seems pretty obvious, doesn't it? The royal college say that there must be a separate structure, because in their view the way things work means that, in their words, they "rarely refer to the effectiveness of clinical/quality governance arrangements in prison." There must be a reason why they say that.

Dr Bromley: That is not a picture that I recognise, I am afraid.

Q152 **Chair:** So they are wrong.

Dr Bromley: From my perspective and from what we see, we have a separate structure for quality and governance, both internally through our organisation and in our relations with NHS England commissioners.

Q153 **Chair:** What is your take on that as a practitioner, Dr Cumming?

Dr Cumming: Having been involved in quite a number of deaths in custody over the years, I know that it is extraordinarily traumatic. Of course it is for the victim and his family. It is a harsh process to go through. What often happens after a death is that everyone thinks, "How am I involved?". The process of finding out who is involved, what has happened and who is responsible is very difficult. Healthcare has so much to contribute to that in developing understanding.

Q154 **Chair:** I understand that. The other thing I was going to ask you about was this, Dr Bromley. There is a slightly different arrangement for private prisons. How would you characterise the differences there?

Dr Bromley: From our point of view, we hold contracts all over with NHS England, so we are contracted in exactly the same way to provide in private prisons as we are in public sector prisons.



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Q155 **Chair:** Do you think the arrangements are clear enough?

Dr Bromley: Yes. From our perspective, they are very similar.

Q156 **Chair:** And the governance structures are clear enough from your point of view.

Dr Bromley: Our governance structures answer to NHS England around quality and performance management, with shared data to the governor, or to the director in the case of private prisons.

Q157 **Chair:** And you work with the providers yourself.

Dr Bromley: Yes. There are two or three prisons that are private sector run where we operate as well.

Q158 **Chair:** Do you deal with Serco, for example?

Dr Bromley: We do. We work with Serco in Doncaster and G4S in Oakwood. Those may be the only two now.

Q159 **Chair:** Why do you think that Serco says that governance structures for healthcare are unclear, particularly in relation to collaborative commissioning requirements and developing and implementing local delivery agreements; escalation actions around local concerns; impact on wider health commissioning; and roles and responsibilities in regional teams? They don't seem very happy.

Dr Bromley: They don't seem to be very happy, do they?

Q160 **Chair:** Surely you have picked that up.

Dr Bromley: Yes. Obviously, I shall go away and find out from our own side, where we work with Serco, where that may be falling down.

Q161 **Chair:** It was not something you were aware of.

Dr Bromley: As far as I am concerned, our quality and governance structures are open and transparent to governors and directors. If there is a local issue, obviously we pick that up. I wonder whether they are referring to their relationship with NHS England commissioners and whether they feel that that is not working sufficiently well.

Q162 **Chair:** You think that might be the case.

Dr Bromley: It is a slightly indirect relationship sometimes, when it comes to reporting, and it may reflect that. A move towards having governors with greater involvement in that reporting, and looking over quality and governance, is very welcome.

Q163 **Chair:** Is that one of the developments you would like to see generally?

Dr Bromley: I would, yes.

Q164 **Chair:** Are there any other particular issues where you think we could change things and move things forward?



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Dr Bromley: For me, the key thing is usually less about the structure, although obviously that is the purpose of our discussions today; it is actually about how we build relationships on the ground, which makes the difference between a well-functioning healthcare unit in a prison and a non-functioning healthcare unit. Anything that supports that development is welcome.

Q165 **Chair:** Fair enough. Dr Cumming, do you want to come in?

Dr Cumming: About?

Q166 **Chair:** About future changes. What would you like to see change or evolve?

Dr Cumming: There are a couple of things I want to stress and bring out today. Everyone seems to see healthcare in prisons as a challenge and a burden, with difficulties and risk. There is another way to look at it, which is that it is an enormous opportunity.

You have an incredibly disadvantaged, highly morbid group who are captive, and there are opportunities to improve their healthcare and sufficiently resource it. They are going to return to the community; all bar about 50 people in prison will be going home. The opportunities to make their health better, with the potential benefits to the healthcare economy when they return, are enormous. There is a different way to look at it, and that is what I would centre.

Q167 **Chair:** I get the sense that you do not feel that is recognised enough.

Dr Cumming: No. The trouble with the tendering process, particularly in a contracting health economy, is that it has come along and is an opportunity for an organisation to make money. The NHS is no different in that way; an NHS provider will go in and see it as an opportunity to make money. We do not know who wins the bids, because it is confidential, but my suspicion is that it is very much driven by the low bid. Of course, if you are trying to make profits, you cut corners, and I have certainly seen resources going down overall. In a contracting health economy, the person who generally suffers is the prisoner.

Q168 **Dr Wollaston:** I am glad that you referred to the public health aspects, Dr Cumming, because that is the approach we took in our inquiry in the Health and Social Care Committee. We felt that there was a huge missed opportunity.

Dr Bromley, I am disappointed that you are painting a very rosy picture of the situation, whereas what we found were huge gaps in care—everything from dentistry to mental health, to prisoners who needed to be seen in out-patient clinics. The gap we heard about meant that they often could not even be taken to those appointments. With the fragmentation in the arrangements and the loss of the prison governor's responsibility, surely you recognise that there are huge gaps in healthcare and missed opportunities.



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Dr Bromley: Let me apologise. I am an optimist by nature, so that always comes out.

I was looking at some numbers just before I came in earlier, and last month, across our prisons, we—doctors and nurses altogether—saw about 50,000 patients. Probably about 3,000 or 4,000 further appointments were made but were not able to be attended by patients. It is a mixture. Sometimes people choose not to come, but often it is exactly the picture you have just painted.

Q169 **Dr Wollaston:** Very often, it is not that they choose not to come—it is that there is no one to take them there, and then there is no follow-up. We had a picture of appointments being missed and people being lost from the system. It is really failing some of the most vulnerable people in our society, isn't it?

Dr Bromley: There are certainly examples where that is happening. We see in some of our prisons that there are significant enabling difficulties, and activity is affected by the inability of patients to get to us and for us to physically see them. But it is a mixed picture across the country—I stress that; it varies from prison to prison.

Q170 **Dr Wollaston:** What are you doing to follow up on appointments that are missed, to make sure that people in prison are not further disadvantaged by suddenly finding that they are lost in the system and end up having to start a referral process again from the beginning?

Dr Bromley: As Dr Cumming said, every prison is different and operates in a slightly different way. I can speak only from my organisation's perspective in terms of how healthcare works for us, but we have tackled it by requiring every single local head of healthcare to have a policy in place that reflects their local site and describes exactly that, Dr Wollaston—how to chase up somebody who does not attend their appointment or has missed doses of medication.

Q171 **Dr Wollaston:** We heard that sometimes it was not just one appointment; it was happening on multiple occasions.

Dr Bromley: There are different types of missed appointment. Sometimes, people do not attend or cannot attend for some reason, and that is followed up individually. We follow up everybody anyway, individually, but there are wider systemic issues on each site. As I mentioned earlier, where we see things working well is where there is a good, functioning local delivery board.

Q172 **Dr Wollaston:** It is even happening within the prison system. People are having primary care-type appointments in the prison, but then there is a serious incident, and there have been a number of occasions when people could not even be seen in the healthcare system within the prison. Is that something you are looking at?



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Dr Bromley: Yes, absolutely. Of course, it is well known that the influx of NPS into prisons has been a game changer.

Q173 **Dr Wollaston:** Yes, that was the key issue raised with us—the number of alarms being raised because of NPS.

Dr Bromley: Again, I had a look at some data. One of our prisons had up to about 35 alarm calls last month, largely around NPS usage. Of course, if our nursing staff are resuscitating people or going to see people who are acutely under the influence of drugs, they are not able to deliver the routine clinics. That has a big knock-on effect.

Chair: Time presses, so we will have to move on a little.

Q174 **Rosie Cooper:** I would like to be a little bit tougher on this. Frankly, a prisoner does not fail to turn up because he chooses not to turn up; he does not turn up because of things outside his control. Those things lie with the governors, commissioners and people like your good selves. Rather than just looking at it, what are you doing about it?

You could be a cancer patient and you miss an appointment. I sat with 15 or 16 prisoners at Walton prison last week, and they talked about not getting brain scans—one guy with a brain tumour. How is that okay in the name of this Government? I mean this Parliament—I am not being party political. How is that okay in the name of Parliament, those who run the NHS and those who run justice? How is that okay? I get it that times are tough, but what are you doing?

Chair: Can you keep your questions fairly short, please, Rosie? We have a lot to get through on this Committee.

Dr Bromley: It is absolutely not okay. A question I was asked earlier was around governance systems, and they are picking up those things. We are aware that people are missing appointments; I get alerts every day about missed out-patient appointments, with exactly the description you have just given.

Where our challenge sits is in working with our prison colleagues. That is why local conversation is really important, to address the numbers of escorts available every day and how we prioritise who goes out with the limited number of escorts we have. Those local systems are important. Again, where good relationships exist, it works; where there are poor relationships, it does not work very well, and I agree that at those points it is the patients who suffer.

Rosie Cooper: Can I ask just one more question?

Chair: This is the last one, Rosie.

Q175 **Rosie Cooper:** Have you looked at HMP Liverpool before and after the recent change of regime and the quality that has suddenly appeared with the very same staff? What lessons have you learned from that?



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Dr Bromley: We do not work in HMP Liverpool, so I am not familiar with all the lessons that have been learned there.

Rosie Cooper: Dr Cumming, do you—

Chair: We will move on to the next question. You cannot have another one for Dr Cumming.

Q176 **John Howell:** The frontline for this is not yourselves but the prison officers. They are the ones who have to identify when somebody needs healthcare. We have had a big increase in the number of prison officers taken on by the Prison Service, and many of them are therefore inexperienced. Do you think they have the knowledge to be able to identify when a prisoner needs healthcare?

Dr Bromley: That is a big issue, and we see problems with inexperienced officers. For us, it is a lot around their fear factor and their concerns about escorting prisoners around, and handling things when they kick off in medication queues and so on.

I take slight issue with what you said. Patients can identify themselves that they need to see healthcare. There are systems in place whereby they can put in applications to us. It is not dependent on officers spotting that somebody is ill; they can apply for appointments in the same way as you and I can at a GP surgery. The difficulty is that officers are responsible for making sure that somebody gets to that appointment and, of course, we cannot expect them to prioritise who does. We have people who go out to the wings and follow up on the wings to make sure that people are safe if they have missed an appointment.

Q177 **John Howell:** Do you think there is enough training available?

Dr Bromley: No, I do not think there is. We would be very keen to work with HMPPS to improve training on what the responsibilities are. There was a loss of the healthcare officer role, as healthcare professionals took over healthcare in prisons. There was a good argument for that in some ways, but the loss was in having experienced prison officers who understood how healthcare operated and what the priorities and their roles were. We would be very keen to work with HMPPS. In fact, we have approached them to do exactly that.

Dr Cumming: In a lot of ways, it may seem fundamentally wrong to have prison officers doing the job of healthcare, but they certainly have a role to play. One issue is staffing; releasing staff for big chunks of training is often not easy to do for half a day or a day. There is a need for a much more modern approach to training at base and so forth. One thing that nobody around this table may remember is that we used to have healthcare officers in prison. They had a healthcare hat on, although they might have come from the military, or they might have been a nurse, and they were a very good bridge between healthcare and the prison.



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To touch on an earlier point, there is no clear model about what works best in a prison. There are so many different choices and options, and it is not well evaluated. One of the key problems is that our services are determined by the financial envelope and not by the needs of the population. That is the big gap. You have to design a service that is right for their needs, not just based on how much money there is on the table.

Q178 Ms Marie Rimmer: In our report "Prison Population 2022", we highlighted the increasingly complex needs of the present prison population. Indeed, the CQC gave evidence on that to the Health and Social Care Committee. Can you give me any particular healthcare needs of prisoners for which there is not currently adequate provision? Would you like to highlight some?

Dr Cumming: It is fairly predictable. It is what it always has been, even when I started 20-odd years ago: people with learning disabilities and neurodevelopmental disorders, such as ADHD and autism. There is increasing knowledge that perhaps 30% of offenders have ADHD, which may be significantly involved in their offending. That gives a huge opportunity to address and reduce offending in the long term.

There is much more complex care with an older population emerging. People with organic brain disease do badly in prison. It is not only about healthcare provision; so much of prison in its wider landscape is not geared up for people with those sorts of disorders and difficulties.

Q179 Ms Marie Rimmer: Would you like to comment, Dr Bromley?

Dr Bromley: I completely agree with Dr Cumming. The other group is the increasingly frail elderly population we see coming in. There has been a significant rise, and the fabric of the buildings does not lend itself to caring for people who are wheelchair-bound or have poor mobility. Social care is very patchy across the country, and how well social care is working has a big impact on health as well. For the frail elderly, particularly those with dementia, we are struggling to provide what they need to keep them safe and healthy.

Q180 Ms Marie Rimmer: You are struggling right across the piece on healthcare provision.

Dr Bromley: I think healthcare provision is an improving picture. By no means are we there; there is always room for continuous improvement. You asked me right at the beginning what the changes were, and I think there has been a change over the last 15 years.

Q181 Ms Marie Rimmer: The question I asked was whether you would like to highlight any particular healthcare need for which there is not adequate provision. That is the question I asked. Would it be easier to tell me which has adequate provision?

Dr Bromley: No. What I would like to highlight is the frail, elderly folk who are in prisons that are not fit to meet their needs.



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Q182 **Ms Marie Rimmer:** What flexibility does the governor or the healthcare provider have to tailor the provided service to meet the needs of the prison population? Do they have an ability to influence it and tailor it to meet the needs of the prisoner?

Dr Bromley: There is some influence. Every commissioner, before going out for a tendering process and at various points through a contract, will have a health needs assessment done within the prison, externally; people come in and look at the needs of that population. There is always a conversation internally, and with our commissioners and governor colleagues, about how we address some of those needs. Some of the needs that have already been highlighted around the specialist mental health needs and around the frail elderly are very difficult to meet with current resources.

Q183 **Ms Marie Rimmer:** It is one thing to specify in a contract, in writing, what is required in multiple and very complex services, and quite another thing to actually deliver to particular needs. I am different from David sitting here next to me. What ability is there to tailor provision to meet the needs of the individual? We are all different. Our GPs have contracts, but when I go to my GP, he will understand me more. Is there any way we can do that? Is that happening?

Dr Bromley: I would say yes. If you were in prison and you came to see our GP, my expectation is—usually it is the case—that they would treat you as an individual, look at your health needs and treat those, and utilise the resources of the wider team to manage those needs.

Q184 **Ms Marie Rimmer:** Dr Cumming, would you like to comment?

Dr Cumming: As a psychiatrist, I am very geared towards mental health. I still do not think we deliver very well for the mentally ill. There has been a lot of focus on that and a lot of funny figures about the high proportion of those with a mental disorder. We built all these secure units outside to get those people with mental illness out, and treat them, and the curious thing is that we are spending well over £1 billion a year on secure services to address a problem on which in prison we are probably spending tens of millions. There is an imbalance and an illogicality about it—making things better in prison by spending money outside. To me, that is very illogical.

Q185 **Ms Marie Rimmer:** Could you tell me what determines the allocation of resources for the different types of health services? Is the governor involved in that?

Dr Bromley: I do not know the answer to that, I am afraid. That sits between NHS England and HMPPS.

Dr Cumming: I have been involved in lots of tendering processes. As I said earlier, you have a financial envelope and you work out what you can fit into that financial envelope. I do not think it is really geared to the needs of the population, and certainly there have been some bids that we



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felt we had to walk away from because we could not deliver something adequate for that need.

It would be interesting to know which bids succeed. I have been involved in maybe a dozen or 15 of them, and my suspicion is that it probably goes to the lowest cost rather than the quality, although they sometimes say that quality is weighted. My suspicion is that cost is the main driver. In a contracting health economy, whether you are a commissioner or whatever, the money is the key thing.

Q186 Ms Marie Rimmer: What would improve the situation where a prison governor sits down with the provider and there is a list of complex needs that are multiple and changing? Is there any one group—the one with the money, the one with the responsibility, or the one that is going to provide—looking at how best to meet the needs of the population in the prison?

Dr Cumming: It is probably wrong to necessarily expect a prison governor to have a knowledge of health in that sort of depth. As I said, my experience is that most prison governors, both before and after, are interested in healthcare working and not necessarily being stressed by something that is going on.

What often happens is that a particularly challenging one, two, three or four individuals pull in services, and there is an expectation that health will respond to that and manage it. There is not the depth and the planning about what we actually need for our population. As I said, I think that is largely driven by the financial envelope and not what the need is.

Q187 Ms Marie Rimmer: Do you have any ideas yourself about how to improve the present situation?

Dr Cumming: As I said earlier, we are spending billions on secure services outside. Perhaps we should be spending some millions of those billions on improving the healthcare inside the prison because most of those people will be going home, and we can get it right.

Q188 David Hanson: I am still trying to get my head around what role and responsibilities prison governors ultimately have in the healthcare services that happen in their prisons. Dr Bromley, perhaps you could help me with this. You are responsible for 43 prisons. Can you give me some concrete examples where governors have intervened, given suggestions or made changes that have impacted on the healthcare in their prison?

Dr Bromley: Yes. How long do you have?

David Hanson: Just a couple of examples.

Dr Bromley: I can give you a couple of good practice examples and a couple of concerning examples. We had an outbreak in Oakwood prison, where we work with G4S. The governor was hugely proactive in working



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closely alongside healthcare to manage the outbreak and keep it contained so that we did not get the whole prison down. The management of that incident was quite highly praised by Public Health England and the Health Protection Agency.

We saw massive problems in HMP Leeds with enabling issues—exactly the situation that was described earlier. We could not get prisoners to appointments and therefore could not deliver healthcare. The governor worked alongside the head of healthcare to identify a couple of officers who were then dedicated to that activity, to enable prisoners to come. We saw a dramatic increase in the number of prisoners who were able to access healthcare appointments. Unfortunately, because of the pressures on the governor in terms of the wider population, those two officers were withdrawn and went back into the numbers for the rest of the prison, and then it started to deteriorate.

Q189 David Hanson: In your view, who is accountable for the outcomes? The governor has some interface with health service issues, but who is accountable? We had a situation in Liverpool a couple of years ago where we had the regional commissioner in front of us, as well as the previous governor and the regional manager. Healthcare problems were central to some of the failures in Liverpool. In your view, who is accountable, and what role do governors have in making sure that either their or your services are accountable to somebody?

Dr Bromley: This is always a tricky answer to give, but we all have responsibility and accountability. Ultimately, NHS England has responsibility and accountability for the provision of healthcare, but we also have a responsibility as a provider. It is very much a partnership arrangement. It is only when that partnership is working well that we can start to deliver. When the partnership does not work well, it starts to fall over. They are very difficult problems to solve. Unless we are all working in the same direction, it is not possible to do that.

Q190 David Hanson: Would you say that governors are clear on the healthcare outcomes that you are set by the commissioning body? Do they get information about your performance on a regular weekly or monthly basis about how healthcare is performing? Do they have any input in resolving the challenges? I am still trying to get a sense of it. If I am the governor of a prison and there are healthcare challenges in that prison, what is my ultimate responsibility and engagement in the healthcare outcomes?

Dr Bromley: Some of that I can answer and some of it I probably cannot. Our responsibility is to NHS commissioners. There is a relationship between NHS England, the governor and HMPPS. As far as I am concerned, our data is open and transparent for governors to look at, but I am not confident that they have visibility of it and that the information is passing through. I cannot answer to that, but I suspect it is not working terribly well. That is how I see it working.



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The local structures that exist are very much around having our head of healthcare as part of the senior management team and the local delivery boards. Then there are regional structures between NHS England and HMPPS.

Q191 David Hanson: If I am the governor of a prison, and you are dealing with mental health issues, drug issues or long-term health issues due to things outside prison beforehand, is it not helpful for the governor to have visibility of what the problem and challenge are in their prison?

Dr Bromley: Absolutely. To take NPS, for example, the governor will be more than well aware that there is NPS in his or her prison, and therefore will have some of that data. We would be looking to share data around the number of incidents we have had and the impact on our healthcare, through local delivery board structures, in order to help the governor to understand the impact on health and the wider health economy of that happening. I am not sure if I am answering your question.

Q192 David Hanson: That's fine. What are the challenges in a prison where there are multiple providers operating? How does the governor get visibility of all the different challenges?

Dr Bromley: I suspect there will be different perspectives on this. We find it works well—I suppose I would say this, wouldn't I?—when there is a single point of contact for the governor, as in the head of healthcare, who has oversight and responsibility for all the healthcare provision at that site.

One of the challenges is when you have mental health subcontractors, for example, or other subcontractors working in an overarching contract. Sometimes, the commissioners do not feel that they have full visibility of the service, and sometimes the subcontractors do not feel they have a voice at the table. That is a challenge that needs addressing, and to a greater or lesser extent is being addressed.

There are pros and cons. There is great expertise from people, for example mental health trusts, for whom it is their business. They have forensic psychiatrists and an infrastructure. Equally, there is great advantage in having specialist prison healthcare that can understand prisons and can produce bespoke policies, guidelines and resources for people who work in prisons. There are pros and cons. I would be interested to hear the governors' perspective, but our experience is that they like to have a single, accountable person in that prison for healthcare.

Q193 David Hanson: Have you ever, in the 43 prisons that you are responsible for, refused a governor's request for anything that the governor has asked for?

Dr Bromley: You are going to ask me for an example. Yes is the simple answer, but it would be largely at patient advocate level. An example would be when I have been asked not to send somebody out when I



believe it is the right thing to do. We would work very hard to get that patient out, regardless of the governor. Obviously, we like to work closely together but ultimately our responsibility is patient care and looking after our patients.

Q194 **Chair:** Dr Cumming, do you have anything on that?

Dr Cumming: I come from the point of view of the before and after—going through a tendering process where you get multiple providers in. Of course, what happens is that the actual requirements of the bid are laid out, a list has been provided, and the lead provider will say, “We need all these bits to try and make it exciting,” but often when it comes down to the money things get cut quite a lot.

You end up with multiple governance systems which, in my experience, often do not dovetail very well. The things they want to deliver have been sacrificed along the way. I do not think that it necessarily works very well.

Q195 **Gavin Newlands:** We have heard concerns from many about the tendering process, including the Health and Social Care Committee. The RCP are themselves concerned that a small number of large companies have a lot of contracts across prisons. They noted that “very often, these providers are expert at winning contracts, because they thrive on ‘business models’, but they offer no guarantee of relevant expertise and lack the community links for providing high quality mental health services in prison.” That is pretty scathing. Is that your experience of the tendering process? Do you think there are particular barriers for SMEs or voluntary organisations?

Dr Bromley: Given that we are the largest provider of healthcare services, that is hard to hear. I am a GP, and my heart and passion is in providing good-quality healthcare for patients in prison. I would be horrified to think that we did not do a good job of it. Notwithstanding all the difficulties and challenges we see, there are massive opportunities, as Dr Cumming said, to make a difference to the lives of some very vulnerable people.

The tendering process varies enormously between contract and contract as to how much is weighted on quality and how much on price. Even where the weighting is on price, there is a huge degree of sensitivity as to how much difference price makes to the overall score. From our perspective, we would never bid for something we did not think we could run within that envelope. We would not bid low just to win. I know there are some people who have done that, and it is very disappointing.

The advantage of having large providers in this space—again I would say this, wouldn’t I?—is the ability to develop bespoke guidelines, policies, procedures and resources for a set of staff who often sit outside other health structures. It is not an add-on to other business; it is the business. I do not know whether I am answering any of your question.



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Q196 **Gavin Newlands:** Do you think the process is skewed towards larger providers?

Dr Bromley: No, I do not think it is. We have been successful in a number of contracts. We have also lost out to local NHS trusts who have written a really good bid and have been able to beat us in a tender process.

Dr Cumming: I disagree. I think it is more likely to go to large providers, just because they have the experience, the muscle and capability to do it. As I said, I have been involved in bids. In an average NHS organisation, the amount of time it takes up is absolutely enormous, and of course that is not costed; you are just doing it. I think it is quite destructive.

If you are a very big provider and you have 40 or 50 contracts, your approach is, "Well, I will lose some here but I am going to gain some there," so you do not necessarily have the local investment that a local provider might have. I can think of a number of examples where people have had an existing relationship with a local prison and they like working there and so forth, but that is not necessarily reflected down the line.

I am one of the people who left because I went through two or three employment changes that I did not want to go through, being bounced and moved from one provider to another. A lot of people in the NHS, say, do not want to lose that. Often what can happen with the contracts, because they are relatively short-lived, is that they spend the first one or two years getting it together and the second and third year delivering something, and then the investment and planning goes away because they are aware that the next set of tendering is due in a couple of years' time. All of that is not very good for long-term planning. It is good for five years, but it is not good for the longer term.

Q197 **Chair:** There is relative distortion around the tender process. That is a fair point, isn't it, Dr Bromley?

Dr Bromley: The change in the length of the contracts is very welcome. It is difficult to deliver in a three-year contract. Our contracts vary from three up to six plus three, so up to nine years.

Q198 **Chair:** Longer is better, basically.

Dr Bromley: Yes. I think it is unsettling for staff, without a doubt. I do not recognise the picture that large providers are not bothered whether they win or lose. In my experience, we are very bothered whether we obtain a contract, but it is unsettling for local staff on the ground when they are not sure who their employer will be longer term.

Q199 **Rosie Cooper:** This is perhaps a little left field. Have any prisoners or their families ever sued, or are they able to sue, the authorities for the lack of healthcare, missed appointments or whatever? Has that ever happened? Would it be possible?



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Dr Bromley: I do not know about missing appointments. I guess it depends on the outcome. If people have missed appointments and it has led to a negative outcome, they absolutely can and will bring a claim against the provider for that. There would be a discussion with HMPPS about how much was the healthcare provider's responsibility and how much it was HMPPS not being able to enable the appointment to happen. Yes, they can and they do.

Q200 **Rosie Cooper:** Do any of the organisations ever worry that it will happen?

Dr Bromley: We have had claims about things. I do not think I can give you an example off the top of my head, but claims are made, yes.

Q201 **Rosie Cooper:** Are they successful?

Dr Bromley: Sometimes, yes, and rightly so. If somebody has not been enabled to go to a hospital appointment for the brain scan you described earlier, rightly so.

Chair: That is helpful. Thank you both very much, Doctors, for giving evidence to us.

Examination of witnesses

Witnesses: Digby Griffith and Michelle Jarman-Howe.

Q202 **Chair:** It is nice to see you both. Thank you for coming to give evidence to us. Perhaps you would introduce yourselves and your positions for the record.

Digby Griffith: I am Digby Griffith. I am the director of safety and rehabilitation in Her Majesty's Prison and Probation Service.

Michelle Jarman-Howe: My name is Michelle Jarman-Howe. I am the executive director of public sector prison south in Her Majesty's Prison and Probation Service.

Q203 **Chair:** Thank you. Mr Griffith, we now have the National Prison Healthcare Board, designed to oversee the national partnership agreement. Those are the two key things. We have looked at the evidence, and one thing is not very clear to us. How do you hold to account the various organisations that sit underneath that?

The partnership has to be delivered by a number of organisations. There are a number of targets to hold them to, and you have the healthcare board sitting above. How do you hold to account for the delivery the bodies who are delivering? What levers do you have to do that?

Digby Griffith: It is still forming. The construction of the national partnership agreement was the start of the process, as opposed to the end of the process. It took a little while to get to that point. Getting five big organisations to agree the content of that was difficult.



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There is a sense of collective responsibility across the board, within the five organisations. The provision of healthcare across our system is owned collectively by that group of people, with functions in the different silos that then report to the board. Where that becomes useful is when there are general concerns. We can feed those concerns into the board and they will accept responsibility for them.

For example, one of the things I am dealing with is the implications of a no-deal EU exit for my organisation. There is a question about the ongoing provision of healthcare and whether that might be affected. I referred that to the national partnership and board, for them to take ownership of that particular issue and for them to hold each other to account for the particular issues relevant to their organisations.

Q204 **Chair:** Does that relate to the provision of medicines, for example?

Digby Griffith: That particular issue—the EU exit no deal? There are two issues. The first is the ongoing provision of medicines and the second is the provision of staff, and whether we might see some of the staff currently working for healthcare providers in prisons begin to disappear. There are no signs of that, but it is a worry.

Q205 **Chair:** They are often EU nationals. That is something where you have a specific concern and you have referred it to the board.

Digby Griffith: Correct.

Q206 **Chair:** I understand that. How do you resolve disputes between the various organisations tasked with delivering the national partnership agreement?

Digby Griffith: We try to avoid disputes where we can. What we see from time to time are five organisations with priorities that sometimes do not match each other spot on. We are trying to get to a position in which, for provision of healthcare in prisons, there is shared ownership of that.

How do we resolve disputes or tensions when they arise? We talk to each other. We talk it out in the board. We have bilateral discussion with each other. I meet my National Health Improvement counterpart every so often. She meets other senior colleagues in my agency, and we resolve issues through that kind of dialogue.

Q207 **Chair:** The CQC was a bit concerned that perhaps it was a system that depended very much on the good will that you talk about and good relationships between the prison, the commissioners and the providers. Should you in fact be evolving something more systematic, with more specific levers to hold people to account, financially or in terms of accountability, or contractually?

Digby Griffith: Any system that we have in any organisation will probably depend to some extent on good one-to-one relationships and good collective responsibilities. In terms of levers, there is a statutory responsibility on health colleagues to provide good-quality healthcare in



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prison. That is the main lever. They have the money and the statutory responsibility. The other partners in that five-way partnership are there to facilitate.

We have absolutely no doubts about where the responsibility rests. What we have from time to time—I think it came up in the previous session—are issues about whether a problem is a healthcare delivery problem or a facilitation of delivery of healthcare problem. One of those is for healthcare colleagues and the other is for my own organisation.

Q208 **Chair:** Ms Jarman-Howe, do you have anything to add?

Michelle Jarman-Howe: No.

Chair: Fair enough.

Q209 **David Hanson:** We are trying to focus on the governor's responsibility overall. When we had the PGA in evidence before us, they said that effectively governors were influencers in relation to the healthcare service rather than co-commissioners, which I think has come out in today's session. If the influencer remains unhappy about the service, what are the mechanisms the prison governor has to take action?

Digby Griffith: I think governors have two responsibilities there. Yes, they are influencers. The second bit is that they must deliver the facilitation of healthcare in prisons.

I will take each one in turn. We expect governors to provide information to healthcare commissioners about their population—their prison and prisoners—and how things operate. For example, the governor of Feltham, with a population of young offenders, is very different from the governor of Grendon Spring Hill with a group of middle-aged to elderly offenders. The healthcare needs would be very different.

We would expect the governors of each prison to liaise with the commissioner of healthcare services in their region to ensure that the needs of the prison and the profile of the prison are clearly set out. We also expect the governor to be engaged in the evaluation process of the bidding. They are going to be working in the governor's prison, so we would expect the governor to have some role in the evaluation.

That moves to the second point, which is that the governor must facilitate the delivery of good-quality healthcare in their prison. In crude terms, there has to be somewhere to deliver healthcare. We have to have a healthcare centre. We have to make sure that we are getting prisoners from their cells to appointments in the healthcare centre and outside. The governor has a very big ongoing responsibility to ensure that the healthcare professionals provided by the commissioners are able to deliver in their setting.

Q210 **David Hanson:** The governor assesses the nature of the prison population and the governor provides facilities. If the healthcare provider



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is not providing a service that the governor, in their professional judgment, believes to be a good service, what mechanisms does the governor have to make any impact on that change?

Digby Griffith: A number of things. First, I would expect the governor to be talking to the healthcare provider as a matter of course in their prison. They are in the prison, and they are one of a number of providers of different services in the prison. The governor is responsible for that prison and will talk to those providers as a matter of course.

There will also be conversations between the provider and the commissioner. That is the more formal route. If a governor is not happy with the quality or the level of healthcare, they should be going to the commissioner, to get the commissioner to resolve that. There is also the local delivery board on which the governor, the commissioner and the provider all sit. They should be having conversations about the quality of healthcare in the prison.

Those possibilities are there. If the matter still has not been resolved, I would expect the governor to escalate their concern to one of Michelle's staff, for example, one of the prison group directors, or to Michelle, myself or one of my team, so that the problems are escalated, and we can take them up at more senior levels of the system.

Q211 **David Hanson:** Let's drill down a little bit into that. If there is a spate of drug-related deaths in a prison, or long-term illnesses that cause some challenges in the prison as a whole, if there is an infection or if there is NPS, where does the accountability for the service ultimately lie? I am trying to get a sense of that.

We had the situation in Liverpool, and we had evidence from people that there were challenges in the system that led to a whole range of underperformance by the health service, by the then governor and by the regional manager, but there were outcomes for the prisoners that left them in poorer health or in some cases led to death. I want to get a sense of where accountability ultimately lies.

Digby Griffith: Accountability for the quality of the healthcare resides with the provider and the commissioner of that healthcare. The accountability for the environment in which that healthcare is delivered is held by the governor.

Q212 **David Hanson:** Do you think that statutorily there is sufficient clarity in that?

Digby Griffith: I think there is complexity built into that model. Interestingly, the World Health Organisation commented that the way it is set up is good practice, but there is complexity within it. For example, one of the issues that will make healthcare very difficult to provide is a badly run prison where there are difficulties, where there are not enough staff and where there are drugs coming into the prison. The governor has



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a responsibility to tackle those issues, and to provide an enabling environment where good-quality healthcare can be provided.

Q213 **David Hanson:** What training, support and guidance do you give governors on the management of healthcare in their prison?

Digby Griffith: Probably not enough is the very simple answer.

Q214 **David Hanson:** What happens now? If I were an assistant governor applying to be the governor of a new prison, what health support qualifications would I require to be able to transfer my employment to governor level, and how would you prepare me for the different challenges?

Digby Griffith: The important thing behind the question is that we are not expecting governors to be clinicians.

Q215 **David Hanson:** I appreciate that.

Digby Griffith: The provision of healthcare is provided by others outside the prison responsibilities.

Q216 **David Hanson:** But if prisoners die in their prison through self-harm, through drug overdoses or through NPS, if an individual has an illness that then causes infection in the prison or if there are mental health challenges in a prison that disrupt the regime, the governor has a responsibility for the prison. They are not clinicians, but what happens in the health service in their prison makes a difference to the way their prison operates.

Digby Griffith: Absolutely.

Q217 **David Hanson:** What assessment are you giving governors, so that they have the support to be able to understand and manage?

Digby Griffith: It is about being a good governor with responsibility for a range of issues in the prison. It is not a clinical issue; it is about the interface between the clinicians, the governor and the senior management team so that they are talking and exchanging information.

To give an example, a number of years ago we looked into unexplained deaths in a number of prisons where prisoners were found dead in the morning. When we looked at that in a great deal of detail with toxicologists, clinicians and governors, one of the things that came out of that piece of work was the interface between those providing healthcare and the security departments.

The security department may have had information that the individual was taking drugs, dealing in drugs or acting as a transit point for drugs. Clinicians had information about what the individual was taking and what the concerns were. What we found was that the two were not sharing information. We expect governors to ensure that information is being shared at proper strategic and tactical levels within the prison, and that there is a coming together of information about any individual prisoner. It



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is not a clinical issue; it is the sharing of information about how the prison is operating and the pooling of knowledge about individual prisoners.

Michelle Jarman-Howe: One of the core roles of the governor is to orchestrate a wide range of providers, partners and stakeholders who operate in prisons, which are very complex environments. Where we have an operational, health or strategic challenge such as NPS, as you identified earlier, one of the governor's roles and responsibilities is not necessarily to command all the provision that supports those issues, such as healthcare, but to have a really good understanding of some of the opportunities that might be provided from wellbeing or health promotion in the establishment. It might be about linking and making sure, where we have brought key workers into establishments to support prisoners, that they are engaged in that issue. It is to make sure that security are engaged and working with intelligence, and that we have the right equipment in place and staff are engaged in the issue of NPS.

One of the key roles is not necessarily knowing lots about healthcare particularly or security; it is about how you bring those services together to solve a problem. You tend to see that happening at a very local tactical level every day—the minutiae. There is also a much greater strategic responsibility to solve some of those issues, and that is what we ask governors to do. It is not necessarily about the commanding process.

Q218 **David Hanson:** Is there any comparison between the way health services are managed and the way education services are managed in prison? What is your view of those twin challenges?

Digby Griffith: It is a valid comparison to some extent. Governors have moved from being in control of all the staff delivering the services in their prison 30 or 40 years ago to places where there is a range of providers working in their prison at any one time, providing a range of services. With health and education, we have employers coming in to do training of prisoners. Facilities management in the past has been provided by external providers. There is a range of functions that the governor has to bring together. He has to provide an environment where all those things can operate.

The education contracts that we have just put in, from 1 April, are very similar. We did the commissioning this time. We commissioned the range of providers we have working in prisons. What the governor has to do is provide an environment where they can operate. The difference is that we are in control of the commissioning arrangements there; we are managing the contracts. There is also an element in the education contract where the governor has complete discretion about what he or she might want to provide.

There are very strong comparisons between the two. That is part of a wider picture in which governors have increasingly become the chief



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executives of an organisation where there are a number of different providers of key and core services.

Q219 **David Hanson:** A chief executive is accountable for everything that happens in the organisation, and when something goes wrong elsewhere the chief executive takes the rap; but in a prison there are still diverse lines of accountability.

Digby Griffith: I think we find that the governor is held responsible for a lot of things over which they do not have direct control.

Q220 **David Hanson:** In Wales, in my neck of the woods, there is a different mechanism. There are a number of prisons in Wales—Swansea, Cardiff and a new prison, HMP Berwyn, in Wrexham. Their health service partnership boards are jointly chaired by the local health board and the governors of the prisons, as I understand it. I am not saying that is better or worse, but it is a different model. What is your assessment of that different model?

Digby Griffith: It is more a question about how different it actually is. In practice, in England we have a system in which the local delivery board is supposed to be chaired by the governor, but in many instances a collective is operating that, with shared responsibility for leadership. It is much like the national board that we have, where there is a rotating chair. Of the five organisations, everyone will chair it at one time, which gives a dynamic of shared leadership.

Q221 **David Hanson:** Are there any lessons to be learned from Wales, or not?

Digby Griffith: There are a lot of lessons to be learned from Wales—lots of things actually. Because there are only five prisons in Wales, it is a more intimate service. It is easier to make changes across a system with only five parts as opposed to 115. Yes, we look at Wales a lot in terms of what they are doing. We try to learn from the best practice there, and vice versa.

Q222 **Chair:** How can we stop governors being held responsible to account for things that they do not have any control over? That seems to me a real conundrum we have to deal with.

Michelle Jarman-Howe: While it is clear, as we have discussed, that governors have a range of responsibilities to make the prison work effectively, based on the strength of the relationships we have with the providers operating in that environment, governors are clear about where clinical responsibility lies in the organisation.

Of course, what that does not and should not prevent are day-to-day discussions about how we make things better. It is important not to lose sight of the fact that most individuals, whether leading a prison or working within it, are motivated to make the prison work well and to provide good outcomes for prisoners. People often operate slightly outside and give some flexibility to try to get good outcomes for prisoners



and to make things work, but I think governors are clear about what they are responsible for and what they are not.

Q223 **Chair:** We take the point that it is in structural terms.

Michelle Jarman-Howe: And in inspection terms. I think that matters.

Digby Griffith: Governors are trying to do incredibly complex jobs. They are trying to satisfy a range of stakeholders. For many members of the public, prisoners are hidden away and the governor is responsible for them. What we are trying to get to is a position where prisoners are simply members of society, with a stake in society and looked after by other services in the way that people not in prison will be looked after by services. Health is a very good example.

I think you will find that governors take very seriously what happens in their prisons. They take it very personally when things go wrong, regardless of whether they have the statutory legal responsibility or not.

Q224 **Ms Marie Rimmer:** Can we look at the justice indicators and performance? What are the measures for healthcare outcomes for prisoners across the estate, and can any lessons be learned from education?

Digby Griffith: Having established the partnership agreement and the national board, we have a piece of work under way to try to put together a range of indicators across the five agencies involved. That will provide us with a national picture of how health is being delivered, its quality and its success down to regional and prison level. We have not done that yet.

What we have is a range of existing measures that give an indication of particular issues. For example, mandatory drug testing gives us an indication of the level of drug use in a particular prison at any one time and across the estate. Part of that is probably reflective of the quality of drugs interventions we have in place provided by healthcare services across our estate.

Q225 **Ms Marie Rimmer:** Are those the health and justice indicators?

Digby Griffith: Health and justice indicators are owned by my health colleagues, not by us. What we want to try to do is pull from those health and justice indicators owned by others and pool them with some of our own indicators to create a package—a suite of measures that we can use across the five agencies.

Q226 **Ms Marie Rimmer:** Are your indicators different from the health and justice performance indicators?

Digby Griffith: Yes. There are different measures measuring different things across the health system and across the justice system. We want to bring together the key ones to provide a suite of measures that we can all use.



Q227 Ms Marie Rimmer: How do those indicators relate to commissioning? How do we measure the outcomes? The health and justice indicators, although they are not yours, are like breath tests, liver tests and blood tests. It is input, but what about outcomes? What happens to that input? Would you explain that to me, please?

Digby Griffith: I will try to explain. I am not sure I am going to give you a satisfactory answer because we do not own those justice indicators. They are owned by health colleagues and not by us. As I say—

Q228 Ms Marie Rimmer: And they are not published, are they? You wouldn't know.

Digby Griffith: No, I am not sure.

What we are trying to do is to pool the key indicators on the health and justice side with the key indicators we have. I suspect that some of those will continue to be input measures. Having outcome measures for health is quite difficult. On other things—for example, employment and education, for which I am also responsible—what I am looking for is that at the end of the individual's time in custody we can see demonstrable achievement and improvement in educational attainment and employability. It is very difficult to see those things on a health dynamic with the same level of clarity. How do we prove that someone is healthier at the end of their prison sentence than when they went in? That is much more difficult to do.

Q229 Ms Marie Rimmer: You could measure my cholesterol as I am going in. You have different blood tests as you are going into prison, and, if your cholesterol is above five or it is eight, they tell you that you need to get it down to below four, and how to do it. There are various different indicators. My GP can tell me that, so why can we not do that in prison?

Digby Griffith: You would have to ask health colleagues rather than me. That would be a pure health indicator that might be useful.

What we ought to be trying to do is replicate what is happening in the community. It is very important that we do not see time in prison as something fundamentally different from time in the community. The indicators we would like to have from a health perspective should, to a great extent, echo the indicators for the community side of health. There are additional things in prison that are peculiar to the prison setting. We can do a mandatory drugs test in prison to measure the level of drug taking. We can get an indication of that in the prison setting, but it is much more difficult to do in the community.

Q230 Ms Marie Rimmer: The Royal College of GPs tells us, "there is no central solution for the interrogation and monitoring" of healthcare data at the present time. Can either of you help us on that?

Digby Griffith: It is probably one for my health colleagues more than us. They have the statutory responsibility. Again, I would stress that we are



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trying to get to a position across the five partners of the national partnership agreement for a suite of measures that will give us indicators for how well we are doing on the provision of healthcare in prisons, and what their effectiveness looks like, to the best extent we can.

Q231 Ms Marie Rimmer: How do we monitor the overall measuring of prison performance on the healthcare measures?

Digby Griffith: At the moment, the overall position is provided by the prison inspectorate, with the CQC being involved. In a prison inspection, they look at a range of factors in the prison performance, including the CQC looking at the provision of health. They give us commentary on the quality of the healthcare provided and the facilitation of that healthcare. Those are not individual measures; that is an overall assessment provided.

Q232 Ms Marie Rimmer: The inspectors go in to see if the performance is as it should be, or as we expect it to be, and we are using that to measure. We are just dependent on inspections rather than regime-operating management.

Digby Griffith: What I am saying is that we are trying to develop a suite of measures that will give us indicators for how well we are doing it.

Q233 Ms Marie Rimmer: You are trying to develop them.

Digby Griffith: Yes. By the end of this financial year, I would expect to have a suite of measures that will tell us what we are doing on health in prisons across the five agencies, and its effectiveness. We want that tiered. We want a national picture for the organisation as a whole. We want a regional picture, so that Michelle and other colleagues can see what is happening in their regions. We want a prison picture, so that individual governors have a very clear picture of what is happening in their prisons.

Q234 Ms Marie Rimmer: Would you like to comment on any of that, Ms Jarman-Howe?

Michelle Jarman-Howe: The inspectorate of course, when they visit, are very much focused on outcomes. They consider health delivery as part of the overall outcomes for prisoners in the establishment. That provides some helpful narrative for prisons and prison governors to move forward on with their health partners.

Digby is right that we are focusing on developing a range of measures for later this year. We have the information and the targets that are assessed in NHS England.

On your point about regime delivery and how we assess it, prisons are well aware of the hours available to access healthcare. That is different from the clinical outcomes that NHS England and the commissioners are responsible for managing.



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Q235 **Ms Marie Rimmer:** How many people have been diagnosed with a mental health condition or learning disability in prisons?

Michelle Jarman-Howe: As a percentage?

Digby Griffith: As a percentage, a very rough estimate is that about 30% of entrants to the prison system have some form of learning disability.

Q236 **Ms Marie Rimmer:** It is a rough estimate.

Digby Griffith: Yes.

Q237 **Ms Marie Rimmer:** Nothing really proper. Where has that rough estimate come from?

Digby Griffith: I would have to go back to the detail on where that came from; I cannot remember offhand. I do not think it will have been from counting the number of clinical assessments done on every individual prisoner. It is more likely to have come from a survey of generalities.

Michelle Jarman-Howe: And reception screening. Every prisoner, as they arrive at the prison, will get some reception screening. All prisoners, as they come into custody, receive healthcare reception screening so there is a level of information that would be available from that initial screening. Of course, it is well known that a proportion of prisoners coming into custody have significant mental health issues, such as anxiety and depression, which is much higher than it is in the general population.

Q238 **Ms Marie Rimmer:** But it is generalisation. The National Audit Office is really good people for getting information. It tells us that a "commonly used estimate is that 90% of the prison population are mentally unwell." That was in 1998, and it "uses a broader definition of mental illness than many clinicians would recognise. NHS England collects information on the number of people in treatment for mental illness, which currently amounts to 10% of the prison population in England." There are different figures coming from different bodies but there is no exact measurement. How can we meet the needs of prisoners if we do not know the exact measurement?

Digby Griffith: That is why we need better indicators than we have at the moment, so that we have a very clear profile of what the profile of the prison population is.

Q239 **Ms Marie Rimmer:** You are working on that.

Digby Griffith: We are.

Q240 **Ms Marie Rimmer:** When can we expect to see it delivered?

Digby Griffith: This financial year. We should have a suite of data and suite of measures to allow us to have a very clear picture.



Chair: That is very helpful.

Q241 **Rosie Cooper:** I have a very quick question for the director of safety and rehabilitation. We are currently looking at the role of a governor, but this is another question, way out left field, that I hope you will be able to help with.

The role of the governor in looking after healthcare applies to everybody in prison, including the staff of the prison. Do you know why all employees in a prison are not vaccinated—for example, against hepatitis? If they want to have that, they have to pay £100 themselves. Are we putting staff as well as prisoners at risk?

Digby Griffith: I am afraid I do not know the answer to that question, but I will go away and find out.

Chair: If you find out, we will pass it on to colleagues on the Health Committee as well.

Rosie Cooper: It is on the record that they are not immunised, and they are putting everybody in danger.

Chair: That is helpful and we will follow it up. We are very grateful to you.

Thank you very much, Mr Griffith and Ms Jarman-Howe, for giving evidence to us.

Examination of witnesses

Witnesses: Francesca Cooney, Paul Cottrell and Chris Emmett.

Q242 **Chair:** Thank you very much for your patience and for coming to give evidence to us. There is quite a lot to get through on these topics, as you can see. Perhaps you could introduce yourselves and your organisations for the record.

Francesca Cooney: I am Francesca Cooney, the head of policy at the Prisoners' Education Trust. I am also here on behalf of the Prisoner Learning Alliance.

Chris Emmett: I am Chris Emmett. I am the director of strategy for offender learning for Weston College. We have the contract to deliver education in lot 1, lot 4 and lot 8, which amounts to 19 prisons.

Q243 **Chair:** Do you know where those are geographically?

Chris Emmett: Yes, Devon and North Dorset, Avon and South Dorset and Kent, Surrey and Sussex.

Paul Cottrell: I am Paul Cottrell, acting general secretary for the University and College Union. Our members provide prison education.

Q244 **Chair:** Can we get an overview of where we are with these things? It is three years since the Sally Coates review, where there were a number of



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very specific recommendations. It is a year since the education and employment strategy was published by the Department. How well is it progressing? How well is implementation of the Coates review in particular, and the strategy, progressing?

Francesca Cooney: The main thrust of the Coates review was to rearrange funding arrangements and give more autonomy to governors so that they could commission, monitor and manage education in their prisons. That is going fairly well in terms of the thrust of the policy aim because new arrangements have come in.

There are a lot of challenges with the implementation of the new PEF contracts, but I am sure we will talk more about that in a little while. The aim to assess all prisoners who come into prison and to have a national curriculum in the main subjects is working well. On the personal learning plans, if you are in a PEF provider prison you will be able to see the plan transferred to your prison.

Q245 **Chair:** How many are in that category?

Francesca Cooney: There are 102 prisons that have PEF providers. The Welsh prisons and some of the contracted-out prisons are not in the system.

Q246 **Chair:** But the majority are.

Francesca Cooney: The majority. You were talking about learning disability and difficulties earlier. Every sentenced prisoner is now screened on arrival in custody. Although we are disappointed that that does not cover remand prisoners and the rest of the prison population who are already there, in time, as we get more sentenced prisoners through, we will have a better idea of how many people have been screened and what their needs are. The data you were asking for earlier, about how many prisoners have those needs, we will know in the future.

Q247 **Chair:** Ms Emmett, what is your take on it?

Chris Emmett: All the education providers delivering the PEF contract, MOJ and HMPPS subscribe to the recommendations in the Coates review. I do not think there is anything in that review or the recommendations that we would have any opposition to. The difficulty in some cases is that the budgets do not allow a curriculum that meets the needs of the whole range of the prison population. It has to cater for majority needs, and therefore that may marginalise others, like older prisoners, or higher level learning or learning in workplaces, not because there is not a will to do it but because the budget does not stretch that far.

Likewise, one of the recommendations in the Coates review was improvement in technology to support education and communication. You can imagine the costs involved in that in a prison estate that might be half a mile from one side to the other, often with very old buildings. There is a significant drive to increase and improve that at the moment,



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but it will not happen instantly; and it will require money both from providers and from the MOJ to support that, but it is in the right direction.

Q248 **Chair:** It is moving in the right direction. You say the providers have all bought into the Coates review.

Chris Emmett: Yes.

Q249 **Chair:** Has the Ministry?

Chris Emmett: Yes, I think it has, but the money is not quite there to make it happen overnight.

Q250 **Chair:** It is about putting the money where their mouth is.

Chris Emmett: Absolutely.

Q251 **Chair:** Mr Cottrell, can we have your point of view?

Paul Cottrell: From the perspective of the classroom and the workshop, our members have not yet seen significant improvements from the new scheme. They are still concerned about the lack of support for the teaching workforce in prisons. One of the things we welcomed very strongly in Coates was the emphasis on improving and developing the workforce. We have yet to see very much coming forth to fulfil those recommendations.

Our members have concerns about the new system. They are concerned that yet again there is more change and more churn in the system. They are looking for more stability and a longer-term horizon for educational planning. If you plan to introduce new courses, there can be a four or five-year process before they are fully bedded in, yet we are still back in a system of commissioning and recommissioning. In the case of the DPS aspect, there are one-year horizons that are not long enough to develop education.

Q252 **Chair:** What sort of period do you need for sensible commissioning?

Paul Cottrell: We need more stability. We need to look at five-year horizons. We also need to have the systems managed by people who understand education. We are concerned about the additional discretion and power that is being given to governors to commission educational provision, because that rather depends on whether governors are interested and committed to education, and whether they understand education.

Of course, the trouble with education is that we all think we understand it because we have all been through it. We would like to see much more input from the educational professionals who are actually delivering education and training to prisoners. We want their voice having much more impact and being listened to and learned from by the people who are making the decisions, who at the moment seem very remote from the classroom to our members.



Q253 **Chair:** What is your take on that, Francesca?

Francesca Cooney: Governors and senior leaders in prison education would agree with you. We did a survey of prison governors and heads of function. We got 60 responses, and only 10 of them felt that their staff team had the skills and knowledge to manage the contracts and commission the services, so they would agree.

Q254 **Chair:** Do you think that enough weight is being given to the technological challenges? There is talk about a review of security arrangements being required. Has that happened?

Francesca Cooney: It is beginning to happen, but it is at very early stages. As Chris said, the resource is not there to make the big difference that is needed.

Q255 **Chair:** What is your members' point of view, Mr Cottrell?

Paul Cottrell: Security is a huge issue for our members. They want to concentrate on delivering education, developing it, innovating and developing good practice. Often, it is very basic concerns about their own health and safety and the health and safety of their students that concern them. It is simple things like having a prison officer available to take a prisoner to a toilet break, for example. We have instances of members pressing panic buttons and not receiving a response for 30 minutes. They are still suffering from the reduction in prison officer staff numbers. We know that is beginning to be reversed, but we would like to see some resources being put into the education side of things as well.

Q256 **Chair:** How much does that contribute to the churn you talked about?

Paul Cottrell: It is enormous. Between July and September last year, 25% of inmates were transferred. If you are a teacher and you have a class and a list of students, you never know from one lesson to another whether they are all going to turn up or not. It is not necessarily because they have been transferred; it may be because of a lockdown. The prison regime always comes first and controls the education. The need to integrate education provision with the regime is the really big challenge that we have never got right, and I think it is probably getting worse, rather than better.

Francesca Cooney: But we have the opportunity to make it better, because now the governors are responsible for education. They will meet their education provider on a monthly basis. They will get data from the new monitoring systems. Ideally, they will integrate those services so that they can see where the challenges are in the system.

It is early days, and I agree that we have not seen that yet in practice, but the potential is there. The infrastructure is potentially there for it to happen.

Chris Emmett: It is very difficult at the moment. In certain prisons, it is easier than in others. If the regime and staffing is stable, there is more



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time for governors to focus on healthcare, education, and so on. When their daily operational life is focused on other more pressing issues of security, decency and safety, it takes them away.

Most prisons do not have something like a three to five-year vision for education. It is a little bit on the hoof. It is then hard for staff working in the prisons to understand what the educational culture is in the prison and to promote that, because they do not understand their role in unlocking prisoners and making sure they get to education. A whole prison culture, rehabilitative and educational, needs to develop. Some prisons have that; others are quite a way away.

Q257 Chair: In April this year, we had the new prison education framework, and I want to ask you a bit about that. The four providers are the same. Given that that is the case, what has changed and what are the pluses and minuses?

Paul Cottrell: I thought what Drs Bromley and Cumming said about the way the commissioning process can lead to over-complexity and fragmentation of the system was interesting. We now have the challenge of understanding a completely new system, even though some of the providers are largely the same.

As I said before, our members are concerned about lack of stability, and the inability, and lack of support, for their development as professionals through continuous professional development, the opportunities for which are fairly limited in prisons; and we are still in a situation where governors are able to negotiate and choose providers, and have control over the courses that are provided. That can change quite rapidly through the dynamic purchasing system, which is something we are particularly concerned about.

To go back to what I said earlier about the ability of governors to handle this, I notice that in the Government's education reform strategy, which introduced these new arrangements, there is a reference to supporting governors with training to help them understand their new role in relation to education. I would like to see what training is being provided for them and how it is being monitored.

Q258 Chair: Have you been shown any?

Paul Cottrell: No. We would be quite happy to provide some ourselves, free of charge, if the Government would like. I would start by saying to all governors, "You need to understand the three Ls when you manage your staff. Listen to them. Learn from them. Look after them." At the moment, our members do not feel that as professionals they are being listened to, learned from or looked after. That needs to be got right if this system is to stand any chance of working.

Q259 Chair: Changing the framework does not alter that. What do you think about the challenge Mr Cottrell makes, Francesca? Are governors actually equipped to be responsible for education?



Francesca Cooney: No, not yet.

Q260 **Chair:** Have we given them a responsibility that they cannot deliver?

Francesca Cooney: The training on managing the contracts happened far too close to the start of the contracts. There was a push to get the contracts into place without the infrastructure being there. The HMPPS team to support the process was also put in place too late, and its roles and responsibilities are still being developed and ironed out. The regional structures are still being finalised in terms of supporting prisons with the legal and technical support that they need to do the commissioning.

It is right that most heads of learning and skills do not have an educational background; they have an operational prison background, so they have not yet got the skills to manage this effectively. That is something that governors and heads of function are very aware of; people would not disagree with that assessment.

Chris Emmett: In some prisons, governors, heads of reducing reoffending and learning and skills managers are very well versed in education. They have made it their business to be so. That is where you find that the partnership between prisons and education providers works well. As Francesca said, in others, it is not quite the same.

In the new PEF contracts, one of the KPIs is something called the teacher quality management plan, which sets out requirements for staff delivering in prisons. Staff should either have, or be working towards within a very short space of time, both teacher training qualifications and upskilling. Our minimum is a certificate in education and training, plus we train prisoners to that level, to support learning on the wings. We have negotiated in the lots where we work three CPD Inset days that are available for all staff. The education regime shuts down and we have all the staff either together or in groups. We invite our prison colleagues to that as well—the heads of reducing reoffending, governors and learning and skills managers. We are all in it together, and to make it work we have to work together.

Q261 **Chair:** As a provider, do you find some of the things that Paul talked about, such as prisoner attendance, for example, and the nature of the regime impacting on your ability?

Chris Emmett: Certainly. Allocation and attendance is an aspect that is commented on, usually not favourably, in Ofsted HMIP reports. That is part of the whole education culture. If a wing officer does not understand why it is important for a prisoner to do English and maths, or learn to do brickwork, he goes to the cell and goes, "Education? No, not this morning," and just shuts the door again.

Everyone has a part to play, and if it is valued, it helps to get the prisoners there. It is soul-destroying for teachers when they are waiting in a classroom or a workshop expecting 10 learners, and two turn up because a couple have been transferred, one has gone to the gym, one is



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still in bed, and so on. It is disheartening, but it is also very satisfying when it works.

Q262 **Chair:** Understood. I think there is agreement there.

We have talked about the move to the new framework. Are there any specific operational challenges that you face in moving to the new prison education framework?

Francesca Cooney: I want to mention the dynamic purchasing system. We have been getting feedback from governors and prison staff, as well as service providers. Overwhelmingly, the feedback is negative so far. We know there is about £60 million in the DPS pot. About £4.5 million has been spent so far on 50 contracts. Three quarters of that provision has gone to information, advice and guidance services.

Smaller providers tell us that the contracts are too short, because they can only be up to 12 months, and that the process is too complex. It takes too long and is time-consuming. Prison staff also tell us that the process is time-consuming. Writing the bids, assessing the bids and evaluating the bids takes too much time. Basically, not enough contracts are coming through the system quickly enough. We are finding that there is a build-up of the funding pot that may not be spent before the end of the year.

Q263 **Chair:** Do you get a sense of why that is?

Francesca Cooney: The process is too complex and it is taking too much time.

Q264 **Chair:** Does that skew it towards bigger providers?

Francesca Cooney: Yes.

Q265 **Chair:** Smaller people do not have the resilience, if you like, or the capacity to go through all of that.

Francesca Cooney: Yes, absolutely.

Q266 **Chair:** Would you tend to agree with that, Chris?

Chris Emmett: Yes. I think the plan was for the PEF and the DPS to go out at the same time, but both had a short timeframe, they are very complex and it did not happen at the same time, which caused problems with TUPE-ing staff, and with bidding.

Francesca Cooney: The prisons were still waiting to find out what was happening with their core PEF contract. Even though the DPS was open, they were not using it because they were still waiting to find out what their curriculum would be from their core provider. They started using it much later than expected.

Q267 **Chair:** What about the staff point of view?



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Paul Cottrell: What worries me about this is that the system could lead to a narrowing of the curriculum because some of the broader elements would come in under DPS. It is important obviously to concentrate on basic skills, because we know that is where the huge lack is when prisoners come in. We know how low their skills are. Being able to assess improvements in things like maths and English is a relatively straightforward thing to do.

I am not saying that all of that is not important, but the business about people understanding the broader importance of education within the prison is very important to breaking down barriers between the prison regime and the education provision. That wing officer needs to understand how education helps the whole prison atmosphere and culture. If prisoners are engaged in purposeful and satisfying activity, their social and communication skills improve. Their self-respect improves, and that will affect the whole culture of the institution and behaviour in the institution more broadly. It is actually in the interests of prison officers to understand and support education. That needs to be built into their training, just as it does into the governor's training.

Q268 **David Hanson:** This inquiry is about governor accountability, responsibility and performance. The question central to all of that is, has the new framework improved the ability of governors to provide and account for what is done in education in their prisons?

Francesca Cooney: It has improved the ability of governors to monitor and evaluate education. They will be getting monitoring data in real time, so they will be able to see what is happening. Higher up though, the governor accountability measures have not been finalised yet. We are still waiting to see what governors will be held accountable for in terms of education. That work is ongoing.

Q269 **David Hanson:** There was a recommendation in the Sally Coates review that "A core set of performance measures should be used by all prisons. Such data should be monitored consistently to drive continuous improvement." Is that happening?

Francesca Cooney: The assessment data will be a core set of data. You will be able to see who is being assessed in maths, in education, and progress there. You will be able to see screening for learning difficulties and disability. There is basic data that will be assessed across all prisons. In terms of outcomes that are more connected to progression and more detailed achievement, we are waiting to see how that is going to be implemented.

Q270 **David Hanson:** What is the governor responsibility for those areas?

Francesca Cooney: We do not know yet. Until the accountability measures have been finalised, we will not know what governors are being held accountable for individually.

Q271 **David Hanson:** When do you expect that to happen?



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Francesca Cooney: The end of the year, perhaps. It is part of the ongoing suite of accountability measures that Digby was talking about earlier.

Q272 **David Hanson:** Who do you see as, in a sense, an outside agency? Who do you see as the essential key decision maker in those decisions?

Francesca Cooney: Ideally, it would be the governor. It is a bit more complicated because the education contracts are run at lot level, which is between four and 10 prisons. A group of prisons is part of that contract, and it is a contract that is being monitored across the lot. Ideally, the governor would be held accountable, alongside the providers, for the performance of education.

Q273 **David Hanson:** Chris, as a lot holder, who do you think is monitoring making you accountable for the delivery of your service?

Chris Emmett: Virtually everybody. Obviously, the learners; we get their feedback. We have informal meetings, but there are monthly minuted meetings with the governor or his representative to look at and sign off what activity has occurred during the month, what issues, what resolutions, and so on. We have monthly communications with the contracts management team and quarterly reviews, plus HMIP and Ofsted input.

Q274 **David Hanson:** When the cake is baked well, does everybody take credit?

Chris Emmett: Yes.

Q275 **David Hanson:** And when the cake collapses, you are responsible.

Chris Emmett: It is not quite like that, but it is difficult. It is a bit like healthcare. We are responsible for what is delivered to learners at the chalk face, but it is the prison's responsibility to make sure that those learners are allocated and get to us, and to support that.

Q276 **David Hanson:** I am sorry to pick on you, but you are in front of us as a lot holder. Let's look at personal learning plans for individual prisoners. One of the proposals in the Coates review is that every prisoner must have a personal learning plan. How many of the prisoners in your 19 prisons currently have a personal learning plan?

Chris Emmett: Every learner engaged in education has an individual learning plan, which is not quite the same. The personal learning plans are still being developed with HMPPS, but the idea would be that they are a journey monitor from induction. Resettlement starts from induction and includes everybody—the offender management team, the healthcare team, the education team and the residential team—with a view to sequencing things on that journey. It will be either paper or digital; it has not been decided yet.

Q277 **David Hanson:** I am going back to 2016 and the Coates review: "Every



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prisoner must have a Personal Learning Plan that specifies the educational activity that should be undertaken during their sentence.” At what stage do you expect that to be a reality in the 19 prisons you are responsible for?

Chris Emmett: It is a partial reality at the moment.

Q278 **David Hanson:** I didn’t ask that. I asked at what stage you expect it to be a reality.

Chris Emmett: I would think by the end of year one, and probably the start of year two, of the PEF contract.

Q279 **David Hanson:** What date is year two?

Chris Emmett: It would be April 2020.

Q280 **David Hanson:** You are saying that by April 2020, in the 19 prisons that your four lots are accountable for, the aspiration of 2016 for every prisoner to have a personal learning plan will be achieved.

Chris Emmett: Yes, because we are partially there.

Q281 **David Hanson:** As a comparator, do you have any information about performance in the other lots that have been awarded?

Chris Emmett: Yes. We meet regularly as providers, and we are all hoping that there will be a generic template that we can all use so that prisoners can take their personal learning plan with them, either a computerised one or a paper version, and it will be recognised if they move prison from one provider to another. We have not yet received an approved version, so we are all doing something slightly different.

Q282 **David Hanson:** To help the Committee as a whole, who do you see as being accountable for making sure that you deliver that service?

Chris Emmett: It will be a part of the KPIs when they are finalised, I would think, but they are not fully finalised yet.

Q283 **David Hanson:** I want to get a sense of who is accountable overall for monitoring the service. You say that you expect to deliver a personal learning plan for each prisoner by the end of 2020.

Chris Emmett: Yes.

Q284 **David Hanson:** You are saying that that will be part of the KPIs.

Chris Emmett: Yes.

Q285 **David Hanson:** Can you give me clarity as to who you think, for your four contracts, is managing and responsible for the KPIs?

Chris Emmett: We will be responsible for meeting them. The governor in the prison, in those monthly meetings, and the contracts team will be responsible for monitoring our progress against them or our achievement of them.



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Q286 David Hanson: Let us say that a lot holder—not you personally—does not meet those KPIs. Who is going to put in a plan for continuous improvement or who is going to terminate the contract? Who is going to ensure that performance is raised? Who has that responsibility?

Chris Emmett: It depends at what stage. Initially, in those monthly meetings, that should be raised with the governor, and there should be an action plan that comes from that which is then monitored the following month. If the issues that are awry are not addressed, it will go to the contracts team and there will be a special measures-type meeting where actions will be laid out clearly. There are financial penalties if we do not meet them.

Q287 David Hanson: Help me to understand this. Who ultimately will decide that there is a financial penalty against the contract? Who ultimately would decide that the contract is terminated?

Chris Emmett: It would be the HMPPS MOJ contracts team.

Q288 David Hanson: What is the relationship between the contracts team and the governor? You might have a situation where, in one of your four lots, there is underperformance, and in three there is not. Who ultimately is going to financially penalise an organisation—not yours, any organisation? What is the governor's role in the decision on that financial penalty and/or the decision on that termination?

Chris Emmett: I am not entirely sure about that. We tend to deal on that level with the contracts team.

Q289 David Hanson: I am still trying to get to the bottom of this. The governor has responsibility for the prison and the education service, but you are now saying that you do not have clarity on who would financially penalise or who would ultimately terminate.

Chris Emmett: My understanding is that it is the contracts team.

Q290 David Hanson: But what is your understanding of the relationship between the contracts team and the governor, just as a provider?

Francesca Cooney: It should be possible for a contract to be breached prison by prison, so it should be possible to penalise a provider because of their service provision in one prison rather than the rest of the prisons in that lot. All those decisions, even if they are initiated by a governor, will be signed off by MOJ contracts.

Q291 Chair: It is all centralised.

Paul Cottrell: I find it extraordinary that we are still talking about this. I can remember going to meetings 15 years ago, or even longer, where we were talking about the learner journey, and ensuring that every prisoner had a learning plan and that it moved with the prisoner as they were transferred; and that they were not subject to reassessment every time and sent back to the beginning of a course that they were already halfway through.



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It is not difficult to solve, surely. We still have not got it right. We ought to have a national system. It should be consistent and it should be applied for every prisoner in exactly the same way. The system itself—the process—does not need to be varied. You can equip every prisoner with a learning plan in a standard form and ensure that it is transferred. If it is not, it ought to be absolutely clear that it is a national system with national responsibility. The responsibility should be with the Minister.

Q292 **Chair:** You are saying that there is lack of clarity.

Francesca Cooney: There has been some progress. The main assessments are nationalised now. The curriculum in the main subjects is nationalised, and those assessments go with the prisoner and can be seen on transfer. There has been some progress, but it is not yet where we want to be.

Q293 **David Hanson:** My final point is that there are four contracts and there are four providers overall. I am interested in how the contract managers/governors/MOJ are managing the different performances, going back to Mr Cottrell's point about delivery by the four different contractors as opposed to one contractor that they can monitor centrally. I am interested in any comments on that at some point.

Chris Emmett: Obviously, we have our individual meetings with the contracts team, which reviews our lots independently—what is happening in this lot, that lot and the other lot—as will the other providers. We also have collective meetings with the four main providers and the MOJ and HMPPS to cover more generic issues, either in terms of their service or our collective service or concerns.

Q294 **Ms Marie Rimmer:** The dynamic purchasing system launched in April 2019 is ideal, the Ministry says, for smaller enterprises; it lends itself to local smaller providers who will be able to work with prisoners and deliver in niche areas. The DPS also allows smaller companies to join the system once they meet the criteria, throughout the year, and everything like that. It is not a timely process and can meet niches in prisons like arts, drama and horticulture through that opportunity. Yet here we are with £4.5 million spent this year, as opposed to £158 million spent in 2017-18. Are we not getting those smaller providers because it is too complex?

Francesca Cooney: To be clear, only £16 million is allocated in the DPS pot. There is only £16 million in that bit of it, within the education framework.

I have no doubt that the intention was for it to be a flexible system and for it to be somewhere you could get niche and specialist provision, and get creative additional subjects for your curriculum. It has not worked out like that yet. It is far too complex and time-consuming. The contracts are too short for it to be feasible. Unless there is a bit of an overhaul of the DPS, we are not going to see that funding spent in this financial year. Learners will lose out on opportunities.



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Q295 Ms Marie Rimmer: A governor is not always expected to use DPS for specialist provision, if their main contractor is through the PEF. They can use that, but they do not have to; there is no obligation to use PEF. Do you think the smaller enterprises and the different niches are going to take much more?

Francesca Cooney: We are getting feedback from service providers that they cannot plan their budgets; they cannot plan what is going to happen to their organisation because they are not getting contracts through as they would normally expect. It is impacting significantly on specialist arts provision, family services and other small voluntary sector organisations working in the criminal justice field. You are absolutely right to be concerned. We are also very concerned.

Q296 Ms Marie Rimmer: Clinks told us that the training for staff is inadequate for it to be effective. Would you agree or not? Do you know?

Francesca Cooney: Yes, absolutely. That is what prison staff have told us as well. They wanted more training, but the user manual was not straightforward. It takes far too much time for them to be able to get on to the system and process the information. They are getting conflicting advice from different specialists about how they can use the tenders, and what they are allowed to tender for. I completely agree that there was not enough training in place for people to be able to use the system.

Chris Emmett: I think the staff's priority in prisons is to get the PEF contracts under way and running, so their focus is primarily on that, which has taken their eye off the ball a little bit on the DPS. Undoubtedly, the services that were available were very much valued, but their focus is on getting the big contracts right and running well. Then they might think about it, but by that time some organisations may not be financially viable.

Q297 Ms Marie Rimmer: And they will have lost that provision this year.

Francesca Cooney: Yes, absolutely.

Chris Emmett: Yes.

Q298 Ms Marie Rimmer: That answers a question raised by the Howard League. It is not there; a lot of what was provided has gone now. A lot of prisoners enjoy the arts and have lots of skills in the arts. Very often, they can express themselves and it takes their mind off other things.

Paul Cottrell: That is exactly what is happening. It is making the DPS side of things the second-class element. It is the bit left over for the relatively small amount of money under the control of the governors, with very short timescales, and it can be chopped and changed, depending on what individual governors feel is available and who might be competing for the provision.

The content of that education ought to be seen as just as important as the basic skills in the PEF because it can be life-transforming. When you



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talk to prisoners whose lives have been transformed, it is often in those sorts of areas—the arts and the creative side of things. It is absolutely essential that we take a fresh look at that. I do not think it is working and I do not think it is going to work. It will have the opposite effect. It is going to narrow the provision, and that is really dangerous.

Q299 **Ms Marie Rimmer:** There are many fine examples—I am sure you know of them—where people and facilities are known worldwide.

Paul Cottrell: Yes.

Q300 **Ms Marie Rimmer:** How are the providers monitored in prisons? Are there challenges for multiple education providers operating in one prison?

Chris Emmett: It is not really happening quite like that as yet, because multiple providers would be the PEF provider plus DPS providers. In some, there may be a DPS provider, but in a lot that is still to come. The actual management of that, which is supposed to be under the auspices of the learning skills manager employed by the prison, is not being seen to its full extent as yet.

Q301 **Ms Marie Rimmer:** It is not happening at the present time.

Chris Emmett: A little bit is happening, but not as much as anticipated.

Q302 **Ms Marie Rimmer:** A lot of money is still being spent and we are not meeting the needs or even the desires, which we should try to do because it is helpful for transformation and rehabilitation. It is a wasted opportunity, isn't it?

Chris Emmett: The other thing with the DPS contracts is that obviously it depends on whether you have staff available. When the contracts come out, they may be bidding now for one that is expected to start in August, but they probably will not know that they have got it until the end of July. They may not be aware whether they have enough staff that are security cleared, ready and available to deliver it. Again, there may be a bit of a delay.

Q303 **Ms Marie Rimmer:** The contracting mechanism is not fit for purpose. It is not meeting the needs of prisoners.

Chris Emmett: Not currently. I think it may longer term, but this year it is going to be a little bit less.

Q304 **Ms Marie Rimmer:** Is it actually being monitored? Is all this being highlighted? Is it being notified to Ministers?

Francesca Cooney: I think so. We are working with Clinks. We have a meeting with providers and the MOJ next week. We are trying to highlight all these issues.

Q305 **Ms Marie Rimmer:** If I was commissioning in the outside world in the private sector and I had problems, right at the start, I would be able to go to the provider and say, "This is not meeting my needs." Has anything



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like that gone on as yet?

Francesca Cooney: Not yet.

Q306 **Ms Marie Rimmer:** Is the Ministry using the opportunity of the new educational arrangements to improve the monitoring of outcomes of prisoner learning?

Paul Cottrell: They certainly need to. My word of warning about that is that the indicators we choose to monitor the outcomes are important. We should not go for the ones that are easily measurable and forget about the broader impact that good prison education and training has, not just on employability—another important measure, but not the only one—but on the way in which, as we said before, prisoners' lives can be transformed.

For example, we need to look at the number of prisoners who continue with their education when they leave prison. That is a good indicator, it seems to me. There is also the impact on reoffending. The Government say that reoffending costs the country £15 billion a year. Research shows that engagement in education and training can reduce that by a factor of between 7% and 10%, or something like that. Think about how much money that is saving. For an investment in England of about £200 million on education and training in prisons, it has to be the best investment out there. It is probably the best investment since Bitcoin at its most lucrative. I cannot think of a better investment. We could double that investment quite easily and get that 10% up to 12%, 13% or 15%. Think about how much we would save then. Think about all the potential victims of crime who would not be victims, and all the knock-on effects of that for the country.

Prison reform should start with education. That should be the centre of it because that is the basis for rehabilitation. If we then join it up with the other supporting services, including aftercare, you will start to have an impact and transform the system.

Q307 **Ms Marie Rimmer:** Education could be the key to everything. The purpose of imprisoning someone is to take their liberty, so that is a punishment, but while they are in there we could use the money much more effectively to educate them and make them a bigger person. They could understand and enjoy life better. They could contribute. It would help them to get employment. They could start up businesses or go into the arts. There is much opportunity available if it is tapped into. How do we do that?

Paul Cottrell: If they are locked up for most of the day, you cannot do it for a start. The constraints on our system at the moment are well known and I do not need to go into them. The prison system is still in crisis. We all know what the problems are: overcrowding, behavioural problems, drugs and so on. You have to do something about that first. At the moment, there is a very high chance factor in whether you get into education and training; it is the people who ask for it and the people who



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press for it, but for many prisoners the opportunity is just not there. The majority of prisoners still leave prison not having benefited at all. About three fifths of them come out without any significant education and training at all. We need to sort out the prisons.

Q308 **Ms Marie Rimmer:** You are saying that it is the whole system.

Paul Cottrell: You have to look at it holistically, but certainly we could start by ensuring that we resource education and training properly. We are not doing that at the moment, and we are not integrating the regime with education provision. We ought to have enough prison officers to support prison education, who understand it, are committed to it and appreciate the importance of it. That needs to go right through the whole system up to the governor. The voice of education needs to be at the top. The people who provide the education and the learners—the prisoner voice as well—need to be there at senior level where the decisions are being taken.

Q309 **Ms Marie Rimmer:** Would I be cynical if I were to say that we are spending money to take prisoners the opposite way? It is the revolving door. Rather than educating them for crime, we could be educating them differently.

Paul Cottrell: Yes.

Q310 **Ms Marie Rimmer:** You are talking about the buildings, the prisoners, officer numbers and the systems.

Paul Cottrell: Agreed.

Q311 **Ms Marie Rimmer:** Is the Ministry using the opportunity to improve the monitoring of prisoner learning outcomes? Is the Ministry using it?

Chris Emmett: Yes, they are. They are putting in place systems that will now provide data directly to them that they can access, so that they do not have to come to providers or the Skills Funding Agency. Ofsted, in the education inspection framework, is also looking at wellbeing, attitudes and behaviour, which are the outcomes Paul alluded to and are equally as positive in some cases as qualifications.

Ms Marie Rimmer: Thank you.

Chair: Thank you all very much for your evidence and for your time. We are very grateful to you.