PRH0039

Written evidence from Her Majesty's Chief Inspector of Prisons

Introduction

1. We welcome the opportunity to submit a response to the Health and Social Care Committee's inquiry on Prison healthcare.

2. Her Majesty's Inspectorate of Prisons (HMI Prisons) is an independent inspectorate whose duties are primarily set out in section 5A of the Prison Act 1952. HMI Prisons has a statutory duty to report on conditions for and treatment of those in prisons, young offender institutions (YOIs) and immigration detention facilities. HMI Prisons also inspects court custody, police custody and customs custody (jointly with HM Inspectorate of Constabulary and Fire & Rescue Services), and secure training centres (with Ofsted). Information about our joint healthcare work is set out at the end of this introduction.

3. HMI Prisons coordinates, and is a member of, the UK's National Preventive Mechanism (NPM), the body established in compliance with the UK government's obligations arising from its status as a party to the UN Optional Protocol to the Convention Against Torture (OPCAT). The NPM's primary focus is the prevention of torture and ill treatment in all places of detention. Article 19 (c) of OPCAT sets out the NPM's powers to submit proposals concerning existing or draft legislation.

4. HMI Prisons inspects all prisons against our four healthy prisons tests: safety; respect, purposeful activity; and rehabilitation and release planning.[1] Within each of these tests is a number of expectations that detail outcomes for prisoners that we expect prisons to achieve. Within the healthy prison test that considers respect, there are a number of expectations that relate to health, well-being and social care. Our response is divided into sections according to the expectations that we consider when inspecting the provision of health and social care[2] and aims to provide the Committee with a broad overview of our recent findings in relation to health and social care provision. It therefore refers to examples of both poor and good provision. In addition, we include some results from our survey of prisoners relating to health and social care.[3] We hope that this will assist the Committee with the first two of its terms of reference.

5. Our response is based on evidence published in inspection reports in the 2017/18 year for adult male and female prisons and YOIs holding those above 18 (the final section of our response separately considers children in custody). We note that we have included information relating to prisons in England and Wales, although commissioning and provision arrangements differ between the two countries.

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[1] See, for example Men's prison Expectations, http://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/prison-expectations/.
[2] The sections are based on the expectations outlined in our Expectations for Men's prisons. We note that our expectations differ in some respects in relation to other types of establishment.
[3] On each inspection, we undertake a survey of prisoners so that we can understand their perceptions of their treatment and conditions. The survey results referred to in this submission are from reports published in the 2017/18 year.

6. Prior to setting out our findings, we set out below some brief information about our joint working arrangements with the Care Quality Commission (CQC), with the aim of assisting the Committee in its consideration of the final point of its terms of reference.

7. The inspection of health services in prisons in England is jointly undertaken by HMI Prisons and the CQC. HMI Prisons remit is to inspect and report on conditions for and treatment of those detained in prisons in England and Wales and in several other places of detention.[4] In the execution of this role, HMI Prisons has a dedicated health and social care inspection team, made up of experienced clinicians (most of whom are registered nurses). CQC was established under the Health and Social Care Act 2008 as the independent regulator of health and adult social care in England. CQC has supported the monitoring and inspection of prison health services since 2010 and began regulating prison health services in April 2013, when commissioning transferred to NHS England. Under the current memorandum of understanding between the two organisations,[5] HMI Prisons leads on ensuring that health and social care services meet expectations, including considering issues such as the impact of the prison regime and environment on care. CQC leads on ensuring that health and social care providers comply with registration and regulated activity regulations, determining if it is necessary to take regulatory action. Inspectors from the two organisations work closely together during inspections, sharing information and judgments, and jointly addressing any challenges that arise in relation to partnership working arrangements between a prison and its healthcare provider. Both organisations contribute to a joint inspection report under a common inspection framework.

8. Unlike CQC, HMI Prisons is not a regulatory body and instead makes recommendations in its reports, which the Ministry of Justice (MoJ) and Her Majesty's Prison and Probation Service (HMPPS) are required to respond to in the form of an action plan. The MoJ and HMPPS determine if they agree, partly agree or do not agree with recommendations providing an explanation of why any recommendation is partly or not agreed. The responsibility for monitoring implementation of recommendations rests with the MoJ, HMPPS and the individual prison. However, HMI Prisons continues in its inspection reports to highlight problems with the ability of prisons, HMPPS and the MoJ to accurately monitor the implementation of recommendations, an issue that was recently acknowledged by the Minister responsible for prisons to the Justice Select Committee.[6] HMI Prisons will continue to support the MoJ and HMPPS to improve their ability to oversee the implementation of recommendations.

9. Joint inspections require the organisations involved to adapt their usual working practices and to work in close cooperation. However, a joint approach provides significant benefits in that it:

    a. reduces the burden of regulation and inspection for establishments; and
    b. allows for a whole-systems approach to inspecting and regulating outcomes for prisoners in relation to health services, enhancing the strength of findings and recommendations and allowing us to work collectively to improve outcomes.

10. The inspection of prison healthcare in Wales is undertaken by HMI Prisons, usually joined by Healthcare Inspectorate Wales (HIW).[7] When HIW staff join an inspection, they shadow

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[4] Full details of HMI Prisons mandate can be found in our 2016/17 Annual Report, https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/annual-report-2016-17/.
[5] The memorandum of understanding can be found on both organisation's websites, for HMI Prisons, the link is https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/02/CQC-HMIP-MOU-October-2016-2.pdf.
[6] House of Commons Justice Committee, *HM Inspectorate of Prisons report on HMP Liverpool*, Fifth Report of Session 2017–19, https://publications.parliament.uk/pa/cm201719/cmselect/cmjust/751/751.pdf.
[7] Full details of the joint working arrangements are found in the memorandum of understanding agreed by both organisations, http://hiw.org.uk/docs/hiw/publications/170316mouhmiprisonsen.pdf.

HMI Prisons healthcare inspectors, supporting by providing information on the local health economy and shadow the HMI Prisons health inspectors.

Strategy, clinical governance and partnerships

11. Our expectations in this area include effective partnership working between the prison, commissioners and providers to ensure that health, social care and substance use services meet the assessed needs of the prison population. NHS England assumed responsibility for commissioning prison health care services in 2013. Specialist commissioning by the 10 NHS England offender health teams has increased the consistency of provision across the prison estate in England, whilst still allowing for localism based on needs. In addition, the separation of commissioning and provision of services provides an additional layer of quality assurance and governance, which supports improved outcomes. However, we continue to observe both some variation in commissioning between areas and some gaps in commissioning, particularly in relation to mental health services such as counselling and in relation to support for those with learning disabilities. These inconsistencies and gaps contribute to poor health outcomes for some prisoners. In addition, we continue to see some ongoing weaknesses in the robustness of the available prison health data, which negatively impacts on the ability to drive service improvement.

12. While the separate commissioning of healthcare services has strengths (as noted above), it can create a risk of disconnect between prisons and the healthcare providers working within them. However, in most prisons we inspect, we observe good partnership working between the prison, commissioners and providers. Good practice we have seen in this area includes healthcare managers forming part of a prison's senior manager team. The inclusion of some health-related measures within the prison performance matrix is welcome as it reflects the need for partnership working. In addition, the recent move to co-commissioning health services between NHS England and the individual prison (which we have seen in a number of prisons) is a further positive initiative as it encourages shared ownership of healthcare provision.

13. We expect that staffing levels and skill mix throughout a 24-hour period will meet service user need. However, we consistently observe acute staff shortages within prison health provision and this is often the primary reason for gaps in provision. These shortages may also impact on staff training and supervision arrangements. In addition, most prison healthcare providers struggle to recruit and retain health staff with the requisite qualities and skills. Long delays in the security clearance process (required to work in a prison) can exacerbate this problem, as successful applicants withdraw during prolonged recruitment processes. We have seen some services, such as at Holme House, respond to these challenges with innovations including comprehensive in-house training to broaden competencies and recruiting/training staff in other specialisms, including assistant practitioners, pharmacy technicians and paramedics.

14. In addition to staffing shortages within healthcare, in several establishments we have seen shortages of prison staff impact on all aspects of service delivery and prisoner health outcomes. Shortages may impact through: a lack of prison escorts for external hospital appointments; inadequate supervision of medication administration queues creating opportunities for diversion and bullying; prisoners not being unlocked for and/or escorted to health appointments which in turn may create a cycle of delays; regime curtailments or lockdowns restricting the access of health care staff prisoners. For example, at Brixton we found the regime had adversely affected primary care and hospital appointments, "during November and December 2016, the 'did not attend' rate for the GP clinic had been 28% with most appointments lost because of the regime (…) in October and December 2016, a quarter of hospital appointments were rescheduled because of regime constraints." At Bristol, "in January and February 2017, 41% of the 3,202 health care appointments made had not been attended because there had been insufficient officers to escort prisoners there."

15. In many prisons, we also see the prison regime take primacy over medicine administration times, which are fitted into the regime rather than medicine being dispensed in accordance with clinical need. For example, some prisoners are given night sedation at 5pm or may have three doses of medication in eight hours but then none for 16 hours, which makes the medicines less effective, is potentially unsafe and drives diversion. The regime may also lead to prisoners being given highly tradeable medicine daily in possession as the health provider cannot facilitate administration at the right time, creating a risk of bullying and diversion.

16. As part of good governance, we expect service delivery to be informed by effective prisoner consultation and lessons to be learnt (for example from adverse incidents and complaints). In reports published in 2017/18, we made recommendations to improve the system for health complaints in just under half of prisons. Most of these recommendations related to the need to ensure confidentiality, delays in responding or the response not addressing all the issues raised. In addition, some health services did not use learning from complaints effectively to drive service improvement. Holme House was one example, where we found "there was no information for prisoners on how to complain about health services. The health complaints forms were not easily accessible on all units and there was no mechanism to return them confidentially."

17. Identification and management of adverse incidents and near misses are essential in health provision to drive service improvement and prevent recurrence. This includes learning from deaths in custody and implementing recommendations from clinical and Prisons and Probation Ombudsman (PPO) reviews. It is crucial that this learning is disseminated to staff. Some prisons health providers we inspect exhibit significant weaknesses in this area. At Preston we found that "all serious incidents were reported and reviewed but too many did not show any learning to inform future practice. There had been 12 deaths since our last inspection (eight from natural causes). There was a health-focused action plan to address health-related Prisons and Probation Ombudsman recommendations following deaths in custody, but it was incomplete."

18. There is the ongoing potential for medical emergencies with prisons, particularly given the high levels of assaults and self-harm currently occurring across a significant number of prisons in the estate and the ageing prison population. We expect competent health staff to respond promptly to medical emergencies with appropriate emergency equipment. All prisons have a system of emergency codes to summon assistance from within the prison or an ambulance promptly. A regular theme in PPO reviews of deaths in custody and on our recent inspections is delays in these codes being called and/or ambulances being called. For example, at Lincoln we reported that "although most custody staff we spoke to were aware of emergency protocols, some were unclear about when to use them, which could delay an ambulance being called". Generally, health staff are adequately trained to manage medical emergencies and have satisfactory access to emergency equipment, but we find inadequate checks on equipment in a significant minority of establishments. Out-of-hours access to trained staff can be a significant issue because not all prisons have healthcare staff rostered on at night and/or there are insufficient numbers of trained officers to commence timely interventions. In prisons that do have healthcare staff rostered on at night, those staff rarely carry keys at night and so need to be escorted, for example, at HMP Bristol. In some prisons, we observed officers either could not access or did not know the location of defibrillators which slowed emergency responses. Several prisons have started to employ paramedics which has led to improvements in emergency care and often a reduction in transfers to hospital, such as at Doncaster.
19. A further aspect of governance is the health environment itself, which is the responsibility of the prison. This can be very variable across prisons and impacts on service delivery. In reports published in 2017/18, we made recommendations in 17 prisons about non-compliance with infection control standards and cleaning standards. In others there were issues with inadequate space to provide services and poor waiting rooms.

Promoting health and well-being

20. We expect prisons to support and encourage prisoners to optimise their health and well-being. This involves a number of factors, including easily accessible health checks, disease prevention and screening programmes and the management of communicable diseases. During recent inspections, we found that most prisoners can access the full range of screening programmes that they would receive in the community. However, the global shortage of hepatitis B vaccines has adversely affected the effectiveness of the hepatitis B immunisation programme in many prisons.

21. More broadly, we expect prisons to take a whole-prison approach to promoting health and well-being. This should involve a prison's health department working in conjunction with a number of other departments, such as education and training, catering and the gym. An example of good practice was seen at Dovegate, where we reported "there was a prison-wide approach to well-being. Relevant departments contributed to health promotion days (…) and healthy eating initiatives. The 12 prisoner health champions were very visible and a powerful force for promoting well-being via physical health monitoring, peer information giving, and encouragement. Two health champions were also smoking cessation practitioners, and two members of staff had been assigned to prepare for the prison smoking ban that was due to start in July 2017. Prisoners were being incentivised to stop smoking." However, recent inspections have also shown that, in a number of establishments, health promotion is being left solely to the health service.

22. In those prisons we have inspected that have become smoke-free, we found that this has generally been well implemented and appears to have improved air quality. Newly arrived prisoners generally have good access to pharmacological treatments and alternatives such as vapes, but access to psychosocial support is less consistent. However, we have also seen markets for illicit tobacco develop and prisoners engaging in some high-risk behaviours such as smoking nicotine replacement patches. We saw a number of these issues at Swansea, which "was managing a number of risks including prisoners using wires to ignite contraband and smoking nicotine patches. The introduction of vaping devices had been positive but not all new arrivals had access to them. The range of nicotine replacement options was too limited and there was no psychosocial support to help newly arrived prisoners to adjust to a smoke-free environment."

23. We expect prisoners to be able to freely access barrier protection, such as condoms, and related health advice. However, we regularly find that availability is poorly advertised, that there are delays in access or in some cases that there is no provision at all.

Primary care and inpatient services

24. Our Expectations in relation to primary care and inpatient services are broadly divided into those relating to: initial health screening and care; ongoing care; and prisoners requiring 24-hour care.

25. In relation to initial health screening, we expect that prisoners' immediate health, substance use and social care needs are recognised on reception and responded to promptly and effectively. Our inspection reports published in 2017/18 indicated that most newly arrived prisoners receive prompt initial health screening to identify key health needs. However, we often see late arrivals from court impacting on the effectiveness of initial health screening as there can be significant pressures to progress people quickly through reception and prisoners may be tired and therefore reluctant to engage. Additionally, if it is very late, the prescriber may have left leading to a delay in medication needs being met, although this is mitigated in some establishments by the use of patient group directions.

26. In addition to a health screening on arrival, we expect newly arrived prisoners to receive a second health screen within seven days to look at wider health issues. This was not consistently occurring in some prisons we inspected due to high non-attendance rates, difficulties accessing patients and staffing shortages.

27. Most prisons we inspected provided a comprehensive range of primary care services, including women specific services in women's prisons, but waiting times were sometimes excessive. This was due to multiple factors including staffing shortages, high demand, high non-attendance rates and prisoners not being unlocked/escorted to appointments. Additionally, in prisons where the regime is very restricted, prisoners may choose to access showers or address other needs over a health appointment.

28. In addition to ensuring sufficient care of patients with ad hoc health needs, we expect that prisoners with long-term conditions and complex health needs will receive appropriate joined-up care. In reports published in 2017/18, we made recommendations to improve management of long-term conditions in around a quarter, including as a result of weaknesses in systems to identify patients with long-term conditions, health staffing shortages and/or lack of sufficiently competent staff. We also noted some good practice, such as at Lindholme and Holme House, both of which had dedicated nurses to ensure patients with lifelong conditions or complex health needs were identified and reviewed promptly.

29. The need for palliative and end-of life care is increasing as the number of older prisoners increases. Some prisons have developed excellent palliative care facilities, such as at Leyhill, but overall the environment remains too variable. We observed very good care at Huntercombe, Holme House and Dartmoor, noting at the latter "palliative care was very good and there were links to the local hospice and charity Macmillan Cancer Care. The monthly Macmillan-led clinic provided expert advice for 26 patients with cancer or life-limiting conditions, including seven undergoing palliative care."

30. Some prisons have units that provide enhanced support for prisoners with complex needs; these may be clinically-led by the health provider (inpatient units) or be prison-led (enhanced care or wellbeing units). Most units we published inspection reports on in 2017/18 had inadequate therapeutic regimes. For example, at Brinsford, "conditions for prisoners in the 11-bed inpatient unit had deteriorated since the last inspection (…) The unit was mostly used for patients with mental health needs. The restricted regime was not conducive to providing a therapeutic environment. The four inpatients during the inspection had little time unlocked and spent only a few hours a day out of their cell." Some were further undermined by having prisoners admitted for non-clinical reasons such as behavioural issues or due to a lack of facilities for prisoners with disabilities on the wings, which blocked beds and reduced support for those with clinical needs. We were very concerned that nurses could not easily access their patients in the inpatient units at Bullingdon and Dovegate because they did not carry cell keys and there was a lack of officers to unlock doors, which created significant risks for patients.

31. In closed prisons, a prison officer escort is required for prisoners to access secondary health services. We found some prisoners waited too long for external appointments as a result of too few escorts to meet demand and also cancellations due to a lack of escort staff. The introduction of in-reaching services including diagnostics and specialist clinics has reduced the demand for escorts in some prisons.

32. We expect continuity of healthcare to be maintained on transfer or release. This has been aided by the introduction of the national computer based clinical notes system (SystmOne) used in all prisons and the nationally agreed reception templates. However, continuity of care is often undermined by delays in receiving information from community services, particularly when people arrive into prison on a Friday. From late summer 2018, prison health staff will be able to remotely access community health records with patient consent, which we expect to improve patient care.

Social care

33. Access for prisoners to community equivalent social care has now been in place for three years in England and two in Wales. HMI Prisons expect that prisoners with social care and support needs are identified and receive assessment, care packages, adaptations and advocacy services that continue on release or transfer. Inspection findings have shown a varied range of provision of social care in prisons. In many prisons, provision has developed well and in some prisons, has been excellent – we noted good practice in four of the establishments we reported on in 2017/18. For example, at Usk (inspected jointly with Prescoed), amongst other things, we reported "social care staff saw all new arrivals at Usk during induction. A social care prisoner coordinator also saw new men promptly and implemented an emergency support plan with the prisoner buddy coordinator, which was then reviewed by the social care team. Well trained and supervised prisoner buddies were allocated to clients, followed a care plan and kept daily records. The social care team reviewed care plans at the monthly buddy meeting." However, we also reported underdeveloped formal structures and systems in 13 prisons we inspected, including at Bristol and Bure, neither of which had identified a care provider. In addition, we have noted weaknesses in the training and support of prisoner buddy systems in some prisons.

34. In partnership with other organisations, including CQC and HIW, HMI Prisons is currently completing a thematic review of social care provision in prisons in England and Wales, the findings from which will be published in the second half of 2018.

Mental health

35. The number of self-inflicted deaths and incidents of self-harm in prisons has been high for many years.[8] HMI Prisons inspects both the provision of mental healthcare and what measures prisons take to keep those at risk of suicide and self-harm safe. In relation to the latter, we expect that prisons will provide a safe and secure environment which actively reduces the risk of self-harm and suicide. However, we too often report that prisons are failing to do so. In our 2016/17 Annual Report, we reported "in almost three-quarters of our reports on men's prisons we were critical of the establishment's response to one or more of the key factors that can contribute to prisoner self-harm or even suicide" and we made main recommendations about this in around one fifth of establishments holding adult men. For inspection reports published during the 2017/18 year, we were critical of one or more of the key factors in 90% of men's prisons and we made main recommendations in almost a third.

36. We found significant weaknesses in assessment, care in custody and teamwork (ACCT) case management in the majority of establishments reported on in 2017/18 (continuing the pattern from previous years). This includes failing to involve health staff in multidisciplinary support that should be offered to people at risk of self-harm or suicide, often due to resource issues or ineffective scheduling of reviews by prisons. At Liverpool we reported "the quality of ACCT documents was inadequate: triggers were incorrectly recorded, care maps were incomplete and reviews were late. Mental health in-reach staff attended many ACCT reviews, but overall reviews were not sufficiently multidisciplinary. Men on ACCTs spoke positively about staff support but poor accommodation and time out of cell undermined the care of these prisoners." We also continue to find prisoners who are being managed on ACCTs being placed in segregation without adequate justification (given that segregation inhibits the provision of support, we would expect that prisoners being managed on ACCTs only be placed in segregation in very exceptional circumstances).

[8] Figures are published by the Ministry of Justice and Her Majesty's Prison and Probation Service at https://www.gov.uk/government/collections/safety-in-custody-statistics.

37. As noted above, we expect learning from PPO investigations into self-inflicted deaths to be promptly implemented and embedded. Around a third of prisons reported on in 2016/17 had not sufficiently implemented PPO recommendations and the proportion was similar for the 2017/18 year. During the year, we issued our first urgent notification following our inspection of HMP Nottingham, highlighting serious concerns over safety, including the repeated failures to implement PPO recommendations made following several men taking their own lives at the prison.[9]

38. In relation to the provision of mental healthcare, in reports published in 2017/18 we made recommendations to improve provision in just over half of all prisons inspected. In most cases, this related to gaps in the range of provision, including due to insufficient staff or a lack of specific interventions such as psychological services, counselling, and support for those with learning disabilities or groups. For example, at Bullingdon the under-resourcing of mental health provision resulted in staff having to prioritise urgent care at the expense of routine services. A lack of staff or sufficient specific interventions may lead to an over-reliance on pharmacological solutions, rather than supporting people to adequately address underlying issues. We have also seen poor implementation of the Care Programme Approach (used in England to manage prisoners with severe mental health problems) in some prisons.

39. The Royal College of Speech and Language Therapists recommends speech and language therapy intervention be a key feature of approaches aimed at reducing re-offending.[10] Most establishments holding boys (under 18) provide such therapy, but there is a gap in provision in adult establishments, where we rarely see provision and see only limited referrals to external services other than for swallowing difficulties.

40. The identification of and support for those who have impairments due to acquired brain injuries and dementia is inconsistent across the estate and insufficient in a number of establishments.

41. Prison officers need regular mental health awareness training to be able to identify and support prisoners with mental health issues. However, this is not mandatory training, and we often find that it is often not available or poorly attended. For example, during our inspection of Portland, we found that only around one fifth of prison officers had attended mental health awareness training in the last three years (although there were plans to improve this).

42. In addition to issues with provision within prisons, we regularly see excessive delays in transferring prisoners requiring inpatient care to mental health facilities (we saw delays in just over 70% of adult male prisons reported on during 2017/18). In most cases, these delays are due to external factors including delays in assessment and the national shortage in secure mental health beds. Some prisoners deteriorate further while they await transfer and are cared for in totally inadequate environments including the segregation unit. For example, at HMP Bullingdon, we reported that none of those transferred within the 12 months to March 2017 had been transferred within the 14-day guidelines, with one waiting 105 days. In addition, we regularly find men and women admitted to prison who should have been diverted to mental health facilities from court but were not because a secure mental health bed could not be located.

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[9] A description of the urgent notification procedure and the urgent notification letter can be found on our website at: https://www.justiceinspectorates.gov.uk/hmiprisons/media/press-releases/2018/01/hm-chief-inspector-of-prisons-demands-action-from-secretary-of-state-for-justice-over-fundamentally-unsafe-nottingham-prison/; and https://www.justiceinspectorates.gov.uk/hmiprisons/media/press-releases/2017/11/hm-chief-inspector-of-prisons-welcomes-new-urgent-notification-agreement-with-potential-to-strengthen-the-impact-of-inspections-in-failing-jails/.

[10] *Written evidence from The Royal College of Speech and Language Therapists*, Justice Select Committee inquiry into Prison Reform, published 7 February 2017, PRF0130.

Substance use treatment

43. Synthetic cannabinoids, illicit medication, cannabis and opiates continue to be heavily misused in many establishments, which undermines the safety of prisons by contributing to high levels of debt, violence and self-harm. High numbers of prisoners continued to tell us in our survey that they had a drug problem on arrival (for surveys published for the 2017/18 year, this was 42% of women and 28% of men). Of concern, in our survey, 13% of men and 8% of women reported they had developed a problem with illicit drugs while in prison.

44. To reduce substance misuse, we expect that prisons will address both demand and supply reduction, taking a whole-prison strategic approach linking both demand and supply strategies. However, we continue to see weaknesses in prisons' strategic approach to substance misuse including insufficient partnership working; poor strategy or action planning and too little attention to demand reduction.

45. A significant element of demand reduction is ensuring access to purposeful activities and adequate time out of cell. Despite this, we continue to find too many prisons failing to provide sufficient activity places, activity that is truly purposeful and prisoners spending far too long locked in their cells. Our expectation is that prisoners will be unlocked for at least 10 hours a day. In adult male prisons for which reports were published during 2017/18, only 16% of prisoners said that they were unlocked for at least 10 hours (this figure was 14% for establishments inspected in the previous year) and one fifth said they spent less than two hours out of their cells on a weekday.

46. In relation to the provision of care itself, in surveys published in 2017/18, a higher proportion of women (73%) than men (59%) said they had been helped with their drug problem in prison. Compared to general healthcare, since the transfer to NHS England commissioning in 2013, we see greater variation in provision rather than less (previously the CARAT model provided for fairly standardised care). Despite this, in reports we published in 2017/2018, psychosocial support for substances misuse remained good in most establishments - several prisons had noteworthy provision and in some we saw innovative services to support prisoners who were using substances illicitly in prison. We made recommendations to improve psychosocial provision in around a quarter or prisons, mostly to address access issues or an insufficient range of services to meet need. Gartree was one example, "the range of psychosocial support was inadequate, primarily because the small substance treatment and recovery team (STaRT) was not adequately resourced, exacerbated by a lack of administrative support and the frequent regime restrictions."

47. Most prisons inspected provided satisfactory clinical services although weaknesses in clinical prescribing relating to substance misuse were found in seven prisons we inspected, mainly around a lack of first night prescribing and inflexibility in prescribing. However, we remain concerned that the clinical provision commissioned in Welsh prisons differs from that in England and creates poorer outcomes prisoners held in Wales. For example, at Swansea, we reported that "prisoners with opiate addiction who arrived on a confirmed community prescription could remain on it. However, those who were not prescribed only received symptomatic prescribing, which created significant distress and drove the demand for illicit drug use."

48. We were pleased to see more consistent integration of clinical and psychosocial services for substance misuse with wider health services, including mental health services. There is further potential for joint provision for those requiring these services such as for sleep hygiene, anxiety management, emotional regulation and mindfulness.

Medicines optimisation and pharmacy services

49. We regularly observe weaknesses in the management of medication. For example, at Northumberland we reported that "medicines management was unsafe. The movement of medicines, including controlled drugs, was not secure, with medicines transported in unlocked bags and containers." Most prisons maintain continuity of supplies relatively well, but in some prisoners regularly experience delays and gaps in treatment due to failures to properly manage medicines. In just over a quarter of prisons, we made recommendations relating to the need for medicines to be provided at clinically appropriate times. For example, at Liverpool, "most medicines were supplied on a named-patient basis and supervised twice daily. However, there was little provision for other administration times, which meant that antibiotics and pain killers were not given at the recommended dosage schedules for effective care, and night-time medicines were given too early."

50. Medication can become a currency in prison and there is consequently significant potential for bullying, diversion and misuse. Therefore, while we expect prisoners to be permitted to self-administer, we also expect that this only occurs following a detailed risk assessment considering the individual prisoner and the type of medication. These assessments should be regularly reviewed. We have found weaknesses in risk assessment processes in around a quarter of establishments inspected, including failing to complete risk assessments at all, assessments not being sufficiently robust, assessments inappropriately allowing prisoners to possess medicines which are highly tradeable, assessments not being regularly reviewed or reviewed at the time of prescribing changes and assessments not being made available to the prescriber. For example, at Altcourse, we reported "too few patients received medication in possession and staff said they did not have the capacity to complete or review risk assessments." In some cases, we have seen prisoners possess medicine despite a risk assessment saying they should not (and vice versa). In addition to problems with risk assessment, we regularly identify weaknesses in the officer supervision of medication administration queues, which created opportunities for bullying and diversion. Further, many prisoners lack secure storage in shared cells to keep their medication safe.

51. It is also of note that we often see prisoners arrive in prison on community prescribing regimes that do not meet best practice guidance. This can create significant challenges for health providers in prisons who then make changes to prescriptions, including some aggressive behaviours and self-harming by prisoners.

Dental services and oral health

52. Many prisoners have poor oral health on arrival in prison and the demand for services is high. Recent inspections have generally found the standard of dental care in prisons to be good when accessed. For example, at Leeds, we reported that "a full range of NHS equivalent dental services were provided through four sessions each week. A dental hygienist clinic was held twice a month. Prisoners had appropriate access to emergency treatment and medicines following dental interventions." However, we reported that waiting times were too long in around a quarter of prisons.[11] For example, at Usk, men were waiting up to 10 months for a routine dental appointment, 6 months at Prescoed, 18 weeks at Guys Marsh and between 11 and 14 weeks at HMP Huntercombe, Aylesbury, Northumberland and Preston.

[11] The most recent national guidance suggests prisoners should receive routine dental care within six weeks of request and urgent care within 24 hours, see, OPM, *Reforming prison dental services in England: A guide to good practice*, July 2005, available at: http://www.ohrn.nhs.uk/conferences/past/D160905PCW.pdf. The expectation to access NHS dental services in the community for a routine appointment is 18 weeks.

Children

53. Boys arriving into prison receive a comprehensive health screening using the Comprehensive Health Assessment Tool, including on neurodisability. In the establishments we reported on in 2017/18, health care provision was mostly good and waiting times were short. However, we found that the the restricted regime and regular lock downs at Cookham Wood increased waiting times and we recommended that the inpatient unit at Wetherby be closed as the environment and regime it provided were inadequate.

54. Mental health service provision in establishments inspected was mostly comprehensive, with the exception of Parc, where the range of provision was insufficient to meet needs. Training provided to custody staff at most establishments was up to date and allowed them to identify and support boys with mental health needs. Feltham A had received National Autistic Society accreditation. We found that transfers under the Mental Health Act were mostly made promptly, but a few boys at Wetherby had experienced delays of up to five months.

55. Our survey and inspection findings show that a high proportion of children held in YOIs and secure training centres report problematic misuse of substances prior to prison, but rarely to a dependent level. Illicit drug use in the establishments we published reports on in 2017/18 remained very low but we reported an increase at Wetherby, where there was no supply reduction plan. Tobacco and cannabis were the most commonly used substances in establishments. At most establishments, we found that boys had their substance misuse support needs identified promptly and the support provided was mostly good. Mental health and substance misuse services had been integrated at Werrington, where boys told us that there was less stigma attending the integrated service than a separate drug service.

Conclusion

56. A number of consistent themes have emerged from our inspections of health care provision over the years. These include the adverse impact that staff shortages and insufficient training (both of healthcare and prison staff) have on health outcomes for prisoners and the adverse impact of restricted regimes and too little time out of cell. In addition, in far too many prisons, we have seen a failure to adequately support and monitor those at risk of self-harm. This is often exacerbated by weaknesses in mental healthcare provision, including delays in transfers under the Mental Health Act. It is particularly concerning that we too often see failures to learn lessons from incidents and deaths.

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