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prisons**

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Summary

Record high numbers of self-inflicted deaths and incidents of self-harm in prisons are a damning indictment of the current state of the mental health of those in prison and the prison environment overall. More excuses are not good enough. The Ministry of Justice, HM Prison and Probation Service and NHS England have a duty of care to those in prison, yet do not know where they are starting from, how well they are doing or whether their current plans will be enough to succeed.

The current level of self-inflicted deaths and self-harm incidents in prisons is appalling and the system for improving the mental health of prisoners isn't working as it should. Government does not have reliable or up-to-date measure of the number of prisoners who have mental health problems and existing screening procedures are insufficient to adequately identify those who need support and treatment.

People in prison are more likely to suffer from mental health problems than those in the community. Yet prisoners are less able to manage their mental health conditions because most aspects of their day-to-day life are controlled by the prison. These difficulties are being exacerbated by a deteriorating prison estate, long-standing lack of prison staff and the increased prevalence of drugs in prison.

Improving the mental health of prisoners is a difficult and complex task, but it is an essential step to reducing reoffending and ensuring that those who are released from prison can rebuild their lives in the community. Despite this, Government's efforts to improve the mental health of those in prison so far have been poorly co-ordinated, and information is still not shared across the organisations involved, and not even between community and prison GP services.

Introduction

There were 84,674 adults in prison in England and Wales in 2016–17, between 10% and 90% of whom are thought to have mental health issues. Rates of self-inflicted deaths and self-harm in prisons have risen significantly in the last five years, suggesting that mental health and overall well-being in prison has declined. There were 120 self-inflicted deaths in prison in 2016 and 40,161 incidents of self-harm, the highest on record. Prisoners with mental health issues face huge challenges in our prison system which witnesses told us that the current prison environment is often ill equipped to deal with.

Her Majesty's Prison and Probation Service (HMPPS) is responsible for the management and operation of prisons in England and Wales and ensuring that the prison environment is safe, secure and decent. The Ministry of Justice is responsible for prison policy and commissioning services in prisons. NHS England is responsible for healthcare in prisons, both for physical and mental health. In 2016–17, NHS England spent an estimated £400 million providing healthcare in adult prisons in England, of which it estimates £150 million was spent on mental health services and substance misuse services, although it could not provide an exact figure.

Conclusions and recommendations

1. **The deteriorating prison estate and long-standing understaffing have created an environment which exacerbates the mental health issues faced by prisoners.** Prisoners are less able to manage their mental health conditions because most aspects of their day-to-day life are controlled by the prison. The current restrictive prison regime caused by loss of prison staff, has meant that staff are less likely to identify prisoners with mental health issues and prisoners are less able to self-refer. Prisoners miss an average of 15% of medical appointments, largely because of a lack of staff to escort them. The Ministry of Justice and Her Majesty's Prison and Probation Service (HMPPS) accepted that low levels of staffing have been detrimental to security and order in prisons. HMPPS told us that it was working to address the issues we identified with the prison environment through a range of activities, including recruiting 2,500 additional staff by the end of 2018, providing enhanced mental health training to all new staff including on suicide awareness and providing each prisoner with a dedicated key worker. While this sounds promising, we are not yet convinced that these plans will be enough to improve conditions for prisoners with mental health issues. While all prison officers receive basic training on mental health awareness when they are recruited, 40% of prisons do not offer existing staff any mental health awareness refresher training. We were also concerned to hear of examples where the loss of prison staff is already outstripping recruitment and of delays of seven months to recruit new staff.

Recommendation: HM Prison and Probation Service should:

- *By the end of March 2018, reduce the time taken to recruit new prison officers and mental health staff and get them working in prisons;*
 - *By the end of January 2018, write to the Committee with details of the number and proportion of prison officers who have participated in the new mental health training; and*
 - *By the end of July 2018, write to the Committee with details of the number of additional staff that have been recruited, deployed to prisons, and how many more have resigned since the National Audit Office (NAO) report.*
2. **The failure to establish effective screening procedures means the Ministry of Justice, HM Prison and Probation Service and NHS England do not know the full extent of the number of prisoners with mental health issues.** There is no reliable or up to date data on the prevalence of mental health issues in prison. The mostly commonly used estimate, that 90% of prisoners have mental health issues, is now 20 years old. Prison staff screen prisoners when they first arrive in prisons, including for risk of suicide and self-harm, and this is followed by a health screen, but neither of these adequately identify mental health problems. The reception process for new prisoners can be chaotic and not all prisoners with mental health issues are identified at this stage. HMPPS analyses screening data at a national level, but its information is incomplete as prison staff leave some questions unanswered. Prison staff did not enter data on the 'risk of suicide' in 68% of screening records, or on the 'risk of self-harm' in 59% of records. NHS England has a more complete dataset as it collects information on the number of people who are being treated for

mental illness, currently 10% of the prison population. But this does not include those who are waiting for treatment so is very likely to be an underestimate of those that need support.

Recommendation: *HM Prison and Probation Service, the Ministry of Justice and NHS England should, by the end of March 2018, write to the Committee to explain how they will improve their screening processes and use the resulting data to make sure they have a complete understanding of the number of prisoners with mental health issues and the treatment they need.*

3. **Increased availability of drugs in prisons has contributed to the increase in mental health issues of prisoners.** The number of drug seizures in prisons has risen from 2,500 in 2015 to just over 10,500 in 2016. There has been a huge switch in drug use in prison towards psychoactive substances, which existing detection and treatment programmes were not designed to deal with. Spice is now a substantial problem in prison, with the number of seizures going up from 408 in 2015 to nearly 3,500 in 2016. HMPPS told us that dealing with these substances has been very difficult as they were previously legal and easily accessible. It told us that it was the first law enforcement agency in the world to train dogs to detect psychoactive substances and that it now had a test in place to detect the drug.

Recommendation: *HM Prison and Probation Service and NHS England should review their detection and treatment programmes to ensure that they reflect the current behaviours and needs of prisoners.*

4. **Poor co-ordination and a lack of sharing information means that prisoners are not receiving continuity of treatment as they move between prison and the community.** People in prison are more likely to suffer from mental health problems than those in the community. Many prisoners move in and out of prison, or between prisons, which makes the job of providing healthcare more difficult. Despite this there is a clear disconnect between the information available to healthcare provider on the care patients have received before, during and after their time in prison, which risks making mental health services almost inaccessible for some patients. This lack of continuity risks worsening prisoners' mental health conditions and undermining their rehabilitation, particularly those with speech and language issues, learning disabilities, autism and dementia. NHS England recognised that healthcare services were not where they needed to be and committed to ensuring that they were better co-ordinated. It told us that it was introducing a system to ensure that prisoners' medical records from the community and prison were joined-up, which it will start to roll-out from November this year.

Recommendation: *NHS England should, by the end of March 2018:*

- *Evaluate the effectiveness of the link between NHS records in the community and in prison; and*
- *Establish and disseminate information sharing protocols between prison, healthcare and probation staff so that all parties are fully informed about the services and support that prisoners will require on their release.*

5. **It is a disgrace that too many prisoners wait far too long to be transferred to hospital or secure units.** Prisoners with acute mental health problems should wait no more than 14 days to be admitted to a secure hospital, but the majority wait far longer than this. In 2016–17, two-thirds of prisoners who needed treatment waited longer than 14 days to be transferred. We were told of examples where prisoners had waited over a year to be transferred to a secure hospital. NHS England is responsible for ensuring that the 14 day target is met. Yet NHS England does not know how many patients who are currently waiting to be transferred to hospital or secure units have waited longer than 14 days. We are deeply concerned that the failure to make sure these prisoners receive the treatment they need is making them more ill at a time when they are most at risk.

Recommendation: *HM Prison and Probation Service and NHS England should, by the end of January 2018, publish quarterly data on the number of prisoners transferred to hospital or secure units, how many prisoners are waiting at the time of publication, and how long both groups have waited.*

6. **NHS England’s oversight of its contracts to provide mental health services has been weak.** NHS England does not monitor the quality of mental health care delivered by private providers, or the outcomes these services achieve. The National Audit Office (NAO) report highlighted two examples where NHS England had continued to pay for services that the contractor had not delivered and had not acted to recoup any costs. Untreated mental health conditions, especially schizophrenia, personality disorders and substance misuse disorders, are associated with higher rates of suicide and self-harm. It is not clear what action, if any, NHS England takes in response to providers who are found to have contributed to a death in custody. NHS England was unable to tell us in our evidence session how many cases there had been where a provider’s failure to provide adequate mental health services had contributed to an individual taking their own life, or in how many of those cases it had taken action against the provider. Taxpayers’ money should not be wasted on services that are not being received or are being delivered to a lower quality than required.

Recommendation: *NHS England should write to the Committee by the end of January 2018 to confirm what actions it will take to ensure that it is getting value for money and that taxpayers’ money is not being wasted by paying for services that are not delivered or are well below the standards expected.*

1 Mental health in prisons environment

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Ministry of Justice, Her Majesty's Prison and Probation Service and NHS England on mental health in prisons.¹ We also took evidence from Dr Andrew Forrester, Consultant and Honorary Senior Lecturer in Forensic Psychiatry at the Institute of Psychiatry, Sarah Hughes, Chief Executive Officer of the Centre for Mental Health, Mark Johnson, Founder of User Voice, and Dr Huw Stone, from the Prison Quality Network at the Royal College of Psychiatrists.

Understanding the scale of mental health issues in prisons

2. There were 84,674 adults in prison in England and Wales on an average day in 2016–17. Her Majesty's Prison and Probation Service (HMPPS) is responsible for the management and operation of prisons in England and Wales and ensuring that the prison environment is safe, secure and decent. The Ministry of Justice is responsible for prison policy and commissioning services in prisons. NHS England is responsible for healthcare in prisons. As part of these arrangements, prisoners should receive an equivalent health and well-being service to that available to the general population, with access to services based on need. They should experience an improvement in their health and well-being, and receive continuity of care between prisons and between prison and the community.²

3. There is currently no agreement in place which outlines responsibilities for the mental health and wellbeing of people in prison. A partnership agreement between the National Offender Management Service (now HMPPS) and NHS England expired in April 2017 and has not been replaced. The high-level objectives in the old agreement were not good enough, and there was a disconnect between these objectives and any sensible joined up plan to deliver them. Both HMPPS and NHS England committed to having the new partnership agreements in place by April 2018. We would welcome a shared, single plan that recognises the roles of each organisation, and commits them jointly to improving the mental health and wellbeing of prisoners. The Ministry of Justice told us that the agreement will be a step improvement on the last one, and both NHS England and the Ministry stated it would set out proper measures that are quantifiable, and look at both clinical healthcare and the role of the prison.³

4. People in prison are more likely to suffer from mental health problems than those in the community. NHS England estimates that 37% of its spend on adult healthcare in prisons is on mental health and substance abuse, which it told us is more than twice the proportion that is being spent within the NHS budget as a whole. Complex social and personal issues such as a history of unemployment, substance misuse or trauma are more common among the prison population, and being in prison can exacerbate poor mental health and well-being. In turn, untreated mental health conditions, especially schizophrenia and personality disorders, and substance misuse disorders, are associated with higher rates of suicide and self-harm. There is no one size that fits all solution to these issues.⁴

1 C&AG's Report, [Mental health in prisons](#), Session 2017–19, HC 42, 29 June 2017

2 [C&AG's Report](#), paras 4, 1.9

3 Qq.73, 86, 119–120, Q 124, [C&AG's Report](#) paras 4, 1.11

4 Qq 1–3, 6, 175–176, Royal College of Psychiatrists ([MHP0006](#)), [C&AG's Report](#) paras 1, 1.3, 1.5

5. There were 120 self-inflicted deaths in prison in 2016. Seventy per-cent of those who took their own life in prison between 2012 and 2014 were known to have a mental health condition. A substantial proportion of prisoners are also known to self-harm and the number of self-harm incidents amongst prisons has risen significantly. Just over 12% of men in prison and 28% of women in prison self-harm. The number of self-harm incidents in prisons has increased by 73% to 40,161 incidents in 2016, the highest in any year on record. Witnesses agreed that the levels of self-inflicted deaths and self-harm in prisons were appalling and a damning indictment of mental health services within our prison system.⁵

6. Despite the rise in the number of self-inflicted deaths and self-harm incidents, government has no reliable or up to date estimate of the number of prisoners with mental health issues. The mostly commonly used estimate, that 90% of prisoners have mental health issues, is now 20 years old. The Institute of Psychiatry told us that it estimated that over half of prisoners have common mental disorders, including depression, post-traumatic stress disorder and anxiety. It similarly estimated that around 15% of prisoners have specialist mental health needs and around 2% are thought to have acute and serious mental health problems.⁶

7. The Ministry of Justice was not able to tell us the percentage of those currently in prison who have mental health issues. The only figures it has are from a survey 10 years ago which showed that around 50% of prisoners were prone to anxiety, which has not been updated. Prison staff are responsible for screening prisoners when they first arrive in prisons, including a basic screening to identify risks to prisoners on their first day, such as whether an individual is at immediate risk of suicide and self-harm. This is followed by a health screen, which is conducted by a healthcare professional. The reception process for new prisoners can be chaotic and not all prisoners with mental health issues are identified at this stage. Prisoners can be unwilling to admit to mental health issues for fear of negative consequences, for example on their eligibility or conditions for parole. The Institute of Psychiatry told us that the current screening process only detects around a quarter of those that it should, and there is a long way to go before the screening process adequately identifies those it should.⁷

8. HMPPS analyses data from screening by prison officers at a national level, but its information is incomplete as prison staff leave some questions unanswered. The initial assessment conducted by prison officers consists of over 120 questions, most of which are voluntary. Prison staff did not enter data on the 'risk of suicide' in 68% of screening records, or on the 'risk of self-harm' in 59% of records. NHS England collects month-by-month data on the number of prisoners who are being treated for mental illness. It told us that 10% of those in prison were currently receiving treatment for mental health issues. But this only includes those who are currently in treatment. It does not, for example, include those who are waiting for treatment.⁸

5 Qq 45, 58, 60, 67, [C&AG's Report](#) paras 2, 1.6–1.7

6 Q 2, [C&AG's Report](#) para 1.3

7 Q 2–3, 6, 82–84, 99–101, 107, British Medical Association ([MHP0005](#))

8 Qq 6, 9, 79–81, 130, [C&AG's Report](#) paras 9, 1.4, 3.10

The impact of the prison environment on the mental health of prisoners

9. Prisoners are less able to manage their mental health conditions because most aspects of their day-to-day life are controlled by the prison. A lack of staff within the prison system has meant that the prison regime has become more restrictive and staff are less likely and able to identify prisoners with mental health issues and prisoners are less able to self-refer. Establishing proper one-to-one engagement between prisoners and prison officers is incredibly important to maintaining the mental health of prisoners, partly because prison staff can identify problems and partly because it can prevent prisoners from feeling so isolated and alone. But existing staffing levels have meant that prisoners have less regular contact with prison staff. We were surprised on our visit to Wormwood Scrubs to be told that just seven prison officers were responsible for 300 prisoners across four floors. Prisoners miss an average of 15% of medical appointments, in large part because of a lack of prison staff to move them from the wing to healthcare appointments. In Wormwood Scrubs, we heard that a lack of prison staff means that more than 40% of medical appointments are missed.⁹

10. The Ministry of Justice acknowledged that the level of staffing has been detrimental to the security, stability and order in prisons, including the mental health of prisoners. It told us that it was committed to improving the quality of care provided to prisoners with mental health issues and reducing the number of self-inflicted deaths and incidents of self-harm. As part of this, the Ministry of Justice committed to bringing more prison officers back onto prison wings and establishing more regular one-to-one contact between prisoners and prison staff. HMPPS told us that it was on track to recruit an additional 2,500 prison staff by the end of next year which would mean that it would be able to significantly improve the ratio of prison officers to prisoners from one officer for every 30 prisoners to 1 officer for every 20 prisoners. It told us that it was also introducing a system so that each prisoner had a key worker and each key workers looks after around six prisoners.¹⁰

11. While the Ministry of Justice and HMPPS' plans sound promising, we were not yet convinced that they will be enough to improve conditions for prisoners with mental health issues. The Ministry of Justice told us that it had introduced mental health training and training on suicide awareness for all prison staff and that 7,000 members of staff had undergone the training to date. The NAO report, however, found that while all prison officers receive basic training on mental health awareness when they are recruited, 40% of prisons do not offer existing staff any mental health awareness refresher training.¹¹

12. We were similarly concerned to hear of examples where the loss of prison staff is already outstripping recruitment and the process of recruiting new prison officers and mental health staff can take seven months. Part of the delay is the need to ensure new staff go through security vetting prior to taking up their posts. The Ministry of Justice and HMPPS recognised that retention of prison officers has been a problem, particularly in areas of the country where the labour market is buoyant, and that it taken too long to recruit new staff. They told us that they were confident that they were improving prison

9 Qq 5–6, 29, 61, 72, 85–86, [C&AG's Report](#) paras 1, 3.24

10 Qq 61, 72, 106

11 Q 61, [C&AG's Report](#) para 3.21

retention and that recruitment of new staff would outstrip resignations. They asserted that the recruitment of new staff has been a particular success, with 1,290 additional prison officers now in place compared to October 2016.¹²

13. The physical prison environment is important to ensuring both the mental health and well-being of prisoners and that services designed to support this are delivered. This is made more difficult by the fact that the majority of the prison estate was not built to provide healthcare. Over a quarter was built before 1900 and some of the newer buildings were not designed with modern healthcare in mind. Much of our prison environment is out of date and need to be upgraded. HMPPS told us that it was working to ensure that new prisons are designed based on international best practice and engagement with external organisations to mitigate mental health issues and promote wellbeing. HMPPS has planning permission for three sites at present: the former prison at Glen Parva; a site at Wellingborough; and a site at Full Sutton. It told us that it has worked with the Royal College of Psychiatrists to develop better environments in prisons for those with personality disorders and has committed £40 million to fund this initiative in prisons and communities.¹³

14. The increase in self-inflicted deaths and self-harm incidents in prisons is also attributable in part to the use of drugs in prison. Drug use in prison is a serious issue and can severely compromise prisoners' mental health. The number of drug seizures in prisons has risen from 2,500 in 2015 to just over 10,500 in 2016. Prisoners can gain access to drugs in a range of ways, including through them being brought in by visitors, put in correspondence, being thrown over prison walls or being flown in by drones.¹⁴

15. There has been a huge switch in drug use amongst prisoners towards new psychoactive substances (also known as Spice) which existing detection and treatment programmes were not designed to address. These have changed the nature of how prisoners behave when under the influence of drugs and are a very real danger to both prisoners and prison staff. Spice is now a substantial problem in prison, with the number of seizures going up from 408 in 2015 to nearly 3,500 in 2016. Figures for the first half of 2017 show that there have already been 1,600 seizures of Spice in prison. Psychoactive substances such as Spice were originally classed as legal and relatively easily accessible in the community and consequently in prisons.¹⁵

16. HMPPS accepted that it took some time to be able to address the challenge posed by psychoactive substances in prison, but that the increase in the number of drug seizures was in part due to better detection methods. It told us that it was working with law enforcement agencies to disrupt supply routes and ensure prisoners have access education and treatment programmes. Testing for psychoactive substances can be difficult and HMPPS did not initially have a test that could detect them. It told us that it now had a test in place and that it was the first law enforcement agency in the world to train dogs to detect psychoactive substances.¹⁶

12 Qq 72, 100, 108, 110, 112, 114, 117–118

13 Qq 33, 138–140, [C&AG's Report](#) para 3.4

14 Qq 27–28, 52, 54–57

15 Qq 27, 52

16 Qq 52–53

2 Continuity of care and oversight

Co-ordinating and planning mental health services for prisoners

17. Many prisoners move in and out of prison, or between prisons, which makes the job of providing healthcare more difficult. Sharing information about a patient's medical history with health bodies who have also treated the patient is crucial to ensuring that they receive the treatment that they need. Despite this, there is a clear disconnect between the information available to healthcare providers on the care patients have received before, during and after their time in prison. We heard that currently many prisoners arrive in prison without an accompanying medical history, which slows down and reduces the accuracy of their initial assessment, meaning that this first opportunity to provide someone with the type of support they need may be missed. The British Medical Association told us that without access to medical records, prison GPs might prescribe medication without the patient's history of pre-existing conditions or drug use, including whether they have a history of overdose.¹⁷

18. Healthcare records for prisoners appear to follow patients through their mental health journey in very few cases. The NHS IT system within prisons is unable to 'talk to' the NHS IT system in the community. It is difficult to see how treatment can be effective if this is the case. We were concerned that this lack of continuity of information makes mental health services almost inaccessible for some patients and risks worsening prisoners' mental health conditions and undermining their rehabilitation. We heard from the Royal College of Psychiatrists, which told us that access to specialist mental health services for prisoners is inadequate and is getting worse.¹⁸

19. NHS England recognised that healthcare services were not where they needed to be and committed to ensuring that they were better co-ordinated. It told us that it was introducing a system to ensure that prisoners' medical records from the community and prison were joined-up. It has signed a contract to deliver a single IT system, which will bring together health records from before a prisoner enters prison and during their time in prison, with prison records, so that all information about a prisoner is held in a single place. It told us that the new IT system would start to roll-out across the prison estate in November 2017 and would be everywhere within 12–24 months.¹⁹

20. Dementia is a growing problem within prisons. The fastest growth in the number of prisoners has been among prisoners aged over 50. Dementia Access Alliance told us that there are currently 10,000 prisoners over the age of 60 and that this number is set to increase unless there are major changes in sentencing trends. As the number of older prisoners rises, so too will the prevalence of dementia among prisoners. Despite this, there is currently no national strategy for prisoners with dementia. We were also concerned to hear at Wormwood Scrubs, and from our constituencies, of a revolving door in prison for people with speech and language issues, learning disabilities and autism. NHS England told us that it was increasing the amount that it spends on mental health services, and that

17 Qq 11–12, British Medical Association ([MHP0005](#)), [C&AG's Report](#) para 1

18 Qq 11, 73–74, 100, Royal College of Psychiatrists ([MHP0006](#))

19 Qq 73, 75, 100

spending in this area was going up at a faster rate than the overall NHS budget. It told us that this would be used to expand the range of services available for people with the issues described.²⁰

21. Issues with security and resources mean that referring a prisoner to an external specialist or hospital can be complicated and time consuming. The British Medical Association told us that its members say that individuals experiencing a serious mental health crisis will frequently be placed on bed watch, with a member of prison staff there to observe and ensure that they do not attempt suicide or self-harm, but unable to provide therapeutic or clinical support. Prisoners with acute mental health problems should wait no more than 14 days to be admitted to a secure hospital, but the majority wait far longer than this. In 2016–17, 1,081 mentally ill prisoners in England were transferred to secure hospital. Some two-thirds of these waited longer than 14 days to be transferred and 7% waited more than 140 days. We were told of examples where prisoners had waited over a year to be transferred to a secure hospital and, in one case, over 20 months. We were similarly concerned to hear from witnesses of examples of a lack of regional and national coordination in transferring prisoners to secure hospitals which means that patients become stuck in a cyclical loop of rejected referrals. Delays in being transferred to secure hospitals can have a substantial negative impact on the mental health and well-being of prisoners. It is unacceptable that the failure to make sure these prisoners receive the treatment they need is making them more ill at a time when they are most at risk. If the number of self-inflicted deaths and self-harm incidents was not already an indictment of poor performance, this is also a disgrace.²¹

22. NHS England is responsible for ensuring that the 14 day target is met as part of its responsibility for both health services in prison and for commissioning high, medium and low secure psychiatric services. In the first six months of 2017–18, 305 patients who were transferred to a secure hospital waited longer than 14 days. In 16 cases, the patient had to wait over 140 days to be transferred. While unacceptable performance, this under reports the true extent of how long patients are being forced to wait for treatment because it does not include 220 people NHS England told us are currently waiting. NHS England do not know how long these 220 people have waited so far. NHS England told us that the 14 day target is currently being reviewed by clinicians to determine whether a single target is still the most appropriate to meet the needs of patients or if a more nuanced target is needed. If clinicians decide a more nuanced target is appropriate, it will be essential that NHS England makes sure that enough data is available to track progress against the 14 day target and compare results.²²

23. NHS England accepted prisoners needing treatment should be transferred much more quickly than is currently the case. It told us that it had undertaken work to better understand the process for transferring prisoners to secure hospital and identifying blocks in the process as part of wider work examining the care provided to patients in prisons. In particular, it told us that it was reviewing where there are gaps and need in mental health beds in low, medium and high secure units for those who have an assessment under the Mental Health Act. This is the second time that NHS England has undertaken such a review, which is due to complete by the end of the year. Given it is being conducted so

20 Qq 131–132, 187–189, Dementia Access Alliance ([MHP0002](#)), Royal College of Psychiatrists ([MHP0006](#))

21 Qq 38–40, 142–149, 206, British Medical Association ([MHP0005](#)), [C&AG's Report](#) para 3.35, NHS England ([MHP0008](#))

22 Qq 142–146, 157–164, 177, NHS England (MHP008)

rapidly, there is a risk that the new review could repeat the work of the first review and we will await the results to form a view on whether it is sufficient to address the problems identified.²³

NHS England's oversight of mental health services in prisons

24. As part of its responsibilities for health services in prisons, NHS England is responsible for ensuring that its contracts with private providers deliver value for money and the services required are delivered. In 2016–17, NHS England spent £400 million providing healthcare in adult prisons in England, of which it estimates £150 million was spent on mental health and substance misuse services (including pharmacy costs). It was not able to provide this figure at the time of the National Audit Office's (NAO) report, but subsequently conducted a survey of providers of mental healthcare in prisons to produce the estimate. NHS England could not provide an exact figure as three-quarters of its contracts for healthcare in prisons rely on a single provider model, so costs are based on best estimates and historical figures. While it provided us with a list of the indicators it uses to monitor the performance of private providers contracted to deliver healthcare in prisons, NHS England does not monitor the quality of mental health care delivered by private providers, or the outcomes these services achieve.²⁴

25. The NAO's report highlighted two examples where NHS England had continued to pay for services that the contractor had not delivered and had not acted to recoup any costs. In one of the cases highlighted by the NAO, NHS England had continued to pay a provider in full even though it had not provided a psychiatrist in line with the service specifications. NHS England asserted that in some cases of recruitment issues, alternative staff are put in place and it would be inappropriate to cut health services and funding for that period of time. It agreed to review the examples of service failure highlighted by the NAO to ensure that they related to isolated smaller issues with payment of services and discrepancies in the recoupment of costs rather than a systemic failure to manage and oversee these contracts properly. NHS England subsequently told us that the two cases, which related to HMP Gartree and HMYOI Glen Parva, were the result of personnel changes and a lower prisoner population respectively. It did not however, provide a convincing response to why it had continued to pay for these services in full when they were not being delivered. NHS England also told us of a different case, at HMP Downview, where HMPPS had changed the prison from a male prison to a female prison and NHS England continued to procure healthcare services during the interim to ensure continuity of service.²⁵

26. It was not clear during our evidence session what action, if any, NHS England takes in response to providers who are found to have contributed to a death in custody. We heard of an example in Chelmsford prison where financial considerations resulted in the healthcare provider downgrading the service provided to a prisoner who subsequently took their own life in prison. NHS England confirmed that the provider in question was no longer contracted to provide healthcare at HMP Chelmsford, but that it does hold other prison contracts within the NHS. NHS England was unable to tell us in our evidence session how many cases there had been where a provider's failure to provide adequate

23 Qq 148–151, 153–156

24 Q 52, 168–170, 172, 176, 198, [C&AG's Report](#) paras 9, 2.22, NHS England ([MHP0008](#))

25 Qq 194–195, 197, [C&AG's Report](#) para 2.27, NHS England ([MHP0008](#))

mental health services had contributed to an individual taking their own life, or in how many of those cases it had taken action against the provider. It subsequently told us that there have been five instances since 2013 where failures in the provision of mental or physical healthcare, or the downgrading of services, have been referred to in the coroner's verdict as contributing factors to an individual taking their own life. Any death as a result of such circumstances is entirely unacceptable. Taxpayers' money should not be wasted on services that are not being received or are being delivered to a lower quality than required.²⁶

Annex: Note from the Committee's representative visit to HMP Wormwood Scrubs, 19 October 2017

Background

1. Care UK is the prime contractor for prison healthcare and subcontract provision of mental healthcare to Barnett, Enfield and Haringey NNHS Trust and Forward (previously RAPT).
2. The mental health team provides a wide range of primary and secondary services including, one-to-one psychology service, occupational therapy, psychological education (anger management coping skills etc.), speech and language therapy, and a specialist learning disabilities service and day care, which provides meaningful activity for those who don't engage with education or employment.
3. There is also a 17-bed in-patient facility, although five of these beds are in a dormitory so can rarely be used given the nature of the patients that need them. The inpatient unit deals with mental health, physical health and end of life care.

Prison Officer and healthcare staff

4. The prison is operating a limited regime on one wing due to prison officer shortages. The rate of recruitment is not matching loss of experienced staff. Pay is a barrier given London's job market.
5. There are similar shortages of healthcare staff and concerns about time taken to on-board staff, given security clearance requirements (DBS and then prison service screening), which can take 5–7 months. The example was given of a nurse recruited to fill a vacancy that existed since September 2016, who was due to start in April 2017, but pulled out given extended delays. The result is that best recruits get poached. Security clearance must be refreshed every three years but no priority is given to new recruits.
6. NHS has commissioned training and support that can be used for prison officers to improve their mental health awareness but there are challenges in releasing officers for enough time to undertake training. The prison recently had no regime for one day to deliver mandatory training on suicide, self-harm and restraint.

Screening

7. The prison's healthcare team operate a triage system with two tiers of screening followed by a full, on-wing assessment by the Mental Health In-reach team for those with identified mental health issues. The screening suggests around 70% of men have an underlying mental health need (compared to 10% who are receiving treatment across the whole prison system). The team does not cross-refer to other services but provides wrap-around care by drawing in other services through triage meetings three times a week.

8. Information received from community healthcare is variable. Community and prison IT systems don't link up (plans to link to community SPINE are still in progress but mental health info often not on SPINE) so prison healthcare staff have to chase information. Some community trusts are slow to cooperate or demand payment upfront for letters (£25 per letter, paid out of prison healthcare budget). Result is that investment in building patient information asset is wasted. This is a particular challenge for the scrubs given high churn in prisoners.

Continuity of care

9. Ensuring continuity of care is very challenging as there is often no notice of when a prisoner is being released. If their case is discontinued they can leave immediately even though they may have significant mental health needs. If they are released on licence, the Community Rehabilitation Company oversees them but may have had very little notice to establish support.

10. This is a particular issue for prisoners with learning disabilities. The threshold for care in the community is much higher due to limited resources so social services will not support many of the prisoners released. They quickly end up back in prison.

11. Links with social services need to be improved. An example was given of an older prisoner who had had a series of mini strokes that led to reduced cognitive function. His sentence finished last November but he is still in prison because the CRC can't find him accommodation through social services. He is too young to go into elderly care. Another example was given of an 80 year old prisoner convicted of arson who now had dementia. He couldn't find accommodation after his sentence was completed as he was deemed too high risk because of his background.

Transfer to secure hospital

12. There are problems getting patients transferred into secure hospitals because of a shortage of secure beds in the community. One current prisoner has been waiting for a secure bed since June and his condition is worsening. He is Psychotic and refuses his medication. The prison healthcare staff cannot compel him to take it but staff in a secure hospital could. An example of a prisoner in Brixton who waited 20 months was also given. He got progressively more unwell over this time, self-harming and even pouring boiling water over himself.

13. This may worsen under the 'new models of care' initiative which is bringing regional commissioners together to identify ways to provide new community mental health provision. The consequence will be fewer beds in medium secure settings. As well as making transfers out of prison harder, this could potentially increase the flow of severely mentally unwell people into prison.

The prison environment and culture

14. Although prison presents an opportunity to address complex needs of a vulnerable group of people, the environment is detrimental to mental health and well-being, increasing the challenge. There are ways for the environment to be more psychologically informed; Feltham has certain rooms that are accredited as autism friendly and HMP Aylesbury has

had some success bidding for funding for enabling environments through the Offender Personality Disorder funding pot. This is good but funding is limited so it only allows change on a very small scale. PIPEs (Psychologically informed planned environments) are also well regarded. These examples are the exceptions not the norm.

15. The Prison Estate Transformation Programme presents an opportunity to address this in new build prisons. Netherlands, where focus is on rehabilitation, does this very well. HMP Grenden was given as an example of a true therapeutic community, with a rehabilitative focus and had received the best HM Inspectorate of Prisons rating possible. It serves a particular type of offender though and would not be suitable for all.

16. Her Majesty's Prison and Probation Service is rolling out training on 'rehabilitative culture' that is a watered down version of having an enabling environment. It is intended to be cost neutral and there are some concerns about whether it will make a difference. The prison environment cannot be changed cheaply.

Formal Minutes

Wednesday 6 December 2017

Members present:

Meg Hillier, in the Chair

Geoffrey Clifton-Brown	Nigel Mills
Martyn Day	Stephen Morgan
Luke Graham	Gareth Snell

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

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

Paragraphs 1 to 26 read and agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

Annex agreed to.

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

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

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

[Adjourned till Monday 11 December 2017 at 3.30pm]

Witnesses

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

Monday 23 October 2017

Question number

Dr Andrew Forrester, Consultant and Honorary Senior Lecturer in Forensic Psychiatry, Institute of Psychiatry, **Sarah Hughes**, Chief Executive Officer, the Centre for Mental Health, **Mark Johnson**, Founder, User Voice, and **Dr Huw Stone**, Prison Quality Network, Royal College of Psychiatrists

[Q1–44](#)

Kate Davies, Director of Health & Justice, Armed Forces and Sexual Assault Services Commissioning, NHS England, **Richard Heaton**, Permanent Secretary, Ministry of Justice, **Michael Spurr**, Chief Executive, HM Prison and Probation Service and **Simon Stevens**, Chief Executive, NHS England

[Q45–217](#)

Published written evidence

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

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

- 1 British Medical Association ([MHP0005](#))
- 2 Catholic Bishops' Conference of England and Wales ([MHP0001](#))
- 3 Dementia Action Alliance ([MHP0002](#))
- 4 Farah Damji ([MHP0011](#))
- 5 Michelle Bradley ([MHP0010](#))
- 6 NHS England ([MHP0008](#))
- 7 Revolving door agency ([MHP0007](#))
- 8 Royal College of Psychiatrists ([MHP0006](#))
- 9 Shimona Warner ([MHP0009](#))
- 10 The Royal College of Speech and Language Therapists ([MHP0004](#))

List of Reports from the Committee during the current session

All publications from the Committee are available on the [publications page](#) of the Committee's website.

Session 2017–19

First Report	Tackling online VAT fraud and error	HC 312
Second Report	Brexit and the future of Customs	HC 401
Third Report	Hinkley Point C	HC 393
Fourth Report	Clinical correspondence handling at NHS Shared Business Services	HC 396
Fifth Report	Managing the costs of clinical negligence in hospital trusts	HC 397
Sixth Report	The growing threat of online fraud	HC 399
Seventh Report	Brexit and the UK border	HC 558
First Special Report	Chair of the Public Accounts Committee's Second Annual Report	HC 347



Public Accounts Committee

Oral evidence: Mental Health in Prisons, HC 400

Monday 23 October 2017

Ordered by the House of Commons to be published on 23 October 2017.

Watch the meeting <http://parliamentlive.tv/Event/Index/f39ee6b9-a095-49a8-885b-6fa7587dbf26>

Members present: Meg Hillier (Chair); Bim Afolami; Heidi Allen; Geoffrey Clifton-Brown; Martyn Day; Chris Evans; Caroline Flint; Gillian Keegan; Shabana Mahmood; Nigel Mills; Layla Moran.

Questions 1-217

Witnesses

I: Dr Andrew Forrester, Consultant and Honorary Senior Lecturer in Forensic Psychiatry, Institute of Psychiatry, Sarah Hughes, Chief Executive Officer, the Centre for Mental Health, Mark Johnson, Founder, User Voice, and Dr Huw Stone, Prison Quality Network, Royal College of Psychiatrists.

II: Kate Davies, Director of Health & Justice, Armed Forces and Sexual Assault Services Commissioning, NHS England, Richard Heaton, Permanent Secretary, Ministry of Justice, Michael Spurr, Chief Executive, HM Prison and Probation Service and Simon Stevens, Chief Executive, NHS England.

Written evidence from witnesses:

- [Add names of witnesses and hyperlink to submissions]



Examination of witnesses

Witnesses: Dr Andrew Forrester, Sarah Hughes, Mark Johnson and Dr Huw Stone.

Q1 **Chair:** Good afternoon, ladies and gentlemen, and welcome to the Public Accounts Committee. It is Monday 23 October 2017. Today, we are considering the National Audit Office's excellent Report on mental health in prisons, which in my view is seminal. It underlines the huge challenges in our prison system for prisoners with mental health problems.

Two things that have arisen from the Report are the fact that the National Audit Office and others have looked at this, and the range of the number of prisoners with mental health problems is anything from 10% to 90%, depending how you measure it; and the fact that 2016 was the highest year on record for people killing themselves in prison and for self-harm in prison. In a sense, that in itself introduces the subject; I don't think I need to say any more.

I am going to ask Shabana Mahmood to kick off, but I am going to introduce the panel first. From my left, we have Sarah Hughes, who is the chief executive of the Centre for Mental Health. Welcome to you, Ms Hughes. Dr Huw Stone is the co-chair of the Prison Quality Network for Mental Health Services at the Royal College of Psychiatrists—that is quite a mouthful, Dr Stone. Mouthfuls seem to be quite the thing in psychiatry, because Dr Andrew Forrester is a consultant and honorary senior lecturer in forensic psychiatry at the Institute of Psychiatry and, I understand, the Maudsley. Is that right?

Dr Andrew Forrester: And the University of Manchester.

Chair: My word, you've had a lot of jobs! Thank you for giving up some time to come here.

Finally, but not least, we have Mark Johnson, the founder of User Voice. I have to say that it is a very big issue for this Committee to reflect user voices where we can. One of the main points of our existence—we think—is to connect people at the receiving end of public services funded by the taxpayer with the people who make the decisions about how those services are formed.

Over to you, Ms Mahmood.

Q2 **Shabana Mahmood:** Thank you, Chair. Welcome to the panel, and thank you all for coming to speak to us today.

We have seen figures for the number of prisoners with mental health issues that range from 10% to 90% of the prison population. What would you say in your experience, with your professional hats on? How would you pitch the scale of mental health issues within the prison population?

Dr Andrew Forrester: We know quite a lot from the international evidence about the prevalence of mental health problems in prison. From



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evidence over the last 20 to 30 years, we can expect 2% of the prison population to have acute and serious mental health problems; about 15% to have specialist mental health needs; about 50% to have substance abuse problems and so on; and perhaps 50%-plus to have common mental disorders—depression, post-traumatic stress disorder, anxiety and so on. We are talking large numbers of people.

Mark Johnson: I would say 100%. I don't think people who go to prison make healthy choices. They often have not made the moral choice to commit a crime—I think their predisposition from life experiences, et cetera, determines who we have got. I would like to say that the figures you have just mentioned are around what we measure—it is in the Report as well, about lack of assessment. So those figures are just who we assess, never mind whether people tell the truth on those assessments. There is that issue around, "If I'm honest about what is really going on, I get treated punitively, rather than getting the care that will affect my life and give me better mental health."

Q3 **Shabana Mahmood:** That fear of possibly attracting punitive treatment while in prison, is that something people report often to you?

Mark Johnson: One-hundred per cent. Psychological services in prison are pretty much there to measure someone's likely risk to society, not to solve the problems—it is about power and empowering. If we have a very siloed approach to how we commission mental health services, clinical services or whatever, then if I am honest with a clinician, that can be used against me, which can affect my parole and my likelihood of actually getting out, so there is an agenda for me to want not to tell the truth.

Chair: Dr Stone or Dr Forrester, do you want to pick up on that point?

Dr Huw Stone: Yes; I think it is a very good point. Looking at mental health in prisons is very complex, as I am sure everyone is aware. It is not as simple as someone going to their GP and saying, "I feel bad today and this is the reason," as Mark has just explained. It emphasises also the whole problem of trying to deliver any type of health intervention in a setting that is not a therapeutic setting in that way—a prison is not therapeutic. It does emphasise some of the challenges that prison mental health teams face when they are trying to deliver mental healthcare in prisons. But certainly I would support Dr Forrester's view that the prevalence of mental health disorders—each one that he mentioned—is much higher in prison than in the community. That is the key point. When we ask why there are so many more people in prison now with mental health problems, part of the answer is that there are more people in prison, full stop, therefore the number with mental health problems in prison will have also increased.

Sarah Hughes: It is an important point that you have just made. We cannot understand the scope or scale of this issue until we start reducing the numbers of people in prison. We all accept that the vast numbers of people in prison are in prison for less than 12 months for low-level crime. We know from the Report and from our own evidence that successful



interventions in that time are virtually impossible to achieve. Fewer people in prison is the first point of call.

- Q4 **Layla Moran:** Dr Stone, as you rightly pointed out, the more people who are in prison, the greater the likelihood that absolute numbers increase. In terms of the proportion, compared with the general population, have we seen a spike? Is the prevalence in the general population not going up while it is in prisons, or is it a general trend across the population that is being mirrored?

Dr Huw Stone: One of the really interesting things about this area is that, if you look internationally, there are very consistent and fairly stable figures for these proportions. If you take the most severe mental illness—some form of psychosis, such as schizophrenia—you find in developed countries across the world that between 4% and 5% of the prison population will have that illness. It is actually something that has remained quite constant for a number of years now. That is why I am saying the prevalence has not increased. The absolute numbers have increased, but as far as we know the prevalence has not actually increased.

- Q5 **Shabana Mahmood:** Staying on screening, usually prisoners will have the reception screening and then a health assessment. What can be done to ensure that those assessments capture as much data as necessary to ensure that prisoners get the treatment they need, apart from setting up something that feels less like a formal interview and feels more like it will lead to therapy rather than punishment in prison?

Mark Johnson: As it said in the Report, we are dependent on limited assessments. And, as Sarah said about reducing the numbers of people in prison, there is a quite prominent point in the Report around restricted regime within that. Often, you can have a very good service that exists—that is, on entry into prison—but if you cannot get access to it, it is pretty pointless having it.

For me, the elephant in the room—not just for this Committee, but for one I did a couple of months ago, which I think Harriet Harman was chairing, on the same issue—is around the restricted regime and addressing that before anything else; before you go into, “How can you improve assessments?”, et cetera. That restricted regime means there is a loss of prison staff, and the qualification of prison staff to pick up various mental illnesses on the wings—or even the ability to self-refer. We are talking about having a very colonialist approach to a professional diagnosing somebody coming through the door with a mental illness, but what about self-referral? If I am ill, I know I can go somewhere and I will get a standard of care like everybody else does.

- Q6 **Chair:** Which of the doctors wants to go first? Dr Stone, you look like you are itching to get in there.

Dr Huw Stone: I know Dr Forrester will have a lot of helpful things to say about screening, which I think is a key thing, but one of the really important things to remember is the reception process. What happens when somebody comes into prison is that there is what they call reception,



and a number of different tasks have to be carried out there, including a health screening. Probably, reception is one of the most chaotic parts of any prison—which also has its own problems as well. So, getting people through there and completing all those tasks can be a real challenge.

One of the things that we are suggesting is that there should be a second specialist mental health assessment or screening done very shortly after reception—perhaps in what is called the first-night centre, where prisoners move to after reception. What the mental health teams tell us is that some of them can do that, and they find it very helpful, but others simply do not have the staff to do it.

One of the issues which we thought the NAO Report was particularly strong on was commissioning and the consistency in commissioning. I am amazed at the differences in the resources available to some prison mental health teams compared to others. That really is a situation where if you have more resources and more staff, you can actually make a real difference in terms of their involvement with mental health in the prison.

Chair: Dr Forrester, do you want to come in briefly on that point? I will then bring in Sarah Hughes. We can't have everyone answering on everything, or we will be here all day.

Dr Andrew Forrester: I think screening is a vital part of the pathway. Unfortunately, at the moment, from the work of Jane Senior and others, we are finding that we are detecting only about 25% of the people that we should be detecting through screening, so we have a long way to go before screening hits where it should be hitting. That is one of the reasons why it is important to do a second screen, as Dr Stone said, within the first 72 hours or thereabouts. I agree with Mark about open referral systems: I think they are vital in ensuring that we offer services to everybody when we can.

Sarah Hughes: I think this also speaks to an issue about the workforce. We know that in the prison system there is a reduced workforce number, but I think there is also something about skills and training and ongoing support and supervision for those individuals undertaking these assessments. This Report found that some of the questions were not being asked by prison officers, and that is because this is a really complex area. The nuances of self-harm and suicide are complicated; there is no one size that fits all, and I think the Report says that. So there is also something about prison officer training, recognising prison officer pressure, recognising what they are dealing with, and recognising the complexity—this is a complex issue that needs a complex solution; it is not easy.

Q7 **Geoffrey Clifton-Brown:** Could I ask our two professionals who the right person to be doing this assessment is—whether it should be prison staff or medical staff supplied by NHS England? Who are the right people to carry out the assessments?



Dr Andrew Forrester: I think the right people to do health screening are health professionals—usually nursing staff—at the point of reception into prison.

Q8 **Geoffrey Clifton-Brown:** So NHS England needs to be geared up to provide enough professionals to be able to do this work for the entire prison population.

Dr Andrew Forrester: Yes, I think everybody should be screened by a nurse when they come into prison.

Dr Huw Stone: We would go a bit further and say that we think that that nurse should be a mental health nurse, particularly for the second stage of the screening. They need to be part of the mental health team within the prison, so that they can immediately signpost somebody to treatment if they require that, and ensure it is delivered.

Q9 **Geoffrey Clifton-Brown:** At the risk of incurring the wrath of the Chair, may I follow up with a very brief question? At the moment, the assessment has 120 questions, most of which are voluntary and are probably not answered in most cases, for the reason that Mark pointed out at the beginning. How far is it reasonable to carry out an assessment and ask some pretty probing questions?

Dr Andrew Forrester: It can be difficult, in reception areas, to answer questions fully. Sometimes people might have only a certain number of minutes—10 to 20 minutes—per reception screen, which is usually difficult. That is the reason why it is important to go back and have a second look, with triaging, up to 72 hours later, when things are often a bit calmer.

Chair: We will now hear from Gillian Keegan and then Heidi Allen—everyone wants to come in, basically.

Q10 **Gillian Keegan:** Possibly this question picks up on something Dr Stone said about how commissioning can make a real difference; some facilities are very good and so on. We visited one recently, and it seemed that the health staff were very good. But how would you actually know? The thing that strikes you about this whole thing, despite all the process breakdowns on the way in, is the disconnect between the objectives and any plan to deliver them, whether that involves sentencing, screening, access to the right staff and then the environment, or whatever. All the way through, the plan does not hang together, so how would you actually know? What would you suggest? It is a complex area, but how would you be able to improve this to have a more outcome-based process?

Dr Huw Stone: I think the commissioning process has not included a proper evaluation of the services that those commissioners are commissioning, and an important component of that is the quality of the service. I am here today representing the quality network for prison mental health teams, which the Royal College of Psychiatrists runs. We would encourage all commissioners to ensure that their prison mental health teams are members of a quality network such as ours, where this is



done on the basis of a peer review, with the network learning from the teams that are really good and those that are struggling perhaps learning how to improve the way they are working. Also, as the NAO Report pointed out, in terms of the whole commissioning process, the re-tendering of services has had a drastic effect on prison mental health teams. If you talk to anyone working in prison mental health teams, they will describe the disruptive nature of this process, where every few years the service is re-tendered out. It can take 12 to 18 months to complete that process; it can cost a lot of money. I think that it is something that really could be done very quickly, to say that that sort of rapid turnover of tendering should cease. We would recommend that services should be provided for at least 10 years before a re-tendering exercise is undertaken.

- Q11 **Gillian Keegan:** If you look at the continuity from the prisoner or the patient's viewpoint, it seems to me that even if you have better quality service and the way in which it is tended is not as disruptive, the record follows the patient through their mental health journey in very few cases. At the end of a prison sentence—a short one, in most cases—how can the treatment continuing afterwards ever be effective?

Dr Huw Stone: I think that things have actually become more effective in the prison system, in that there is now an electronic patient record that goes across all prisons. When a prisoner arrives at a prison, the staff can immediately look up all of the prisoner's records—not just from that sentence but perhaps even from previous sentences. I have seen a huge change in that during my lifetime working in prisons.

- Q12 **Gillian Keegan:** But the NHS records are the missing piece.

Dr Huw Stone: You're quite correct. As you say, there is a big disconnect between what happens in the community, both before someone comes into prison and after they are released from prison. That is when there is a big disconnect.

- Q13 **Chair:** So to pick up on Ms Keegan's point, what can be done to make that work better? That question is for any of you—Sarah Hughes, you seem keen to answer.

Sarah Hughes: We believe that it is important that there is now just one commissioner for healthcare in prisons, which has been a fairly recent development in the grand scheme of things. That is a step forward, which gives us a better chance of making the information links.

- Q14 **Chair:** That's within prisons, but what about the link between prisons and the NHS? What about that continuity?

Sarah Hughes: I think that is a process that is about to happen. We need to recognise liaison and diversion, and that there has been an improvement in information sharing.

The bigger issue for us is about when people leave prison and sharing of information through the gates, so that there is continuity of care at that



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point. It is improving when people are coming into prison, but we would say that there is still a problem when people are leaving prison.

Q15 Heidi Allen: This is a question to anybody really. It seems to me that for any good process to work you need the data, targets, the right number of staff, the right training for staff, the right processes in place and the right sharing of information, such as NHS records. Have any of you seen it working well anywhere in your careers? Sorry—that is far too doom and gloom. I saw it in prisons when I was looking at work readiness, from a work and pensions point of view. Some places are really good. The governor seemed to be the key ingredient to delivering a better service to their prisoners. Have you seen it anywhere and, if so, what does it look like?

Chair: Quick fire—has anyone seen it, first of all?

Dr Andrew Forrester: The place I saw it working best was where the same provider was working in police custody, in the local magistrates courts, in the local prisons, and back out in the community, because that offered continuity of record, movement and professional—

Q16 Chair: Presumably that commissioning was done through separate pots. It wasn't one commissioner commissioning the same provider.

Dr Andrew Forrester: Well, at the time the commissioning was done differently. It wasn't done by NHS England, but that does not exist in the same way in many places now.

Q17 Chair: Could that happen under the current commissioning system?

Dr Andrew Forrester: I think that is a question for the commissioners who come later, but possibly, yes.

Chair: Mr Johnson.

Mark Johnson: I could probably give you 12 examples of where it is working, with the NHS. It is working by putting the patient at the centre of the room and having monthly meetings with all the services in every establishment.

Q18 Heidi Allen: And where is that happening?

Mark Johnson: In 12 prisons across Kent, Surrey and Sussex at the moment. The problem is that we are actually commissioned to do 17, but in two years we have not even been able to get into five because of the systemic failures of security, and so on, of actually getting into work—

Q19 Chair: Could you write to us with that full list—the ones you are in, not the ones you are not in?

Mark Johnson: I just have to say, that is a consistent theme. Never mind actually getting into work; if people with lived experience—and we are absolutely driving patient voice and offering something of quality to the system—are not being allowed in because of their past, there is a problem.



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It is working in 12 prisons. On the procurement, it is working right the way through commissioning. On the commissioning of services that get into prison, we have a 10% procurement score for the prisoners themselves. There are two examples where they have almost been kingmakers in the contracts, saying that actually one service was needed more than another. I think that the monthly meetings and the process that is given for everybody to be involved in what services they get are profoundly transformative, because everybody is involved in it.

Q20 Heidi Allen: Does that continue when a person moves prisons—to a resettlement prison, for example?

Mark Johnson: There is peer-to-peer drive, which is what User Voice stands for, but I'm not doing a sales pitch here as we have no market competition strangely enough, of people with lived experience having a proper stake in this. If I have a mental health issue, then surely the ultimate answer is that I am given the skills to take control and responsibility of my own condition; that if I need help, I can go and get it; that I can go to prison and reach an enabling environment, where I am going to address the reasons that got me in there in the first place and not come back once released. Surely that is the purpose. Yet, what we often have is this systemic failure. Through the 12 commissioned areas in Kent, Surrey and Sussex, I think that there is a chance for it to be addressed, because people are getting to talk to each other more.

Q21 Heidi Allen: We would certainly be interested in more detail.

Mark Johnson: I would absolutely invite anybody to come in to have a look.

Q22 Chair: If you could write to us with that list that would be really good.

Mark Johnson: Absolutely.

Q23 Chair: Sarah Hughes, could you please answer that question? **Sarah**

Hughes: A point connected to where things are going well is where interventions that are provided by both primary and secondary care are designed to meet complex needs. Currently we have IAPT in prison and secondary care in prison, and sometimes the people that we are talking about are improving access to psychological therapies.

Q24 Chair: Could you spell it out?

Sarah Hughes: That scheme is open to people with fairly mild to moderate conditions. Taking your point about the complexity of people going in, in terms of substances, self-harm and other issues, sometimes IAPT is not able to address their needs. We certainly advocate for interventions that are designed to work with people with complex needs and for not necessarily helicoptering in things that are working okay in the community.

Q25 Layla Moran: Mr Johnson, at the top level of commissioning, does someone with lived experience currently sit at that table?

Mark Johnson: No.



Q26 **Layla Moran:** Do you think it would help if they did?

Mark Johnson: Yes. Absolutely, 100%. Getting closer to the problem, one of the big things that startles me really is what is mental health? You described the layers; I think it is very important to set that out. I would say that the biggest, especially around the drug and alcohol community and the recovery community, is the ability to have the space to just talk about stuff. I think that it should be allowed to happen in prison, because it's free. There are recovery groups outside in the community that want to get in but cannot because of the systemic security and failures to get them in. That is something that this Committee and the people in the room could actually do and achieve. Then let's see what happens after that.

Chair: Thank you, Mr Johnson.

Q27 **Shabana Mahmood:** I would like to pick up on issues around drugs in prison. There has been a huge increase in drug finds in prison. Seizures of different drugs in prison have gone up from 2,500 in 2015 to more than 10,000 last year. In particular, there has been a huge increase in Spice in prisons. Do you think that that is connected to the increased levels of self-harm and violence in our prisons?

Mark Johnson: 100%. We did a report on it last year, commissioned through the NHS. Prisoners call it the bird killer—that was the expression that was used. Basically, it kills your bird—your time—because there is nothing else to do. That is not just about workshops and not even about boredom either. There are a few different reasons actually: accessibility and the fact that there is not a test that is fit for purpose. We have a new emergent theme right now because of smoke-free prisons and the probably unintended consequence through what I believe is poor design—I might get shot down a little bit. Tobacco is bigger contraband than Spice right now and it would cost more to buy than Spice. I think it is a ticking time bomb not only in prison but actually out in the community, where people who have been in for the second or third time come back out and they have changed their drug of choice now—it is not crack and heroin. There is a question mark on whether the services are designed for this new type of drug use.

Dr Andrew Forrester: I agree that drug use in prison is a huge issue and can seriously compromise people's mental health when they are in prison. I see people all the time in my clinics who have been using lots of Spice on the wing and have become acutely mentally ill, sometimes requiring transfer out to hospital, because of that Spice use in prison.

Q28 **Gillian Keegan:** We have talked about the rise in self-harm and suicide. How much of that do you think is linked to Spice?

Dr Andrew Forrester: That is a difficult question to answer. The increase in self-harm and suicide rates is probably attributable to a range of factors, of which Spice is one. The deteriorating prison environment also has to be put into the mix; as numbers of officers have gone down, and as incidents of violence have gone up, so things such as time out of cell have become difficult. There are some reports of prisoners spending less than



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an hour out of their cell per day. All those things within the environment are important as regards self-harm.

Q29 Gillian Keegan: We were quite surprised when we went to a wing with 300 prisoners—

Chair: Just to be clear, we went to Wormwood Scrubs—

Gillian Keegan: In Wormwood Scrubs, we went to the wing with the less engaged people who were not going out to work, etc. There were seven prison officers for 300 prisoners on four floors. It seemed obvious that that would keep people in their cells more, but there is also an impact when the care is available: less than 60% of the appointments were met because people could not get there. It seems to me that the whole system and the design do not hang together. Even in the bits that you use, you are looking at one individual element of it and there is no holistic plan—with the exception of you, perhaps, Mark—to have the patient at the centre of the care. What would you recommend in terms of a prison environment that would—

Mark Johnson: If I can be really honest here, political decisions were made a couple of years ago that, I believe, played quite a big role in causing this problem.

Q30 Gillian Keegan: What was the decision?

Mark Johnson: The reduction in prison staffing levels and in interventions and stuff as well. I am talking about direct interventions. Not only that, but no new way or innovation was put in place instead. The old, archaic controls, etc., are still there. I see prison from a different perspective; I see that prisoners run prisons. They do. That is a fact. Yet we still control them and lock them up. There are no staffing numbers, but there are peer-led interventions that we could do that are proven worldwide. They create an enabling environment so that prisoners can play a more active role in their own rehabilitation. We have a very colonialist approach to administering rehabilitation, when—speaking from lived experience—it is very different from that.

The frustrating part for me is that prison governors are measured on how many people break out of their prison, and not on how many people come back in. We need to change the dynamics of that and create a whole revolution and drive towards people being equipped with what they need in order to never go back into prison.

Q31 Gillian Keegan: Going back to self-harm, how easy is it to self-harm in prison? How can they protect prisoners from that kind of environment? We saw lots of broken windows and things. What is your view?

Mark Johnson: Prison is a place of isolation. Anybody would tell you, and I am sure the doctors would tell you, that there are three types of abuse—mental, physical and sexual—but it is not the event that causes the damage, it is the sense of isolation. Prison is a place of isolation. Nobody talks about this stuff. If you have seven prison staff in a wing of 300, is



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that suggesting that they are even qualified to understand what mental health is, never mind being able to physically do anything about it?

Q32 **Chair:** But in terms of actual harm, things like broken windows and ligature points—

Mark Johnson: It is easy. It is absolutely easy. It is like drugs. People say, “There are no drugs in my prison.” There will always be drugs, because when there is a market and a need, there is a drive to want to go and find it. Razor blades, plastic, you name it; any implement can be used to self-harm. The question is why. That is the question. Why? What environment are we putting these volatile people into in the first place that is exacerbating the problem of their doing this stuff?

Q33 **Chair:** Dr Forrester, on that point?

Dr Andrew Forrester: One key thing is that many of our prison environments are completely out of date and need an upgrade across the board. Ligature points are a huge issue for suicide in prisons. It is difficult to address in older Victorian prisons that were built in 1843 and so on, but we must be able to find a way to solve the ligature points issue.

Q34 **Chair:** You say, “You must be able to,” but have you got any ideas about how that could be done? In other inspectorates they have to identify ligature points in other settings.

Dr Andrew Forrester: There are ways of doing things around safer cells, for example. Perhaps building different prisons is a way forward.

Chair: That is under way, I suppose.

Q35 **Gillian Keegan:** That is under way, but I worry about whether this thinking is actually inputted into the planning process for the new prisons.

Mark Johnson: It’s not.

Q36 **Gillian Keegan:** You don’t believe it is.

Mark Johnson: I don’t believe it is.

Q37 **Gillian Keegan:** Dr Forrester, have you seen any evidence?

Dr Andrew Forrester: To an extent. Sometimes bodies such as the Royal College might be asked to comment and so on, but I think that more expertise could be put in to these new designs.

Sarah Hughes: I think that there is something about recognising self-harm too. Some people who are repeatedly self-harming are at a greater risk of suicide because of physical health and so on. It is not just about going immediately to the ligature points, although that is incredibly important. Ritualistic self-harm on a daily basis needs to be understood, and the only people who can are the people on the wings—peer workers and officers.

Q38 **Shabana Mahmood:** I want to ask about transfers to secure hospital



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settings and the 14-day target, which is obviously hardly ever met. We saw examples at Scrubs of people who had been waiting for months, and we were told of other examples in other prisons where people had been waiting for over a year—in one case, 20 months. How can we fix this problem? That is a scandal.

Dr Huw Stone: As with many of the problems, there is not one thing that is stopping it from happening. One of the things that we as psychiatrists need to do is be better at working with people in prisons. When I started working in prisons, I found that you saw a completely different side when referring somebody to the secure hospital, which I also worked in, compared with when you were sitting in that secure hospital. It is about understanding between the two so that there is not, for example, a repeat of assessments. If an assessment is undertaken by psychiatrists in the prison, it should be accepted by a receiving hospital. That is one way it can be reduced.

This is an example of where the whole pathway needs to be looked at. It is not, as somebody said just now, one bit of it in the prison. What are the issues with secure hospitals and the problems with getting beds in those at present? It is something that NHS England has to look at. The point in the NAO Report that there are different commissioning streams from NHS England is really important, and perhaps there is a case for bringing those two together.

Chair: The fragmentation certainly comes through.

Q39 **Shabana Mahmood:** Do you think the changes to commissioning will lead to a decrease in the number of secure beds available? Are we about to see this crisis get worse?

Dr Huw Stone: Are you talking about the changes to new care models within—

Shabana Mahmood: Yes.

Dr Huw Stone: I think that is one of the most exciting things that is going to happen. I am involved in our local area, the south-east of England, in the new care models development. For the first time it actually gives the people who understand the issue, including people with lived experience of it, a chance to have a say in shaping that service. It is not just led from a higher-up commissioning level, so I think that has the opportunity to make big changes.

Q40 **Geoffrey Clifton-Brown:** We saw 120 self-inflicted deaths in 2016—an increase of 97% since 2012. Further to Ms Mahmood's question, the Department of Health guidelines say that people should be sent to a secure hospital within 14 days. Some are up to 140 days. Surely we ought to have a mechanism? Maybe it is that those properly qualified mental health staff, which you talked about at the beginning, ought to be brought in quickly to get those people out of prison quickly when there is a really serious problem. After all, if those people were in the civilian population, in the worst circumstances they would be sectioned and got



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into hospital within a matter of hours or possibly days. If that happens within weeks or months in prisons, no wonder they get so many cases of self-harm or, even worse, death.

Dr Andrew Forrester: There is an issue about developing liaison and diversion services in particular, so that vulnerable people do not get into prison in the first place. Last I heard, there was 50% national coverage of liaison and diversion services. We certainly need to get up to 100% coverage so that we divert people as early as possible.

The second point I would like to make about hospital transfers is about lack of co-ordination. There is often a lack of regional and national co-ordination about these referrals. As a doctor working in a prison setting, I would often make a referral to a medium secure unit, for that to be rejected, to make a referral on to a psychiatric intensive care unit, for that to be rejected, to make a referral back to the same medium secure unit, and on and on—it goes round and round. I am a section 12 approved practitioner, and I can determine whether someone requires hospital admission or not. That is a problem that we need to solve.

Sarah Hughes: Liaison diversion is, I think, at near 70% with an achieved target by 2020, so it is moving at pace. The point of the matter is that these people should not be in prison in the first place. Liaison and diversion is critical to making that happen.

Q41 **Geoffrey Clifton-Brown:** Is there a role here for the Ministry of Justice and the justice system considering these problems in the round before they make a sentence?

Sarah Hughes: For sure. Absolutely, we would argue that these decisions need to be made with full information at hand: with a full, complete assessment of somebody's needs. We know there is a huge number of people that should not be in prison. Liaison diversion has been designed and set up to alleviate the pressure. It is not rolled out 100%; it is near that. But it is also about integration and people understanding and respecting those assessments and diverting people away to community services. Mental health treatment orders are not quite at optimum level yet, either.

Q42 **Layla Moran:** Dr Stone, to come back to the question I asked at the beginning, I sense there is a general picture that things are getting worse, yet you said that the proportion was not really changing. Have I misunderstood that?

Dr Huw Stone: No. I think the proportion of people in prison with severe mental illness is, as I say, remarkably constant. However, you could argue, "Why isn't it reducing? Why isn't it improving?" Over the last 10, 15 years, we have had a big expansion of the secure hospitals, so there are far more beds now than there were 10 to 15 years ago. So the question is: why isn't it getting any better?

One of the reasons why things are getting worse now is, I would say, everything in prison is getting worse. We have heard very graphically from



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Mark about what it is like in prison, and that is our experience as well, working in prisons: everything is getting worse. So when things are getting worse within the environment, then mental healthcare is bound to get worse as well, I am afraid.

- Q43 **Layla Moran:** If we called you back in one or two years' time, in terms of that proportion, what would success look like, numerically speaking? What would be an achievable goal?

Dr Huw Stone: I do not think it is possible to put a figure on it. What success would look like is well-resourced mental health teams working to a service specification specific to the area they are working in. NHS England is currently working on a service specification for mental health teams, but I understand it is a one-size-fits-all. Will that be sufficient, say, for a women's prison compared to a male prison, compared to a young offenders' institute, compared to a remand prison? There needs to be greater emphasis on looking at what the specific needs are within the different prisons that exist at the moment.

- Q44 **Caroline Flint:** I want to ask you about the staff working in prisons. All of you have mentioned that there are just not enough staff. I am interested in your comments. What is the responsibility for mental health support for some of those staff as well, if they feel under enormous pressure all the time from having seven people to 300? Or they may have been victims of an attack, which is going to affect their mental health in terms of returning to work. Have you done any research on that that correlates to the needs of prisoners and also the staff?

Sarah Hughes: We did some work with the Howard League at the beginning of the year and published four reports talking about this very issue. What we would say is that the pressure on prison officers is vast. It is not just about the risk of assault, actually. It is about the risk of trauma: finding somebody who has self-harmed or tried to take their own life, or has indeed succeeded in doing so. This is a daily occurrence. So we cannot overestimate the impact of that.

We, working in clinical services, will have clinical supervision, ongoing training and monitoring—all of those things. Prison officers do not have that. They are being faced with highly complex issues on a daily basis, and I do not think we can develop an understanding of need without really thinking about the officers that are doing the work.

Chair: Thank you all very much. That was really useful evidence. The transcript of this bit of the hearing and the next bit will be up on the website, uncorrected, in the next couple of days. You will be sent information about that, as witnesses. Our report will be coming out, we hope, by Christmas—I cannot guarantee that. We will send you a copy just ahead of that. Thank you very much indeed.



Examination of witnesses

Witnesses: Kate Davies, Richard Heaton, Michael Spurr, and Simon Stevens.

Q45 **Chair:** Good afternoon, and welcome back to the Public Accounts Committee on Monday 23 October 2017. For the benefit of the new witnesses—and particularly Mr Stevens, who is a frequent flyer, to make sure he is on the right topic today—we are looking at the National Audit Office’s Report on mental health in prisons. As I said earlier, we do not need to say much more than that 2016 was the worst year for self-inflicted death and self-harm in prisons since records began, which is pretty stark. I will not repeat what is in the NAO Report—you have seen it, and we have seen it—but this is a very big issue.

Before we go into the main hearing, I will introduce our witnesses, and I want to ask Mr Heaton and Mr Spurr about a couple of issues relevant to your area in the last couple of weeks. We have Michael Spurr, who is the chief executive of Her Majesty’s Prison and Probation Service—I think we last met each other just over a year ago in Doncaster; Richard Heaton, who is the Permanent Secretary at the Ministry of Justice; Simon Stevens, who is the chief executive of NHS England; and Kate Davies, who is the director of health and justice, armed forces and sexual assault services commissioning at NHS England. That is a very long job title, Ms Davies. It is good to have you here. I think this is your first time in front of us.

Kate Davies: It is, yes.

Q46 **Chair:** Welcome. We are a very friendly group of people. Our hashtags today are #mentalhealth and #prisons, if anyone is following on Twitter. I want to ask, Mr Heaton, about what is happening at Long Lartin. It was a pretty horrific set of events in October. Was that because of cutbacks on prisons officers?

Richard Heaton: No. As far as I know, Long Lartin was fully staffed, and I don’t think what happened there—

Q47 **Chair:** You say it is fully staffed, but is the complement enough to prevent this sort of thing from happening in future?

Richard Heaton: On the day, I do not think there was a staffing issue. I do not think that was one of the proximate causes at all, but Mr Spurr may be able to help.

Michael Spurr: Long Lartin is a high-security prison. It has a large staff group. There are vacancies in that staff group, but staffing was not an issue in terms of the incident that happened recently. The prison has been able to run a full regime. There were a set of issues that we are looking into, and we will investigate what happened at Long Lartin, but it was much more about the dynamic between prisoners themselves and the way that staff were managing the prisoner issues than anything to do with the regime or staffing numbers at Long Lartin.

Q48 **Chair:** How many vacancies were you carrying at Long Lartin then and



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how many do you have at the moment?

Michael Spurr: I was not expecting that question, but it is around 22 prison officers out of a complement of, I think, 280. Those are large numbers, but they will be covered through potential for overtime payment plus and so on. It is about the same number—20-some—of vacancies for operational support grades, who are the next grade down from prison officers, out of 100-plus. Again, that is an overtime grade and will be covered through overtime.

Q49 **Chair:** Thank you for that. Sorry, I thought we had notified you of that question; forgive me if I did not do that.

This question is also to you, Mr Spurr. It is on community rehabilitation companies. You yourself came out quite boldly, saying they have not achieved as much as they could. We discussed this when we were in Doncaster on that nice sunny day last summer. Are you now changing tack on how you deliver these—

Michael Spurr: No, I was answering a straight question with a straight answer. It was a question about resettlement services. I referred to the chief inspector of probation's report on the Through the Gate programme, which indicated that that was not working as had been anticipated, and I confirmed that is the case. It is not working as well as we would have wanted was my precise phrasing, and that is the case. But what we have been doing—I said this as well—is working with the CRC providers, in terms of looking at what the service provision is and what we can do to improve that service; we are continuing to do that at the minute.

Q50 **Chair:** We did flag up some of these concerns in our report, so what has changed since that you are now beginning to act? Were you doing things after that report came out?

Michael Spurr: To be fair, one of the key issues that was flagged by the NAO and, indeed, by your report was the changing volumes for CRCs. I recall that you said specifically, and the NAO Report said, that we needed to address that. That is one of the things we have been doing; indeed, it is one of the reasons why we made some changes to payments and how we would structure payments in the summer. I know the NAO, again, is looking at that. It was precisely to address an issue around a change in the case mix that CRCs have faced, and not just numbers in terms of volumes, but the different types of cases that they are having to manage. We have restructured contracts to some degree to try to address that.

Q51 **Chair:** But if you are restructuring contracts frequently, does that perhaps mean that the flexibility is not in the system for people to deliver what they need to deliver for the individual who is sitting in front of them at the time?

Michael Spurr: This was a first-generation outsourcing contract of a pretty large nature and involving complex service provision, so it would have been a surprise, and I think that, again, it was recognised in the NAO Report and in your previous engagement that we needed to look at and manage this. We delivered, as the Report said, the implementation of the



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policy pretty effectively, but it was always going to be about how the policy worked in practice, and we are into that very key area at this moment.

Chair: Okay, we will leave that for now. I am going to hand over to Shabana Mahmood to pick up on wider issues.

Q52 **Shabana Mahmood:** The number of drug seizures in our prisons went up from 2,500 in 2015 to just over 10,500 in 2016. The number of Spice seizures in prison went up from 408 in 2015 to nearly 3,500 in 2016; and in the figures that we have for half of 2017, the number of drug finds for Spice is already over 1,600. I think it is fair to say that drugs are rife in our prisons and there appears to be a bit of a Spice epidemic. Why is there such a failure to prevent drugs from getting into our prisons?

Michael Spurr: As Mark Johnson said in the evidence earlier, there has been a huge switch in drug use over recent years towards psychoactive substances, which has been a very difficult thing for us to deal with in prisons. Those substances were for a period classed as legal. That is why we had the terminology of “legal highs”, and they were relatively easily accessible in the community, which meant that people—initially, friends and so on—began to try to supply these drugs, but they were quickly seized upon by serious organised criminals, who saw a market in prisons. They have targeted that market quite mercilessly, in our view. We have been working with police colleagues and others to try to address that. We have done a whole range of things to address the threat that these drugs have created for us in prisons.

There were over 300 different compounds, which meant that testing for them was difficult. We do now have a test, and we are testing regularly for these drugs. We could not detect them. We were the first law enforcement agency anywhere in the world to train dogs to detect psychoactive substances. We could not previously do that.

For a period, that meant that prisoners were getting access to these drugs in a whole range of ways, including through throw-overs; even though it is illegal, they were coming over the wall. We were picking them up. That is why the numbers of finds were much increased. We found an awful lot of this, but some gets through. It gets brought in by visitors; it gets brought in through a whole range of measures, including technological aids like drones, which have been bringing drugs in.

It took us some time to begin to address this real change that has spread across the prison system in England and Wales so swiftly. They are very dangerous types of substances, as Mark and, indeed, the doctors themselves quite rightly said in the previous evidence. They have changed the nature of how people, when they have taken drugs, respond in prisons. It has been extremely difficult for us, but we are working with our law enforcement partners—the police—in communities to try to deal with the supply routes, as well as actually working with our NHS colleagues on treatment and education. We have a huge education programme in prisons through prison radio and a whole range of arrangements.



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- Q53 Shabana Mahmood:** Your interventions do not appear to be impacting on the number of finds, which have not actually gone down; for the six months of this year, they are already at least half of finds in the whole of the previous year. How would you say you are succeeding in all of the measures you are taking?

Michael Spurr: You can look at finds in two ways. The fact that we are detecting them means that we are actually stopping them getting to prisoners. A lot of those finds will be ones we have taken before they get anywhere near prisoners; some will be from prisoners' cells and so on. Detection, disruption and finding, and now being able to charge prisoners internally for having possession of drugs as well, which we could not do initially because we weren't able to detect them, is part of a strategy that says you have to try to attack the supply of the drugs coming into prisons from external sources; to make clear to prisoners that that is an unacceptable practice—clearly it is illegal and you cannot have illicit items in prisons, including drugs; to tackle it with the individuals; and to then provide treatment options for them to come off those drugs. You need a holistic strategy, much as we do in communities, to be able to address that whole problem.

- Q54 Shabana Mahmood:** On the issue of supply, the drugs are either thrown over the perimeter into the prison estate or are flown in by drones— my understanding is that lots of the NPSs are flown in, in particular. Why has it proven so challenging to stop the drones getting on to the prison estate?

Michael Spurr: We are doing a lot to try to prevent drones coming close to prisons. At the moment, that is a minority way of coming in; it is high profile when people see it, but it is the minority way of coming in. It is difficult because prisons are very often in communities, so it is often about air space and stopping things and about what you do that does not prevent other people legitimately doing things like using their mobile phones outside a prison and so on.

There are lots of ways that drugs get in, as I said. Another route people have been sending them in by is simply putting it on correspondence; there is a way of getting psychoactive substances on to letters and then smoked or sniffed and so on. There are a whole range of different ways that we are constantly looking at to try to disrupt and prevent drugs entering prisons.

- Q55 Shabana Mahmood:** On drones in particular, my understanding is that you have the data about how many drones that were about to bring drugs into a prison that you were able to stop, but you do not release that data. Is that true?

Michael Spurr: We record a whole range of things about drone sightings and so on.

- Q56 Shabana Mahmood:** But specifically about drones bringing psychoactive substances into a prison? You know how many you have stopped, but you don't share that information?



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Michael Spurr: I am not sure we would have information about what drones we have stopped bringing psychoactive substances into a prison.

Q57 **Shabana Mahmood:** Any type of information on any type of drug?

Michael Spurr: I am not sure we would differentiate between drones bringing things into prison. We have data about drone sightings and on where we were able to stop drones. I am not sure what we have done in terms of putting that into the public domain; I am happy to look at that and write to you.

Q58 **Shabana Mahmood:** Moving on to rising self-harm and suicides in prison, self-harm incidents have increased by 73% and we have the highest numbers on record of people taking their own life in prison. That is a pretty damning indictment of mental health within our prison system, especially when you consider that 70% of those who took their own life were known to have a mental health condition. Do you agree that that is a damning indictment of the state of mental health services within our prison estate?

Michael Spurr: The level of self-harm and the deaths in prison are a dreadful thing. Yes, it is a damning indictment that anybody takes their life or dies in prison, and levels of self-harm going up like that is something that worries all of us who work in prisons. Every time I hear of a death, which I do for every single one, it is, of course, dreadful.

Q59 **Shabana Mahmood:** It is more than dreadful—it is a sign that the system has utterly failed, is it not? When 70% of those people are known to have had a mental health condition, it is a sign that mental health services in prison have utterly failed.

Michael Spurr: As was said earlier, it is a sign of a whole range of things that are not working how we would want. I think there is a whole range of factors that have led to increasing self-harm and suicide in prisons. Some of them were referred to earlier in your evidence.

Q60 **Chair:** A lot of those things are within your control or the control of the prison system, Mr Spurr.

Michael Spurr: Some things are in our control, absolutely. I am not denying the whole issue about changes in the prison regime and changes in numbers of staff, but there is equally an issue, as we have just described, about changing drug use and the changing nature of people who are coming into prisons as well. In particular, I would say from my experience that the psychoactive drugs have had a wider impact, as mentioned in the earlier evidence, than you are perhaps reflecting on.

There is no question but that the levels of self-harm going up have been a real issue. In effect, just over 12% of men in the system are self-harming, and 28% of women are self-harming. That is a significant proportion of people, and the incidence of self-harm has increased significantly. In terms of the number of deaths, 2016 was a horrible year. Thankfully, the figures released in June for the year from June 2016 to June 2017 are better. We have been working incredibly hard to address and reverse the



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increase in the numbers of deaths. Those June figures were better, but not where we would want them to be, and the rate at 1.1 per 1,000 is much too high. We want to reduce them and are working hard to do that.

- Q61 **Shabana Mahmood:** Given the increase in self-harm and suicide, what is the specific plan that has been put in place to see those numbers come down? I address that to Mr Heaton and Mr Stevens in particular, because you, in effect, hold the pen on a strategy for getting these numbers down.

Richard Heaton: This is about how the Prison Service performs, as well as the NHS. Let me make that absolutely clear. We are responsible for the care of the individuals who take their lives and, as Michael said, it has been a very dreadful thing.

I will mention a few things. The first is mental health training generally, and training on suicide awareness, among our staff. All our staff will go through that. Already some 7,000 members of staff have started going through that training.

Secondly, I know we mention this a lot, but the level of staffing has been detrimental to the security, stability and good order in prisons, including the self-confidence and resilience of offenders. It was the case that offenders had regular human contact with prison officers more often than has been the case in the past three years. Bringing some prison officers back on to the wings and establishing proper one-to-one engagement with prison officers is incredibly important. That is partly because they can pick up problems and is partly because conversations can happen and the human space can operate whereby people do not feel alone.

Then—as Mr Spurr has not said this, I will—there is the matter of responding better to recommendations made by the ombudsman, by the inspector and by this and other Committees. We have not been as good as we should be on responding and keeping up to date with the recommendations against us—the ones that we have accepted—so we are working very hard to ensure that when observations are made about the failures, they are acted on. Those are three things, but maybe Mr Stevens—

- Q62 **Chair:** Before we go to Mr Stevens on this, you mentioned the response to the ombudsman. A lot of these responses to the regulatory bodies, inspectorates and so on are not statutory requirements. Is that right?

Richard Heaton: The ombudsman is not a statutory being, correct.

- Q63 **Chair:** What about the inspectorate? Is it statutory?

Richard Heaton: The inspectorate is statutory, yes.

- Q64 **Chair:** So you have to respond?

Richard Heaton: We had clauses in the Prisons Bill before the election that would have strengthened the inspectorate. We are replacing that with



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administrative measures, which come to the same effect. We are going to treat it as such.

Q65 **Chair:** But administrative measures are not statutory. You have hit the nail on the head about why I am probing on this.

Richard Heaton: You're right, but, for example, we are introducing a system with the inspector where, if the inspector sees something really serious, he can bring it to the immediate attention of the Secretary of State who has to act. There is no statutory force behind that, as there would have been had it been in a Bill, but we are doing it anyway, and that stuff will be rolled out within weeks.

Q66 **Chair:** Is there a reason there is no statutory measure? Why has it been dropped from the new Bill? Is that a policy decision?

Richard Heaton: There is a pressure on legislative time because of the Brexit legislation and other things.

Q67 **Chair:** I shall bring in Mr Stevens, and then I have others coming in too.

Simon Stevens: I agree with everything that Richard has just said. May I also start with a personal declaration of interest? My partner is an unpaid member of the independent monitoring board of a prison in London. I just want to put that on the record.

From the NHS point of view, we would say that the range and the quality of prison health services have improved over the last several years, relative to the hotch-potch that it was when it was all locally commissioned by PCTs. However, we do not think that we are where we need to be, so there is quite a significant programme of work both to expand the availability of services and to get better join-up between the prison system, the specialised mental health services and continuity of care for prisoners before and after. One of the foundational assets of that, alluded to in the NAO Report, will be a health information system coming online. That will mean that when prisoners are screened at point of reception—that is a couple of hundred thousand people a year—we will be able to do a more comprehensive longitudinal assessment of their mental health and ensure that they then get the services they need.

I agree with Richard that the teams of staff providing healthcare in prisons are part of the broader team. The very welcome efforts that the Prison Service is making to increase staff numbers will help with getting prisoners to the health appointments made for them within the prison estate.

Kate Davies: You asked, Chair, what the plan was for the reduction of deaths in custody. I absolutely agree—it is an appalling situation to be overseeing health and justice commissioning with that horrible, stark stat. One thing that is really important is focusing on operational issues as well as strategic and partnership responses. The panel before us was questioned about this. We have improved and put as a mandatory requirement all levels of screening within our healthcare commissioning services. Our healthcare services have a requirement to screen on reception within five hours. They also have a requirement to screen within



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24 and 72 hours. That improvement has been showing dividends as part of the improvement in healthcare and the risk factors within our prisons. I know that some of the panel have seen some of those.

We have to look at the point made about the right people getting into prisons, particularly on remand and in the new reception centres. We have a massive churn in prisons. We have 87,000 people currently in our adult prisons and about 200 going through the churn of the system at any one time. In reception prisons particularly, we need an emphasis on more access to healthcare and more support—for example, the Samaritans' listening service. We are very pleased to be working on that in partnership with Her Majesty's Prison and Probation Service. It is also about designing more peer support and getting to people much sooner, before they are at risk. We know there are absolutely massive levels of self-harm, and one of the issues is working with a number of people who are self-harming. There are large numbers, but there are also clusters, so it is about identifying those. I know that—

Chair: I am not trying to demean your evidence, but you are describing the problem. What we are really after, in the time we have, is solutions. We have all read the Report and were pretty shocked—that is a word we do not use too often in this Committee, otherwise we would be shocked every week, but this is really shocking. I think we all agree on that, so let's take that as read.

Q68 **Heidi Allen:** That is exactly where I was going with my question. Kate, you were starting to give me hope, but Richard, I have to say that I was bitterly disappointed. I do not for one minute think this is one single person's responsibility to fix. Committees clearly have an important role to play, as well as the NAO and so on, but all you gave us was more training. I appreciate that staff numbers going down has played a massive part in this—I don't underestimate that at all—but I want to hear why you are not looking at the whole process end to end and re-engineering it, rather than waiting for Committees to tell you their recommendations.

Richard Heaton: We are absolutely not waiting for this Committee to make recommendations. This has been top of our operational and strategic attention during the last two years. The most vulnerable time in a prisoner's journey is in reception, in the first few days in custody, so we are improving prisoners' experience in the first few days in custody. We have a system to assess someone's susceptibility to suicide, and we have improved that. The attention that we have been paying to this will show through in the October figures, which I hope will show a further improvement. The June figures were an improvement on the horrific figures we had last year.

Q69 **Heidi Allen:** Do you have some target numbers?

Richard Heaton: I would not like to set a target that could be suggested to be an acceptable number of prison suicides. That would be wrong. Every prison has to make appreciable reductions in the self-harm and



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suicides in their prison. That is something we measure and look at in every performance and accountability board we have.

Q70 Chair: At Bristol prison, there were three deaths in 18 months. Our colleague, Alex Chalk, has raised that with concern in this House and with us in advance of the hearing. Since then he has had an answer from the Minister saying that 31 additional prison officers have been appointed to that prison. But why did it take three deaths to say that there was a problem at Bristol, when people were aware of the problems there before that?

Michael Spurr: We were certainly aware of that. We had identified Bristol as a prison of serious concern when we published our assessment ratings of prisons in the summer.

Q71 Chair: Was that after the three deaths, or before?

Michael Spurr: Deaths, tragically, can come in clusters. That occurs in the community and it certainly occurs in prisons. You can have deaths, very sadly, in prisons that are running well, and sometimes prisons that are not good manage not to have deaths. The complexity of why you have particular deaths in places is very difficult.

Q72 Chair: So how do you identify the problem in Bristol before that?

Michael Spurr: You look at other measures, self-harm being a particular issue. There is a much greater volume of self-harm than individual deaths, which statistically are still quite small, though each one is tragic. I want to come back to the point about what we are doing and looking at. Lord Harris did a review a couple of years ago on the whole issue of deaths of 18 to 24-year-olds. His main recommendation to Government was reinvigorating and providing a case worker for each of the young people whom they could relate to. In putting an initial 2,500 staff into prisons, we have taken the model that Lord Harris looked at. We are looking to introduce that across the system, with key workers for every individual prisoner and around six prisoners for each key worker to look after and manage. That was the rationale for the additional resource that we were able to secure. It is absolutely the right way to try to address the deficiencies we have at the moment, with people feeling more isolated, and to make sure regimes are more consistent—something that was raised previously. That is a very specific and clear change we are bringing into place. We are on track to recruit those 2,500 officers. The latest figures, published last week, show 1,290 additional officers compared with October last year.

Q73 Gillian Keegan: Mr Stevens, you mentioned a hotch-potch of services that were there previously. Rarely have I seen such disconnect between the high-level objectives—providing health and wellbeing services in prisons, and looking to improve health, tackle health inequalities and reduce reoffending—and any semblance of a sensible, joined-up plan. You talk about little bits and parts of tackling each individual piece as a solution. None of those will be effective without a sensible joined-up plan. What are you doing to achieve that?



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Simon Stevens: Kate is obviously our prisons expert here. Looking at the history of this, I think in 2005 responsibility for prison health was transferred to the NHS but was largely the responsibility of local primary care trusts. Then in 2013, for the first time, we were able to take a national point of view on that. As contracts have come up for renewal, we have been able to drive more consistency into the way in which those contracts are being let. I do not say that we are at the end of the line on that. There are clearly some intersections that are not working as they need to. Those are, in many cases, rightly pointed out in the NAO Report. But in terms of both the investment and the quality of care, let us remind ourselves that the NAO Report says in several places, “clinical care is broadly judged to be good”. I think that is correct.

- Q74 **Gillian Keegan:** That might be true, but the process disconnect almost makes the service inaccessible. There is the continuity of records—of NHS health records and GP records—going to the prison and a treatment plan that is joined-up and has the prisoners’ needs at the centre of it. Then there is the problem with the records following the patients—the screening and diagnosis—and then, when you have got an appointment, when you have a treatment plan, there are not enough prison officers to take you out of your cell and deliver it. The appointment rate is 60%. If you have not got records to follow this up, it is not working.

Simon Stevens: Fundamentally, yes, but your stat is wrong. I think 15% of appointments are not kept, as measured off the most recent information set for the performance.

- Q75 **Gillian Keegan:** We went to one prison on Friday. They said that only 60% at best were kept, and they thought they were doing well.

Simon Stevens: That was Wormwood Scrubs, was it?

Gillian Keegan: Yes.

Simon Stevens: If that is the Wormwood Scrubs position as of Friday, that is significantly worse than the national position. The underlying point is correct, which is why we have taken action. In fact, we signed a contract on the Friday just gone for the equivalent of a GP medical records set that will be available for prisoners. We will be able to import their medical records for their prior treatment in the community and subsequently export their in-prison healthcare experience. We signed that contract on Friday, and it will take between 12 and 24 months to get a complete roll-out across the whole of the adult prison estate, youth prisons and other parts of the criminal justice system, but that is going to make a hell of a difference.

If you had come with me to Belmarsh prison, where I was a few weeks ago, you would have seen some of the improvements that have been made more recently, such as the smart card that enables prison health teams to get access to the summary care record, which was previously not available. Previously, faxes were flying around the system with bits of information.



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Chair: Sorry, we were just laughing at the idea of the faxes. Our fax machines are gathering dust.

Simon Stevens: Well, indeed. Was that a pretty screwy system? Yes. Have we taken action to tackle it at root? Yes. Will we see the clinical benefits of that over the course of the next 12 to 24 months? Yes.

Q76 **Gillian Keegan:** How are you measuring your clinical benefits? In your new agreement, have you got measurable outcomes?

Simon Stevens: There is a chicken-and-egg aspect to this. If we have not got the longitudinal medical record, it is hard to track what is actually happening to prisoner health status. Once we have that record, we will be able to do that.

Q77 **Gillian Keegan:** So you accept that we have no idea whether the £400 million we have spent so far has been effective or not.

Simon Stevens: No, I think that is a generalisation.

Q78 **Gillian Keegan:** Give me a specific example of how it has been effective. We can't see anything that you can measure—reducing reoffending, for example.

Simon Stevens: Here is the indicator set that we use—I can leave this with you, although you may have got it—to track what is happening inside the health services in prisons. It is pretty extensive. Is it all-singing, all-dancing? No, but to say that there is nothing here in this phone directory's-worth of information would be a mistake.

Q79 **Shabana Mahmood:** From that document, can you tell us how many people in prison today have a mental health issue? Does that document capture that information? I have not managed to find it anywhere else.

Simon Stevens: Yes. We have that on our mental health registers, which show the month-by-month prevalence of severe and enduring mental health problems. I have got the figures here for June, but no doubt we have got the data. The answer is 9.5% at the severe end of the spectrum. Over and above that, there is a figure in the NAO Report of 37%, which I think is an HM inspectorate of prisons number. As we get the comprehensive screening in place using the new systems we have got, we will be able to produce that on a real-time basis.

Chair: I want to clarify that number, but I think Mr Stevens might have just done that for us.

Oliver Lodge: My understanding is that that is the number of people in treatment.

Q80 **Shabana Mahmood:** My question was not about the number of people receiving treatment for mental health issues. It was about the number of people with a mental health concern in prison.

Simon Stevens: We think the number of people with severe mental health problems is the number of people—



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Q81 **Chair:** To be fair, Mr Stevens might know more about the treated people, because that is his responsibility. Mr Heaton, how many people in prison have got—

Richard Heaton: I see the gap as follows. We know, from the 10% number, the number of people who are in treatment—

Q82 **Chair:** Sorry. Let's cut to questions and answers. Do you know the percentage of prisoners with a mental health problem? Have you got any figures you work from?

Richard Heaton: No. The only figures we have are about 10 years old. They are from an in-depth survey we did, which showed that roughly 50% are prone to anxiety or depression.

Q83 **Chair:** So you don't know the scale of the problem, and yet you have got—

Richard Heaton: We know in scale terms, but we don't have precise data showing how many people are prone to anxiety in 2017. We can't give you that figure.

Q84 **Chair:** You choose anxiety, but there are different grades of mental health problems. Do you have any figures for any of them? You have got the high end, because those are some of the people Simon Stevens's side of things is treating.

Richard Heaton: No. At a national level, we have some good intelligence but we don't have sophisticated data on gradations of healthcare needs or mental health needs in our prisons, as far as I know.

Q85 **Shabana Mahmood:** So we don't have a full understanding of the scale of the problem. Do we know how many people request treatment but do not receive it? That is to either Mr Stevens or Mr Heaton—whoever is responsible for that data.

Simon Stevens: Kate will come in here, but we have the missed appointments, which by definition are people who are supposed to be coming, and that is running at about 15%.

Q86 **Shabana Mahmood:** That is not the same as those who have requested treatment and then not received it. We understand that that happens across—

Simon Stevens: The health service works on the basis of care according to need, not on the basis of care for people who request care. A clinical judgment is made as to what the appropriate medical response needs to be. But Kate will speak on prevalence.

Kate Davies: On prevalence, when we talk about a plan, it is also important to say that we started commissioning this with no indicators or measures of performance. It was really important to have that plan and to get those indicators in place, and we have done that in partnership with Public Health England and the MOJ. We always said that those indicators of performance that we are measuring at the moment would be there for



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three years, and we are reviewing them now. We will refine them; the 20 indicators for mental health within those indicators are being reviewed as I speak. They will be improved and go live for April 2018.

That will also include a stronger emphasis on the aspect of mental health that I think you are talking about in terms of numbers—that is, on anxiety and depression. Lastly, I slightly dispute what was said in the NAO Report: all our healthcare commissioners do health needs assessments, and it is from those health needs assessments that we know that the prevalence is around 18%. We also know about mental health needs through our service users and lived experience panels.

Q87 Shabana Mahmood: How long has NHS England been in charge of delivering mental health services in prison?

Kate Davies: We have been commissioning since April 2013.

Q88 Shabana Mahmood: So you have had some years to try to get some of these basic metrics and indicators in place, and there has been a failure to do that. That is a material point, isn't it?

Kate Davies: I would argue that there has not been a failure to do that. What was absolutely important was, for the first year, to ensure that we had the quality, as was mentioned earlier.

Q89 Shabana Mahmood: Would you agree that, if you start with no indicators, as you said in your previous answer, and we still do not know the scale of mental health issues in prisons, we have basically failed to get the most important indicator in place?

Kate Davies: We have that indicator for severe and enduring conditions, and we have that—

Q90 Shabana Mahmood: You have just said in your answer that you will move towards looking at what you describe as the lower end: anxiety and depression.

Kate Davies: Yes, absolutely.

Q91 Shabana Mahmood: You accept that they are part of the mental health piece in prisons?

Kate Davies: Yes, I accept that that needs to be improved.

Q92 Shabana Mahmood: When you took over those contracts in 2013, it ought to have been clear that we should get some indication of all these elements of mental health-issue indicators in place right at the start.

Simon Stevens: One indication is how quickly people are able to get the mental health appointment inside prison. If we are talking about equivalence, the comparison is between that and how quickly someone might be able to get a mental health appointment outside prison. The figures we have show that the appointment times are fewer than six days on average, and indeed, for an urgent GP appointment they are faster in some respects in prison than outside.



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Q93 **Shabana Mahmood:** With respect, we have not yet moved on to the quality of the service or what we mean by equivalence.

Simon Stevens: I thought quality was what we were debating.

Q94 **Shabana Mahmood:** We are talking about the basics of data collection, so that we can work out whether you know the scale of the problem and how much it will cost to fix it, or whether we have a dysfunctional and more expensive system in place. Right at the start, when you took over these contracts, it should have been obvious, should it not, that a proper understanding of the scale of mental health issues across the piece—not just the most serious issues, but anxiety and depression—should have been core business bullet point 1?

Simon Stevens: I disagree, because that is to misunderstand the way these contracts came up for renewal. When we inherited them, there was a duration—a run-off—on these contracts. What you have heard from Kate Davies but have not taken account of is that, as the contract comes up for renewal, a health needs assessment is done for that prison, taking account of the mental health and other health needs of those prisoners. That is then reflected in the contract that is let. It is happening on a rolling basis.

Q95 **Gillian Keegan:** How do you do that assessment if you do not know how many people have a mental health issue, you do not have a proper screening process and you do not have the GP records beforehand? How do you do it?

Chair: Practically?

Kate Davies: If we are talking about data, there are a number of elements as well as the data we have, including the substance misuse data from the national drug treatment misuse service and mental health data from both primary and secondary care. The data also include the healthcare data that we have locally within prisons; all our healthcare providers also support us with a local matrix of information. They also include the P-NOMIS information that we work with within our prison system, particularly the important information on gender, race, ethnicity or age, and particularly some of the information that is key—

Q96 **Gillian Keegan:** Just to stop you, when we went to Wormwood Scrubs we heard how inadequate the mental health professionals felt the records that they had were. They were asking for GP records that they never received, and having to pay £25 to get one, if it ever came. They did not have any information at all. The screening had almost half the questions not answered. So you don't have the information to start.

Simon Stevens: That is why we are procuring the new health information system—the electronic medical records system—for all prisons.

Kate Davies: That includes the new clinical templates. I completely agree—

Q97 **Gillian Keegan:** But you are talking about the last four years. You spent £400 million or something.



Kate Davies: But we really wish we could have had that in earlier. We have had to take that and develop it. It is a new £30 million service around the health and justice information system. We are really proud to have been able to put that in for the first time in England and, as far as the World Health Organisation is concerned and has fed back as part of the global, it is something that we are absolutely keen has to be improved. There is no doubt about that, but alongside substance misuse, mental health and vulnerability, including learning disability, it is absolutely essential that we now put that in place and commission it in the way that we have.

Q98 **Caroline Flint:** Ms Davies, you have a long-standing career in this area: the National Treatment Agency, drugs and so forth. I would have thought that taking that experience into NHS England would be paramount to dealing with the problems identified on page 31 of the Report. Paragraph 3.10 says: "Staff did not enter data on the 'risk of suicide' in 68% of screening records, or on the 'risk of self-harm' in 59% of records." In fact, a number of the questions associated with potentially discovering the state of someone's mental health are optional rather than mandatory. In your experience, Ms Davies, how can that enable NHS England—I will come to Mr Spurr and his 40-odd-year career in the prison service—to understand better what is going on in terms of identifying the data needed?

Kate Davies: I have answered the question once, and I think you are quite right, particularly about my personal experience with the National Treatment Agency. That is why one of the first things that we have done is look at what the baseline information and data need to be, and get those systems commissioned and in place within a prison system, particularly around self-harm and suicide. We have also done that alongside service users and lived experience and said, "What is it that would help that isn't there already to support that information and those data?" That is something we have been developing constantly over the last two and a half years.

The first year was very much about making quite sure that we had the level of services, not just in mental health but in secondary and primary care, dental and physical care, within all our prisons. Some of those particularly—

Chair: I think Ms Flint was asking particularly about the questions being asked or not asked.

Caroline Flint: The questions are not even being asked.

Q99 **Chair:** That brings us to Mr Spurr, because this is at the prison end. Aren't the prison officers well-enough qualified to do this?

Richard Heaton: It is a prison service screening, not a health screening. It is a day one screening. You would never expect to get healthcare data from lay screenings done by prison officers. It is done for a different purpose: to determine, for example, day one risks and cell-sharing risks.



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Q100 **Caroline Flint:** But when I look at figure 6 on page 32, you are quite right—it does say “Prison officers conduct Basic Custody Screening”—but then it says, “Healthcare staff conduct healthcare screening”. For goodness’ sake, Mr Heaton, surely there should be joined-up thinking between the interviews related to the basic screening and those related to the healthcare screening assessment, to make sure that as soon as possible—maybe not on the first night, because that might not be appropriate, but at least within the 72 hours indicated in this lovely diagram—the figures are being met. You can’t just say, “That’s our job, not NHS England’s.” The pair of you need to sort it out.

Richard Heaton: You’re absolutely right. The investment that has been mentioned is incredibly important. You are right: NOMIS, the prison service IT system, does not talk to the NHS system outside or inside the prison, and it is a huge disjoint. The one system that can bring together health records from before a prisoner enters prison, health records inside the prison and, crucially, prison officer records, so that all the intelligence and observations about an individual, whether they are done by a lay officer on a wing or by a healthcare professional—

Q101 **Chair:** But Mr Heaton, you may not remember, although I am sure Mr Spurr will, the Magee review of data within the justice system, which mapped all the data that could or should be shared and showed the gaps between prison, probation and courts. Some of the stuff that you are dealing with now in the court system—that was nearly a decade ago, and yet we are still not sharing information, not even within the same Department.

Richard Heaton: Some of the Magee recommendations have been fixed. This one hasn’t, but it is being fixed now, which is a great leap forward.

Chair: It was a whole decade ago. Mr Spurr, did you want to add anything?

Michael Spurr: To be fair to NHS colleagues, that specific paragraph is about the basic screening tool conducted by prison staff. The NAO Report says that 58% of the time, the question of whether someone is at risk of suicide is not completed—that is about a basic screening and an officer not being able to determine whether that individual is at risk of suicide at that moment. There is an issue around contact with mental health services, which is a mandatory question that has been completed. That is the very basic screening tool that officers use at the first point of reception. The individual is then seen every time by a healthcare professional with the potential for that individual to be seen again.

Q102 **Chair:** Could you be clear? Ms Flint asked why some of these questions are not compulsory. Can we have a quick-fire answer on whether they should be compulsory at some point in those 72 hours?

Michael Spurr: Some are compulsory for answering and some are about taking answers from an individual. At that point it is not an assessment of a person’s suicide risk when a basic screening—



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Q103 **Chair:** Should they be compulsory at some point in those first 72 hours?

Michael Spurr: Yes, but the health screening is absolutely compulsory, which follows that.

Q104 **Caroline Flint:** I understand that the first 72 hours is the most important time in which to assess whether someone is at risk. I totally understand that you might not want to do that within hours of them arriving, because it would be destabilising, but some follow-up in the next 72 hours and clarity on who is asking which questions seem vital. Why is that not happening?

Michael Spurr: It is happening.

Kate Davies: That is happening from a health perspective. One of the things to do probably is to join up the way that that works in every different prison and within the healthcare provider. One of the essential things is joint planning between individual prison governors and the healthcare providers, to join up that compulsory information as part of health screening.

Q105 **Caroline Flint:** I get that, but why is that not happening? The lack of joined-up thinking is nothing new. Mr Spurr, you joined the prison service in 1983 as a prison officer. You have moved up the ranks and you must have a massive amount of experience. You have mentioned the staffing problems. At any time from 2010, in your position either as director of operations for NOMS or as its chief executive, did you raise concerns or ask for a direction from Ministers about the impact of staffing cuts on the provision of services, with respect to the issues we are discussing?

Michael Spurr: I have not asked for a direction from Ministers. We have tried to deliver the Government's expectations to run with a reduced budget, as many Departments were required to do. We tried to introduce the staffing changes in a way that would continue to deliver adequate and proper services to all our prisoners. The Justice Committee did a review of our staffing review of benchmarking just before the 2015 election, which said that the rationale and the way we were doing that had merit. It questioned—rightly and perceptively at that point—whether our staffing ratios were going to be sufficient given the change in need. That proved to be right. That is why we made the case for additional funding, which we have now received, to increase our staffing ratios.

Q106 **Geoffrey Clifton-Brown:** Mr Spurr, when will the difference between the benchmarking and the staff in every prison be closed?

Michael Spurr: Our aim is to have new staff in post by the end of next year, which will certainly mean that everyone will be operating above what they were on benchmark. Our aim is to go well above that with the 2,500 additional staff and to introduce different ratios for staff to prisoners. There are 11 different benchmarks—there is not one for every prison. There are different ratios and ways to operate depending on different types of population, such as women, high security prisoners and young people. They differ depending on geography, because you have to operate with the geography of an individual prison. In basic terms, the ratio

change that we are introducing with the extra 2,500 staff is a move from a starting point of one to 30 prisoners to a position of one to 20 prisoners, which is a significant improvement in the staff-to-prisoners ratio.

Q107 Geoffrey Clifton-Brown: Mr Heaton, you said very clearly that the screening was your responsibility. You heard my question in the previous session. Do your staff have sufficient training, probably from NHS England, to be able to carry out this screening on a proper, professional basis?

Richard Heaton: They are not healthcare professionals, so they are not trained to be healthcare professionals. The screening is, in healthcare terms, fairly rudimentary, which is why it is so important to follow it with professional healthcare screening, which is not the responsibility of HMPPS staff.

Q108 Gillian Keegan: When we were at Wormwood Scrubs, they explained to us that the loss of staff and people leaving was outstripping recruitment. That was the first issue. The second was that your process for the recruitment itself takes seven months to clear somebody—both mental health professionals and prison officer staff. Trying to plan your career with a seven-month wait is impossible. Are you creating the problem of not having enough staff in prisons or in mental health provision in prisons?

Chair: Who is that question addressed to?

Gillian Keegan: Mr Heaton and Mr Stephens.

Richard Heaton: Retention of officers is a problem, particularly in areas of the country where the labour market is buoyant. However, our staff in post—not just numbers of recruits but net numbers of staff in post—is going up. We are outstripping a retention problem, and we are also improving retention in those prisons with the worst numbers. It is disappointing that it takes sometimes too long to get prison officers in post—

Gillian Keegan: Seven months.

Richard Heaton: I am not sure how representative that number is. We have worked very hard to reduce the time to hire.

Q109 Gillian Keegan: What is your objective?

Richard Heaton: I cannot give you a number.

Gillian Keegan: You need a number.

Richard Heaton: I cannot give you a number right now.

Q110 Chair: Can you write to us with a number?

Richard Heaton: I can write to you with a number. We are working very hard. This is a volume recruitment and it is proving very successful. We are getting people in and through training. You are right that we have had to tackle the time to hire. We need to do decent levels of security



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vetting—we do not want that to not happen—but you are absolutely right. There are processes that happen sequentially that can happen in parallel, and so on.

Q111 **Chair:** If you could, write to us with not just the current time for vetting but the trends, and also if you have any suggestions about how you might speed that up, because that is helpful to us when we are writing our report.

Richard Heaton: I will certainly write to you with that.

Simon Stevens: From our point of view, we agree completely. As these process improvements happen, that will be of great benefit to the healthcare providers as well.

Q112 **Gillian Keegan:** Were you aware that it was taking seven months to clear mental health professionals to work in the service?

Simon Stevens: Yes, we are aware that there are delays, and we have been in discussion with the Ministry of Justice about that, because in just the same way as the operational—

Q113 **Gillian Keegan:** And when did you become aware?

Simon Stevens: We get constant feedback from staff and from our healthcare providers in different parts of the country.

Kate Davies: It is something that we were working on for a number of months. In fact, I know that, at the moment, we have 67 staff waiting for clearance after being employed. As increased levels of staff in a number of prisons—

Q114 **Gillian Keegan:** We have also heard of third parties that do a similar service and that do it in a couple of months. They do not create any delay whatsoever. Is it just your inefficiency or failure to address the problem? It will clearly never lead to the staff you need.

Richard Heaton: There are various pinch points in the process and we have addressed some of them. For example, one of the pinch points is in our shared service provider. We have recruited additional staff, seconded to the share service provider, to help that part of the process. The other pinch point is vetting, where we have used—

Q115 **Gillian Keegan:** Have you given them a service level? So they would have to do it in x months or x days or whatever?

Richard Heaton: We certainly have an aspiration for how short the time to hire needs to be. I wish I could give it to you now.

Chair: An aspiration is not a service-level agreement; it is just wishing when your contract is in.

Richard Heaton: It is an aspiration agreed by all parties to this process. I cannot give you the number now.

Q116 **Chair:** What are the consequences to your contractors of not meeting



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your aspiration?

Richard Heaton: Some of the partners are contractual, some are Government partners.

Q117 **Chair:** That is a laden comment. Is it that the Government partners are the reason for the delays?

Richard Heaton: Security vetting is a Government function. Shared services is a contracted function. We are bringing pressure to bear and working with partners in both of those fields.

Q118 **Gillian Keegan:** Prison staff are key to delivering this aspirational service that you have. If you do not get this right, I think you may as well not bother with the rest of it.

Richard Heaton: We are successfully addressing the recruitment challenge.

Q119 **Gillian Keegan:** It is the joined-up thinking that is completely missing again. Does your new partnership agreement address that joined-up thinking? Do you have a single plan that will actually be able capable of addressing this?

Richard Heaton: On staffing?

Gillian Keegan: On everything.

Richard Heaton: Yes. I hope the new partnership agreement will be a step improvement on the first one, which, as has been said, was better than the multiple arrangements that pre-existed NHS England taking on this work. I am hoping that the new partnership agreement will set out proper measures that are quantifiable for health and wellbeing across the prisons—not just in the clinical parts, but in the prison service parts.

Q120 **Chair:** Can you give us a date for when that will be published?

Richard Heaton: The next one is in April 2018, I believe.

Kate Davies: April 2018.

Q121 **Chair:** But the last one ran out in April, am I right?

Kate Davies: Because of elections and also a change in Government policy—

Q122 **Chair:** Sorry—have elections had such an impact on something that was a work in progress?

Kate Davies: There were changes in the way that the MOJ and HMPPS, which was NOMS, were working. We have had a partnership agreement—we have a working partnership agreement—but going back to the question, we have also done work to set measurable objectives and metrics. That includes continuity of care within the new partnership agreement.

Q123 **Shabana Mahmood:** Ms Davies, the agreement with the six objectives,



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four of which relate to mental health issues, was set for 2015-16 and then extended to April this year. That's correct, isn't it?

Kate Davies: These are new and improved objectives. That is one of the things the—

Chair: Sorry, will you answer Ms Mahmood's question? Repeat it, Ms Mahmood.

Q124 **Shabana Mahmood:** The six objectives that you were discussing with Ms Keegan were in place for the partnership agreement between HMPPS—NOMS, as was—and the Ministry of Justice, NHS England and Public Health England for 2015-16, and then they were extended to April this year.

Kate Davies: That is right.

Q125 **Shabana Mahmood:** How has the election had an impact, then, on your ability to evaluate those things? I fail to see the relevance of the election putting you off course on getting your new partnership agreement in place.

Kate Davies: The new partnership agreement will now include also—

Q126 **Shabana Mahmood:** No, you haven't answered my question. How did the election put you off course? You said the election put you off course; I didn't. You said it put you off course. How?

Kate Davies: Because our partners within NOMS and particularly within MOJ commissioning—it is probably for Mr Spurr to support this—were of the opinion that they would like to change the partnership agreement and the way that it extended the accountability and the support of partnership work.

Q127 **Chair:** Mr Spurr, did you realise in April this year that you wanted to change the way you did it? Surely, if you were planning to change it, you would have been planning before then.

Michael Spurr: We have been going through a whole range of changes structurally within the Department and with other colleagues, including changes to responsibility for commissioning within the Department; that is now the Department's responsibility rather than my agency's responsibility. Those arrangements were changing. We asked for an extension of the current partnership arrangement while we put our new structures into place so that we could then engage in a rather more effective way about how we wanted to improve their performance. It is a perfectly fair point that we should have got on to that earlier—I accept that. We put it to deal with next year rather than last year—Kate Davies is right in saying that—because we have a whole range of other structural changes that we are managing as we move to the new agency arrangements.

Q128 **Shabana Mahmood:** Just to mop up a couple of things quickly before we move on to other issues, when will Spine—the connecting up of the records—be in place? What date?



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Kate Davies: As Mr Stevens said, we are really pleased that we signed that contract on Friday—

Q129 **Shabana Mahmood:** Just give me the date.

Kate Davies: Sorry, 22 November is the go-live date.

Chair: Thank you. That is a very precise date. Ah, Mr Stevens is now—

Simon Stevens: Hang on. Let's more comprehensively answer the question.

Shabana Mahmood: No, I just wanted the date, Mr Stevens, with respect.

Simon Stevens: The twenty-second of November is not when magic will happen across the totality of the prison estate.

Shabana Mahmood: No, this is our hearing, Mr Stevens; I don't want an explanation.

Simon Stevens: There is a phased roll-out over the course of 24 months.

Chair: Mr Stevens, we know the date that it's starting. Thank you.

Simon Stevens: Well, I don't want to mislead the Committee. It is not that it is starting comprehensively across England on—the roll-out for the GMS service will take 12 to 18 months, so it will actually probably be 24 months, tops, before it is completely layered in everywhere.

Chair: Twenty-four months before it is completely in place, but it starts on 22 November. Thank you.

Q130 **Shabana Mahmood:** On the collection of screening data—the first screen and the health assessment screen that take place in prison—the upshot of the National Audit Office's Report is, in essence, that HMPPS, or NOMS as was, collects the data nationally but it has gaps in it, whereas NHS England has more comprehensive data but does not collect it nationally. How can you join those two things up? As quickly as possible, please. Who is going to take responsibility for that? Mr Heaton? Mr Stevens? Mr Spurr?

Michael Spurr: We need to join them up—accepted. That is one of the responses to the Report that we need to actually give.

Shabana Mahmood: Okay. Let me move on to the level of unmet need in prisons. We have mostly been discussing things that come up in the assessment, but you would all accept that there is probably quite a high level of unmet need. That is certainly the anecdotal evidence that we have received from prison staff and mental health staff in prisons. Would you all agree with that? *[Interruption.]*

Chair: Do we take silence as agreement?

Richard Heaton: I am sure there is, as there is in the community.



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Simon Stevens: There is unmet need for mental health services across England and, in all likelihood, Wales, Scotland and Northern Ireland as well. Yes, that is true in prisons, but it is true across the country. That is why we have a costed programme to expand mental health services.

Q131 **Shabana Mahmood:** Indeed it is true, Mr Stevens, but particularly in relation to unmet need with regards to speech and language issues, learning disabilities and autism, we were told at Wormwood Scrubs—I know this from my own experience as the constituency MP for HMP Birmingham—that there is a revolving door for people in that cohort of need. They come in and out of prison because their needs are simply not being met, and the interventions needed to help them are not coming. What are you doing to address that?

Simon Stevens: So you are talking as much about services that are available on the NHS out of prison, to try and avoid that revolving door.

Q132 **Chair:** Across the piece, yes.

Simon Stevens: I should make two points, I think. The first is that we are unequivocally now increasing in real terms the expenditure by the NHS on mental health services, and mental health service spending is going up at a faster rate than overall NHS funding growth; so that, over time, will expand the range of services available for the people that you are describing in communities across the country. Secondly, I would particularly point to the extra investment that we are targeting at liaison and diversion services, which, as you know, are a sort of intercept, so that people can have their mental health needs assessed and met while they are interacting with the court system, rather than ending up in the prison system. Since 2014, the coverage of these NHS liaison and diversion services has expanded, from a quarter of the country. I think it is 78% of the country now; 42,000 people last year benefited from interaction with these L and D services. So I think it is a general answer on the expansion of health services and it is a targeted answer on liaison and diversion services, with 100% coverage by 2021 as previously promised.

Q133 **Shabana Mahmood:** 2021—that is what I was going to ask; thank you. I just wanted to just touch on BME health inequalities. One of your objectives is obviously to deal with health inequalities. I do not know if you are aware of, or have read, the Lammy review, recently published, and what that has to say about the experiences of BME prisoners and mental health reporting. Are you aware that this is a concern, and what are you doing to address it?

Richard Heaton: Certainly we in the MOJ have all read the Lammy report, and we have got a team specifically within Michael Spurr's agency to address the prison aspects of BME experience, both of disciplinary and other services in prison. Absolutely: we are all aware of Lammy.

Q134 **Shabana Mahmood:** Mr Spurr, what is the timeline of work for that team that you have got within HMPPS?

Michael Spurr: There is a range of different work going on, so we want—



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Q135 **Shabana Mahmood:** Yes, but specifically in relation to mental health services, and under-reporting by BME prisoners of mental health issues.

Michael Spurr: The mental health services response is an NHS-specific response.

Kate Davies: We worked very closely with the Lammy review. It was an excellent opportunity. As part of that we have agreed that we will review and look at the needs and screening, and the outcomes, very importantly, for BME communities. As part of that, we know that we have increased the amount of black and minority patients going through liaison and diversion—both men and women—and that is really important. We also know that 26% of the prison population is black and minority, putting it into over-representation.

Q136 **Shabana Mahmood:** The review that you have just mentioned: when did that start, and when will that work finish?

Kate Davies: That has been part of the same piece of work that we talked about around the information management, but also around the review of our indicators and our mental health targets. That is April '18 that we hope to look at that, as part of the recommendations in the review.

Q137 **Shabana Mahmood:** I don't think I got an answer for the date.

Kate Davies: It is April 2018; sorry.

Q138 **Gillian Keegan:** Can we just move on to the prison environment? Another thing that is quite important is actually the prison itself, and enabling mental health and wellbeing services to be delivered—and, indeed, places that would promote mental health and wellbeing. How involved are the NHS or the mental health professionals in the design of the new-build prisons to optimise the building with mental health in mind?

Michael Spurr: We have had a wide range of involvement from, certainly, NHS colleagues but also wide international and academic input into the design of prisons. The new prisons that have been designed: I am very confident about those designs bringing together the best practice internationally, at trying to design environments that will mitigate the issues—the pains of imprisonment, as it is called in criminological terms—to try and promote wellbeing.

Q139 **Gillian Keegan:** When can we expect to see this? When will we expect to see these new prisons?

Michael Spurr: We have got planning permission for three sites at the moment: the former prison at Glen Parva, which was closed in the summer, a site at Wellingborough, which held a prison some time before, and at Full Sutton. We are pursuing the position in terms of developing tenders for contract at the moment. We have still got to get through the final parts of the business case, but I would anticipate that, within the next few months, we will be proceeding with some of those sites.

Q140 **Gillian Keegan:** We had heard that actually you were not really taking



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that input in the prison design. Is it one of these open-ended consultations, or are you absolutely convinced that you have had the right experts giving you right advice, again going back to joined-up thinking?

Michael Spurr: Yes, we have had an extensive amount of engagement with a range of different bodies, individuals and academics. I am very happy to take people through how we have done that—it is not appropriate here—but yes, I am absolutely confident that we have engaged widely.

The environments are really important. Just to say, we have worked very closely with the Royal College of Psychiatrists about developing better environments in prisons—therapeutic environments. Psychologically informed planned environments—PIPEs—for particular personality-disordered offenders are a real success story over the last few years, where we have had something like £40-something million diverted from wider secure health settings to support personality-disordered offenders in prison and in the communities and in approved premises. We have been working to develop enabling environment award standards in the way that we deliver services in approved premises in probation. One whole prison, Drake Hall female prison, has gained that award from the Royal College of Psychiatrists. So we have been working very closely with professionals about environment and wellbeing.

Q141 **Gillian Keegan:** The cost of reoffending is estimated to be between £7.4 billion and £10 billion a year, so there is a clear business case for you to get this right. Do you look at it in that way? Do you analyse and measure it?

Michael Spurr: Yes. You asked previously about reoffending. Of course, there is too much reoffending. I have spent my whole career trying to reduce the risk of reoffending. The numbers have actually improved—not as much as we would have wanted, but from prison specifically the 2015 figures, the latest available, are that 43.4% of people who left prison reoffended within a year. Of course that is too high, but that is 2.1% better than the previous year and five percentage points better than it was 10 years before that.

I accept that that is not good enough. That is why the whole reform agenda—the White Paper agenda—needs to take that forward. But of course it matters. We talk about preventing victims by changing lives. It matters, because if we can prevent somebody offending, that prevents a crime and a victim in the community. So absolutely it matters.

Q142 **Shabana Mahmood:** I want to talk about the transfer of prisoners out of prison to a secure hospital for treatment. The National Audit Office Report covers the 14 days target and we know that 63% of prisoners waited longer than the recommended 14 days to transfer from prison to a secure hospital. How many prisoners are currently awaiting transfer and have been waiting more than 14 days?



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Kate Davies: We are aware that there are just over 200—I think it is 220—prisoners awaiting either the appropriate transfer or mental health assessment as part of that process at the moment. As you quite rightly say—

Q143 **Shabana Mahmood:** Sorry, 220 prisoners today have been waiting more than 14 days for transfer to a secure hospital.

Kate Davies: They won't necessarily have all been waiting more than 14 days, but yes we are aware that—

Q144 **Shabana Mahmood:** I am trying to establish how often and how regularly the 14 days target is breached. It would be helpful if you could stick to how many have been waiting more than 14 days.

Kate Davies: The 14-day breach, at 34%, has been a consistent percentage for the last six months to a year.

Q145 **Shabana Mahmood:** How many of that 34%—the consistent level of breach—have been waiting more than, say, 20 weeks?

Kate Davies: That is reducing. The period—

Q146 **Shabana Mahmood:** Just the number, please, if you have got it.

Kate Davies: I don't know that exact figure, actually, but I will certainly find that out for you.

Q147 **Shabana Mahmood:** When we were at Scrubs, we were told of one prisoner who had been in since June, awaiting transfer, who was in the grip of a mental breakdown and needed access to anti-psychotic drugs. We were told of other examples in other prisons of people waiting more than 20 months. As one of the mental healthcare staff said to me, "You wouldn't treat an animal like that." If the number of self-harm and suicides in prison was not an indictment of performance to date, certainly this is also a disgrace.

Kate Davies: Absolutely, this is not an issue that we take lightly at all. It is not good enough.

Q148 **Shabana Mahmood:** But if this was happening on the outside—if it was an equivalent NHS target for people outside the prison environment—it would have been fixed by now.

Kate Davies: I think there are issues around waits in all parts of the community. We are doing a particular piece of work with our specialised commissioning colleagues to get an understanding of the transfer, the remissions of patients in prisons—it is really important that people see them as patients—both as part of the assessment earlier on and as part of bail, and the alternatives to custody. That is absolutely crucial.

Q149 **Shabana Mahmood:** Why is it so difficult to get this right? These people are a particular risk. Most of them, as we have heard, should not be in prison anyway, but the failure to get them the treatment they need in a secure hospital is making them more ill. That costs more when they do



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access that healthcare. In any other setting, outside of prison, these people could sue you for negligence.

Kate Davies: We are doing a piece of work at the moment—it starts next week—to reassess that level and look at where those blocks are. We have done that before, but we are doing it again. We have been focusing on a number of those prisons—

Q150 **Shabana Mahmood:** But when you did that piece of work before, where did it tell you the blocks were? What specific measures did you take to unblock those previously known blockages?

Kate Davies: I think the previous panel was discussing that. I concur with what they were saying. We are also looking at where there are gaps and needs in mental health beds in low, medium and high secure units for people who have that assessment under the Mental Health Act. Those people are being kept and supported within the prison environment, but ideally we would prefer to get them transferred much swifter and much sooner.

Q151 **Shabana Mahmood:** So your new review could easily be doing the work of the previous review again? What confidence can you give us that you will get it right this time round?

Kate Davies: I am really confident that what we are doing currently, alongside my specialised commissioning colleagues and the regions, is getting single points of access and focusing on those individual patients. I can quote different prisons and the number of people who we have already successfully supported to transfer to the right mental health environment, but we still have a way to go.

Q152 **Shabana Mahmood:** What is your target for getting that 34% down? This time next year, what would you like that number to be?

Kate Davies: I would like to see that number completely—

Q153 **Shabana Mahmood:** Are you confident you can eliminate that number?

Kate Davies: Am I confident? We still have quite a long way to go, but that is absolutely a necessity and something we are working very hard to achieve.

Q154 **Shabana Mahmood:** How long will the new review take that you say you are doing?

Kate Davies: The actual benchmarking process only takes until mid-November, so it is quite rapid. We will look at it within this calendar year to support what that means immediately and to influence what that is within the next financial year.

Q155 **Shabana Mahmood:** The review is very quick, so you will know again where all the blockages are. What is the timescale for producing your action plan for dealing with those blockages?

Kate Davies: We are already doing that. We are already producing, and have produced—



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Q156 **Shabana Mahmood:** Which rather proves that you don't really need a review because we all know where the problems are.

Kate Davies: Of course we need a review, but what we cannot do is not concentrate on those patients and the needs of those patients now—quite rightly.

Chair: Can you write to us with that list of prisons where you are already doing this work, Ms Davies.

Simon Stevens: Can I add a couple of other points to that?

Chair: Very quickly.

Simon Stevens: Some of these patients in prison are people who need a low or medium secure bed. Frankly, those low and medium secure beds have also got gummed up, relative to local mental health services. One of the things that we are doing in about half the country—and I am very positive that it is likely to produce some un-gumming of the system—is that local mental health trusts and their partners are taking responsibility for the flow of patients from their local services to the medium secure facilities. That means that they are doing the case management for the individuals and they are able to reinvest savings from services that are not needed in the medium secure unit in building local alternatives to those services, such as better crisis care and community alternatives. They say that that will free up quite significant bed space in some of the low and medium secure units.

The related piece, however, is the high secure psychiatric hospitals. Some of the people that we are talking about are waiting for places at institutions such as Broadmoor. I have recently been to Broadmoor and talked to patients in the high secure intensive care unit, as well as to staff. It had quite a challenging CQC report a while ago—it is run by West London Mental Health Trust—

Chair: Could you speak up?

Simon Stevens: Yes. That was about both the physical estate and staff vacancies.

I think Carolyn Regan, the chief exec, has done a good job of tackling some of the staff vacancy problems that existed at Broadmoor. They are about to move next year to a physically much improved new building, adjacent to their site. Some of the changes happening in the high-secure psychiatric hospitals, whose operational pressures really mirror those of prisons, will help with this problem as well.

If you did a visit to Broadmoor, they would say that in order to free up spaces, they need to be able to return patients to prison settings when their treatment has finished. We have to get the inflows and outflows right; it is not just a one-way valve.

Q157 **Shabana Mahmood:** Who has overall responsibility for making sure that



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that 14-day target is met?

Simon Stevens: NHS England has responsibility both for prison health services and for commissioning high-secure psychiatric services and low and medium-secure psychiatric services.

Q158 **Chair:** So you do—NHS England does.

Simon Stevens: But the 14-day target is being reviewed right now by clinicians, to see whether a blanket 14 days is or is not the right way of doing it, or whether it makes more sense to nuance it, perhaps to have a faster standard for more severe—

Q159 **Shabana Mahmood:** But for the target as it stands, NHS England has responsibility.

Simon Stevens: The target as it stands was a 2011 ex cathedra statement by the Department of Health. We are taking a hard look, with clinicians, at what the right operational standard is from the point of view of prisons, hospitals and, above all, patients.

Q160 **Shabana Mahmood:** The issue of whether the target was right or not is different from the issue of who has specific responsibility, at this point, for doing it.

Simon Stevens: We are not saying that we think the 14-day standard is the right approach in the circumstances.

Q161 **Shabana Mahmood:** You sound rather like you are trying to evade responsibility for not meeting that target, Mr Stevens.

Simon Stevens: No. It is a target that is out there, but it is not a target that we have promulgated, and we do not think that it will necessarily always be appropriate.

Q162 **Chair:** We know from parliamentary answers that last year 1,141 prisoners waited more than 14 days for a transfer. Do you know what the figure is for this year? If not, will you provide it to us?

Simon Stevens: I am sure we do know that figure, but I don't have it on a piece of paper right in front of me.

Q163 **Chair:** It would be very helpful if you provided it.

Kate Davies: The figure has reduced, as I have indicated, but—

Q164 **Chair:** Could you send us the figure?

Kate Davies: Absolutely, yes.

Chair: We will obviously keep a note of what we need to ask from you.

Q165 **Gillian Keegan:** As well as a lack of clear targets or a clear sense of who is responsible for them, there is something else bothering me. I think the way this works is that there is a fixed contract price, with mental and physical health all going into the same area. How on earth are you going to make sure that the budget is sufficient to deliver the service that we



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have talked about today?

Simon Stevens: By setting a specification for the service to be delivered at a particular prison and running competitive procurements to choose the most advantageous provider.

Q166 **Gillian Keegan:** But you are going to be spending more, aren't you?

Simon Stevens: Actually, the effect of some of the competitive procurements has been to create some savings in aspects of the way these services have been provided. But looking over the next several years, my expectation is that we will be spending more in this area. If you look at our health and justice programmes, not just in prisons, but in the round—including liaison and diversion, sexual assault services, immigration removal centres, young offenders institutions and so on—NHS England has been increasing investment in those programmes faster than the increase in the overall NHS budget.

Q167 **Gillian Keegan:** Are you going to ring-fence mental health services?

Simon Stevens: Within the prison? Definitely not, because that would cut across the integrated clinical model that most people think makes sense. Most people who actually try to run those services—a GP, a counsellor or someone in substance abuse services—say that it would be deeply unhelpful to somehow partition the physical and mental health and wellbeing or addiction services they provide.

Kate Davies: As Mark Johnson said earlier, we need to ensure that 100% of men and women within our prisons, including children and young people, are receiving a levelling assessment around mental health, vulnerability and substance misuse at all levels, as part of that service. That does not mean—this was quite rightly part of your question—that we should not also commission services that are required and needed for mental health or substance misuse or other elements of healthcare. What is really important, certainly from the feedback we have got from all our service users and patients in the last 18 months, is that they want to see that assessment and that need run through all services on mental health, substance misuse and vulnerability.

Q168 **Gillian Keegan:** Well, it's going to be a step change from the way that you work today. You don't know how much you are spending today.

Simon Stevens: That is not true. I think I wrote to you a year ago, Chair, saying that we thought we would be spending £150 million out of the £400 million last year on mental health-related services, and subsequent to the NAO Report, when we went and kicked the tyres, that is indeed what we were spending. It was £148 million, in fact, so we do know.

Q169 **Chair:** Just to be clear: that is in on mental health services in prisons.

Simon Stevens: Mental health and substance abuse in adult prisons.

Q170 **Gillian Keegan:** But we have talked about the inadequacy of the records, of the screening and of the treatment, and the fact that people cannot get to the treatment—

Simon Stevens: Yes, but you just said a different thing, which is that we do not know what we are spending, and we do.

Q171 **Gillian Keegan:** So you are happy that what you are spending is meeting the objectives that you set out, which are to provide equivalent health care and to make sure that people have the support that they need to reduce reoffending. Are you happy that you are spending enough to achieve the objectives? This is the whole point: the objectives are not clear and the spend is not clear. They are not tied together.

Simon Stevens: As we said earlier, I agree with the NAO and others when they say that clinical care is broadly judged to be good. I note that the speed at which prisoners get access to GP services, mental health services and substance misuse services within prisons is as good as and, in some cases, faster than would be the case if they were outside prison. I also believe that there is a net need for a number of these services in just the same way as there is across the country as a whole, so for that reason I expect that we will be spending more on these services in the years to come. The NAO Report says that improving the mental health of those in prison will “require a step change in...resources”.

Q172 **Chair:** Which brings me to the NAO and the numbers. Just to clarify, can we be absolutely clear that we are talking about the same numbers here?

Oliver Lodge: On the figure of £400 million that we quote in our Report for physical and mental healthcare, we worked very hard with NHS England finance staff to try to disaggregate that between physical and mental, and we were not able to do it because of the form of the contract. I am surprised by that answer—

Q173 **Chair:** Mr Stevens, you are very sure of that number. Do we have a dispute?

Simon Stevens: In fairness, I don't think there is a disagreement between ourselves and the NAO on this point. We do not think it would be right to fragment the clinical delivery of services based on these rather arbitrary physical and mental health distinctions, and indeed, in the rest of the national health service, we are seeking to overcome that. But—

Q174 **Chair:** But Mr Stevens, a psychiatrist will not be fixing a broken leg. A mental health nurse will not be—

Simon Stevens: Yes, but the GP services and the primary care services: are they mental health or are they physical health?

Q175 **Chair:** But Mr Stevens, you are splitting hairs. Some things will definitely count as mental health and some things will definitely be a physical thing.

Simon Stevens: Sure. So when I say that 37% of our spend on adult prison health is on mental health and substance abuse, that is more than twice the proportion that is being spent in the NHS budget as a whole, and—



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Q176 **Chair:** Can we just be clear? You are saying that 37% of the spend—

Simon Stevens: Yes, which, by the way, is what I said to you in my letter last summer. Just picking up Sir Amyas's point, subsequent to the NAO Report and guided by their interest in the matter, we conducted a survey of all the providers of prison mental health and got a detailed breakdown from those providers. That is the basis on which we can confirm that £148 million appears to be the substance abuse and mental health spend last year.

Q177 **Chair:** Can you share that document with us, please?

Simon Stevens: Sure.

Chair: Great.

Sir Amyas Morse: On this 14-day target, if you are going to nuance away from that, can we make sure that that is not a formula for losing track of whether you are making progress or not?

Simon Stevens: Sure.

Sir Amyas Morse: What I suggest the Committee asks for is something that takes the numbers apart, so that we can follow the trail from the old 14-day target to any new target that you produce. We can see the point of a more subtle target, but it will not be good enough to start the clock again next year.

Simon Stevens: Agreed.

Chair: We do not want to move the goalposts and then not be able to compare. Layla Moran—quick-fire questions now, please.

Q178 **Layla Moran:** On staffing, I recently spoke to my local trust about our local mental health services. They said that across the piece, they are having issues recruiting. They also have a large proportion of EU citizens who do this kind of work. First, do you have enough staff to do what you need to do? Secondly, what impact might Brexit have?

Simon Stevens: These are very challenging services to staff, and it takes a particular type of dedication for people to choose to operate in these environments. You will have seen that when you talk to people in your area and on the prison visits you have done. I do not think we can pretend anything other than that there is a real operational challenge, at a time when—

Q179 **Layla Moran:** How big is that challenge?

Simon Stevens: It is at a time when we are wanting to expand mental health services in general, so people are looking to recruit across the rest of the NHS in mental health. There are particular issues around mental health nursing.

Q180 **Chair:** What about the impact of Brexit? Ms Moran asked in particular about European nationals.

Simon Stevens: Of our 1.3 million staff, about 65,000 are from the rest of the European Union, outside of the UK. We have a higher proportion of EU doctors—probably about 9%, versus the 5% proportion of the total.

Layla Moran: We know those numbers, but what about the specific area of mental health?

Simon Stevens: Mental health nursing is an area where, given that we have retention and recruitment issues, being able to continue to recruit internationally makes sense. But there is, in some respects, slightly less of a dependency, because the communications aspects and cultural aspects of mental health nursing can be different from some of the other nursing disciplines.

Chair: Can we pin you down? Do you have a figure for the number of people currently who are EU citizens working in this field, in prisons specifically?

Q181 **Layla Moran:** I understand that recruiting to work in prisons is also difficult and that there is a higher proportion of EU citizens working in prisons.

Chair: Is that right?

Simon Stevens: We can track that and get you the answer for those prison health services that are provided by NHS trusts, because their numbers will be captured in the staff census, but those that are provided by third-party contractors will not be part of the NHS staff census, so we will not be able to get you those numbers.

Q182 **Chair:** This is potentially quite a risk if between you, Mr Heaton and Mr Stevens, if you do not know the numbers. If there was an issue of those people leaving because they are no longer—

Simon Stevens: There is a fairly detailed plan for expanding mental health staffing—the Health Select Committee has recently begun to look at this—which will obviously also have an effect on prison health. Health Education England has set out the aim to expand the number of mental health staff by 21,000. I do not want to do anything other than say that we are concerned about the availability of staff in mental health services, including prison mental health services.

Q183 **Layla Moran:** This question is to Ms Davies particularly. You heard earlier from the preliminary panel that users would like to sit with you at that top table, to help you with this. Would you be open to that?

Kate Davies: Absolutely, and they do already. I was at the liaison and diversion board today, which has lived experienced members on it and has done from day one. We support and expect all our local commissioners to have service users involved in the process. As we heard from the panel before, in some areas that is working really well, and some are pushing quite strongly to improve that. We also have a new public and patient involvement group for service users, which has been running for over two



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years and has been massively influential in some of the solutions and objectives we are setting.

Q184 **Caroline Flint:** There are four prison establishments in Doncaster. Three of them are in my constituency. Where does the NHS England plan for mental health services sit with the local services? Is it good news for local services that we have this area within our borough boundaries, therefore raising the expectations and quality, or will it be a drain?

Simon Stevens: It is not going to be a drain, because it is not being funded out of the money available to your local CCG.

Q185 **Caroline Flint:** I know that. I mean that it could be an opportunity to develop services across from the prison estate, into the community as well, in terms of the number of skilled people working in this area. Presumably some of the same people are supporting the prison service and the community services.

Simon Stevens: Yes, that is the opportunity.

Q186 **Caroline Flint:** So is it going to be good for Doncaster?

Simon Stevens: I fear that however I answer that question, you will regard it as the wrong answer.

Caroline Flint: Okay, let's move on—

Chair: One last point, because we need to move on.

Q187 **Caroline Flint:** Where does dementia fit into this plan, in terms of mental and physical care?

Simon Stevens: You are absolutely right to raise that point. The fastest growth in prison numbers has been among people aged over 50. We are seeing big increases in the proportion of people aged 60 and over. We have 10,000 prisoners aged over 60—

Caroline Flint: I know all that.

Simon Stevens: Therefore some prisons are doing things like introducing dementia-friendly prisons, in the same way as we are doing with dementia-friendly communities.

Q188 **Caroline Flint:** But there is no national strategy, is there? The Dementia Action Alliance says that there is no national strategy for older prisoners with dementia, let alone for older prisoners with other mental health needs. There is no national strategy. Is that right, Mr Spurr?

Michael Spurr: We have not written a strategy for dementia. I will say that the social care Act, which actually provides support from local services, has been really important. I was in a prison last week where they were promoting active citizenship and where there is a huge amount of work going on with local services—



Q189 **Caroline Flint:** There is no national strategy for dementia, is that right?

Michael Spurr: There is a national strategy on health, which includes older individuals, and dementia is a part of that. There is no specific strategy on dementia.

Q190 **Caroline Flint:** Where does it fit within mental and physical health then, within the partnership arrangements?

Simon Stevens: This is precisely why the integrated approach to commissioning and care delivery makes more sense. If we had to try to split it out and argue, "Is dementia service being provided by the primary care"—

Q191 **Caroline Flint:** I understand that, but if it is not there—

Simon Stevens: It is part of the needs assessment that will be done for individual prisons as their services are commissioned. For example, a few months back, or perhaps a bit longer, I was in HMP Preston. In Lancashire they have got an ageing population, so an end of life/palliative care service has been developed as part of the in-prison health facility. That is specific to the profile of prisoners in that particular prison. The same would be true for dementia.

Q192 **Caroline Flint:** I understand that. We are all going to die, so you have got to have a plan for that. I am thinking about people who have got Alzheimer's or are developing dementia, which can be 10 years away from—

Simon Stevens: Yes, and the point I am making is that in reception prisons, where there is a big churn of the whole of the prisoner population turning over in the course of a year, that is potentially rather a different situation than where there are ageing, long-term prisoners.

Q193 **Caroline Flint:** Hang on. We have got that. For example, in one of my prisons I have got sex offenders who split into two groups: young offenders involved in rape, and older offenders. Frankly, apart from how we can let them out into the community for sex offences going back over a number of years—they have got their own pensioners' club within the prison—I am not sure how their needs are being addressed when it comes to dementia or other health concerns.

Kate Davies: That was the point that I was going to make. Alongside our prison partners, the cohorts within the prison reform include older prisoners and include dementia. Dementia is not just about older prisoners; it can obviously be about younger men and women as well. It is part of that cohort, and the prison reform is looking at the way that it will support older prisoners. We are working with Public Health England under a dementia and older persons' strategy at the moment to support that cohort of older prisoners. You are quite right: among vulnerable prisoners, particularly our sex offender population, that is where our biggest need is, but it is not solely in that category of offenders, obviously.

Q194 **Shabana Mahmood:** With specific reference to paragraph 2.27 on page



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28 of the NAO Report, why has NHS England paid for some services it has not received?

Simon Stevens: For a very good reason: in the particular circumstances described—I stand to be corrected by the NAO here—my understanding is that, in the main case, it was because the prison service had determined that the prison was going to switch from being a male prison to a female prison, and during the interregnum, rather than terminating a contract and then re-letting it, we decided that it made more operational sense to continue to secure the availability of that health service, to ensure continuity. I think that was the particular case you mentioned, wasn't it?

Kate Davies: I think we were referring to HMP Downview. That's right, and that was also—

Oliver Lodge: Sorry, is that in paragraph 2.27?

Q195 **Shabana Mahmood:** Yes. There are a number of examples in paragraph 2.27.

Oliver Lodge: Neither of which were Downview.

Chair: Just to quote, "One of the commissioners had continued to pay a provider in full even though it had not provided a psychiatrist in line with the service specifications". That is on page 28 of part 2 in paragraph 2.27.

Simon Stevens: It may be that in some cases, if they have a recruitment issue with the psychiatrist and therefore are putting alternative staff in place to cover for that recruitment gap, are we really going to cut the services and funding in that period of time? Put it this way—

Q196 **Shabana Mahmood:** It is a matter of interest to my constituents who are taxpayers and should not be paying for services that are not being received—

Simon Stevens: Sure, but with the other breath you are criticising us for not having sufficient adequacy of service.

Shabana Mahmood: No, it is an understanding of the service—

Chair: We are simply trying to understand.

Simon Stevens: Then with another breath we are being criticised for not having enough flexibility. We sometimes have to respond flexibly to these operational challenges.

Q197 **Shabana Mahmood:** Are you confident that any of the failures highlighted on page 28, relating to payment of services and discrepancies in recoupment of costs, are to do with the smaller issues that you have raised, and not to do with the systemic failure to have management oversee these contracts properly and centrally?

Simon Stevens: I am sure Kate would be happy to look at each and every example, and then be able to answer that question definitively for you.



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Q198 **Shabana Mahmood:** Okay. Will you be writing to us then, Miss Davies?

Kate Davies: Yes, I will. And just to go back on how we will also scrutinise that, we have nine local teams that commission across a particular geographical patch. It is absolutely—obviously—our national responsibility and their responsibility to look at those contracts and make quite sure that the public purse is supported, and see where there are any issues or discrepancies, such as this.

Chair: So, for instance, Ms Flint can speak to her local team if she has got some issues about that? Right.

Q199 **Shabana Mahmood:** Finally, what actions do you take against providers who, for example, are found at an inquest to have contributed in some way to a death in custody? Ms Davies? Mr Stevens?

Simon Stevens: Have you got evidence that providers have contributed to deaths in custody?

Q200 **Shabana Mahmood:** Well, there is the famous case of Dean Saunders, which was the subject of a debate in the House of Commons some months ago. There was a specific finding in that case by the inquest jury that financial considerations had led to a downgrading of his treatment. He had no mental health issues. That death took place at Chelmsford prison. I just wonder what the penalty for that provider is, because it is my understanding that that provider continues to provide care for tens of thousands of prisoners across the prison estate.

Simon Stevens: Are you talking about Care UK?

Q201 **Shabana Mahmood:** Yes, in that specific case.

Kate Davies: They are not in HMP Chelmsford any more, but you are quite right that they have other contracts, and in all of our contracts there will obviously be performance measures. If we feel that a service isn't performing in the way that—

Q202 **Shabana Mahmood:** We've had 120 deaths in custody—self-inflicted deaths, suicides. In how many of those cases was there a finding at inquest that the mental health provision, or failures, or downgrading, was a contributory factor to that individual taking their own life, and in how many of those cases have you taken action against a provider?

Kate Davies: There certainly has been action against a provider and certainly with this case, as we were saying, this provider is not actually within that prison any more. There have been other examples where there have been performance measures on providers, and that has obviously also included follow-up, as there should be, as part of inquest reports.

Chair: Can you write to us with answers to both those questions? We will obviously put this in a letter to you, as well.

Q203 **Geoffrey Clifton-Brown:** Right—three quick questions. First, we have not covered at all the issue of discharges. Prisoners at the end of their term often find it very difficult to access public services, not least of



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which are mental health services. Unless that is improved, the chances are that these people will reoffend, costing the nation a great deal of money. What are you doing about it?

Richard Heaton: One immediate thing—for the first time, prisoners will be able to register with a GP before they are released from prison. It hasn't been the case to date. So that has happened already this year.

Q204 **Geoffrey Clifton-Brown:** When?

Richard Heaton: I think it was operational in July this year.

Q205 **Geoffrey Clifton-Brown:** Okay. These 120 deaths in 2016—with your suicide watch, clearly your officers are not being well enough trained, or they are not responding quickly enough. What further measures can you take to reduce these deaths in the future?

Michael Spurr: The last set of figures showed a reduction and we want to continue that. As we heard before, there is a whole range of complexities. Not all of those people were on, or had been identified as being at, crisis point. We spend a lot of effort trying to reinvigorate understanding of when people are at crisis point and what we do to intervene at that moment, but then you've got a whole range of human interactions that occur, which means things can go wrong.

We look at every inquest outcome and findings about what has happened in individual cases. Often, it is about how people apply judgment, not just process, because the process is generally okay; it's the judgments that are made. And that is why there is training and engagement with staff to understand how they can better apply those judgments. The focus in every establishment that we've got, and there is further work with the Samaritans, is to be able to address the need and the crisis points that are reached.

So, there is a whole host of work that we are doing as part of our safety programme with NHS colleagues to try to reduce again those figures, because they are, as I say—

Q206 **Geoffrey Clifton-Brown:** But, clearly, if you cannot get prisoners to a secure mental health institution in 14 days, let alone in some cases in 140 days, that must have had an effect in some of these cases. So what can you urgently do about that?

Michael Spurr: Again, we have to deal with the individual cases, which can need a whole range of measures. Sometimes it is clinical—we put people on to constant watch. That is not a great place to be forever for the individual; we have to try to humanise the position, so that they can actually engage with the regime. We try to engage and promote investment in the regime, which I agree has been more difficult in some places because of staffing resources, as you saw in Wormwood Scrubs. We generally try to find positive things for the individuals to do and to engage them and give them something to work towards, working with our clinicians and our other partners.



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There is no simple answer to what we do in each individual case. Each individual case is specific to itself. We have a whole range of action, in terms of trying to up our whole focus on this in individual establishments, including putting additional resource into regional-level support, with specialists to support individual establishments and work with their staff to understand and to be better able to intervene at those crisis points.

Q207 Geoffrey Clifton-Brown: Finally, a question for Mr Heaton, which I asked in the previous session: what is your Department doing to keep out people who clearly should not be in the prison system at all—whether they have dementia or so severe a mental illness that they should never have been sent to prison in the first place?

Richard Heaton: I think it is a great question. One of the numbers that is totally unsatisfactory in this area is the fact that only 1% of community sentences have a requirement to attend mental health treatment, which is why the work on liaison and diversion is so important. It would be quite wrong if sentencers were to think that the only place a prisoner could get treatment is in a prison, where it is wholly inadequate if they have a mental health condition.

The more people that can be diverted, not just, as Simon said, from being sentenced to custody, but from being engaged in the criminal justice process in the first place, the better. That is why liaison and diversion works at the point of arrest, as well as at the point of charge and the point of sentencing. I would like to see that 1% substantially increase.

Q208 Geoffrey Clifton-Brown: What directions are you giving to the judges in that respect?

Richard Heaton: We don't give sentencing direction to judges; they sentence independently. We are working with the Department for Health to test a protocol for community sentences with mental health treatment requirements. We will be testing that protocol in a number of areas and making an announcement on that very shortly.

Q209 Chair: That is a big one to land at the end of a hearing; we might come back to that in other ways.

Mr Heaton, you mentioned earlier the Prisons and Courts Bill, which was lost at the election and is now the courts Bill only; no prison Bill has been announced for this session. We know there is pressure on time, although we are not voting very often, so there is not that much pressure on the timetable. Do you need legislative change in order to tackle some of the serious issues we have discussed today?

Richard Heaton: I don't think so. I think it would have been nice if the ombudsman had been on a statutory footing, but that is not strictly necessary. I do not think any of the changes we have discussed today require primary legislation. We lost a clause on the purpose of prison, which would have been a good, symbolic thing to have, but it is operationally not essential.

Chair: Mr Stevens, do you think any legislative change is necessary to



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better achieve the aims we discussed?

Simon Stevens: The main legislative question, as far as we are concerned, is the review of the Mental Health Act, which the Prime Minister commissioned from Sir Simon Wessely, the former president of the Royal College of Psychiatrists. That covers a number of issues around how people end up in secure parts of the mental health service and potentially the criminal justice system as well. Simon's review and any legislative consequential is where we will be putting our effort.

Chair: That is useful to know.

Michael Spurr: We haven't mentioned IPP.

Q210 **Caroline Flint:** I asked earlier about staff involved in the prison service and what sort of occupational health arrangements are made, either by MOJ or in the partnership agreement, to support those staff? Health professionals working in these highly stressful situations often have access to counselling and support. Can somebody give me an answer to that, please?

Michael Spurr: We do have occupational health separate from our arrangements for NHS England, which are about the provision we give to prisoners. It is a separate occupational health support system for staff. You are right that that varies in terms of the level of support that can be given. Additional support is potentially available after crisis points, and for those working with particular types of individuals—in therapeutic or interventions work, for example—separate support is available.

Q211 **Shabana Mahmood:** On the subject of landing big things at the end, what are the current numbers of IPP prisoners, and how many of those are judged as having mental health needs? Are those needs being met or not? Can you give us an update?

Richard Heaton: The IPP population at the end of June was 3,553. The number of IPP prisoners released has been, even though the residue is getting smaller, the highest to date, so we are really working on the backlog. I can't give you now a number for how many remaining IPP prisoners are judged to have a mental health problem; I can look into it.

Q212 **Chair:** If you could look into it and write to us, that would be good. We were talking earlier about sentencing and community sentences, which is a big issue at the end of a hearing. Can we just be clear? The Sentencing Council for England and Wales is independent of the judiciary and is a non-departmental body connected to your Department, so it could set the guidelines for community sentences—

Richard Heaton: But it doesn't take ministerial direction. It is chaired by a judge.

Q213 **Chair:** Okay, but it could of its own volition do that; it doesn't need ministerial direction, does it?



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Richard Heaton: I'm thinking yes. It certainly doesn't take a ministerial direction, but it certainly wouldn't need a ministerial direction to look into this area.

Q214 **Chair:** Thank you; that is very helpful to know. This is my final question to you all, and thank you for your patience and time this afternoon. It has felt like a long afternoon, but this is a very serious subject. On a scale of one to 10, how confident are you that this is an issue that you are really making a difference on, that you are going to get solved? A number of you have worked in this sector for a while. I don't doubt that you care about it, but we are, as you will have sensed, a bit frustrated by the slow pace of change. Let's start with Mr Spurr.

Michael Spurr: I think we are doing the right things to make a change. I am confident about that.

Chair: On a scale of one to 10, then?

Michael Spurr: I don't like doing scales. I am confident we are trying to do the right things. I am glad the numbers came down the last time they were published. We will work very hard to bring them down in future and all the time. I think the staffing and regime changes are right. The approach of trying to give more time back for staff to work with prisoners is absolutely the right approach. So we are doing the right things, and we are working well, I think, with our NHS colleagues. We need to work more, and we will take the NAO Report recommendations to develop that. I am confident about that, but the scale of the challenge is very high.

Chair: Very high. Mr Heaton?

Richard Heaton: If it was simply to meet a need that was standing still, I would be totally confident, because I genuinely think the steps we have got in place, in terms of getting drugs out, training staff and increasing staff, will meet the demand.

My only worry is that the demand out there gets worse and worse. Things are happening in society that we see reflected in prisons. We will struggle to keep up with a worsening demand and a worsening cohort coming into prison, but I am confident that we will see the back of the really horrific numbers we saw last year on suicides, which is perhaps the number that alarms us most. I am confident that we are going to crack that.

Chair: It is a very important number. It is not the only issue, of course—

Richard Heaton: It's not the only issue.

Chair: But it is the one that was very stark to us when reading this Report. Mr Stevens?

Simon Stevens: I obviously agree with what both Michael and Richard have said. I guess the only other thing I would add is that although we have been talking particularly about prison mental health, there is a broader change agenda on prison health in the round, and I think that is



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going to require us to rethink quite a lot of assumptions about the way in which prisoners get secondary health services. In particular, if you look at the number of prison officers who are tied up with transfers for out-patient appointments and all the rest of it and if you think about the opportunities we have for telehealth, doing dialysis on the prison estate and so on, we could, I think, drive quite a lot of change in the clinical operating model that would have benefits not just for mental health, but more generally for the efficient running of prisons.

Chair: That is your aspiration, but on a scale of one to 10, how far do you think you are—

Simon Stevens: Like my two comrades—

Chair: You don't want to come out with a number!

Simon Stevens: I am not going to respond to your unkind invitation at this stage of the afternoon!

Q215 **Chair:** Well, Mr Heaton talked about being very confident if it was a standing-still situation. Would you be very confident if it were a standing-still situation, Mr Stevens? Do you share Mr Heaton's confidence?

Simon Stevens: There is stuff that we have got to do from the NHS in terms of the availability of services in prisons. That has a magnifying impact, both for good and for ill, based on the other stuff that is happening to improve what is going on inside prisons in the way Michael talked about. Frankly, prison officer recruitment is really important, because if you have got that right, you can get prisoners to the health services they need. Likewise, if we get right the interface between prisons and the medium-secure and high-secure psychiatric services, that will help to free up some of the operational pressures in prisons. It is quite complex, but it is interdependent.

Q216 **Chair:** Absolutely. We keep coming back to the numbers of prison officers, it seems. Ms Davies?

Kate Davies: As you said earlier, I have been around the system for quite a while, and this is probably the most challenging time to be providing any services within our prison estate and particularly healthcare services. I am very confident we have a very dedicated group of staff and there is some superb work with service users, which I think is essential. Also, the increase in the importance of mental health in the whole of the NHS and NHS England has been incredibly important for us to be able to maintain the level of care.

Q217 **Chair:** You say this is very challenging. Is the number of prison staff a big part of the challenge?

Kate Davies: I think that is part of it. It is also about the physical environment of prisons. I welcomed the prison reforms when they came in, and what I welcome even more is executing that transformation of the prison estate and those environments so that we can, as Mr Spurr said, make quite sure we can develop an enabling environment.



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Chair: Thank you very much. As ever, the uncorrected transcript will up on the website in the next couple of days. We will obviously send you a copy of that and a copy of the report, which we expect to get out before Christmas, but I think you can gauge from the engagement of the Committee in this issue that we will be keeping a close eye on it and our recommendations will reflect our impatience to see something done. I think you share that impatience, so I am sure you will welcome our report. We all aim to make sure that we have fewer deaths and less self-harm in prisons and generally a better mental health service across the prison estate. Thank you very much indeed.