



National Audit Office

Report

by the Comptroller
and Auditor General

**Her Majesty's Prison & Probation Service,
NHS England and Public Health England**

Mental health in prisons

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NHS England and Public Health England

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Report by the Comptroller and Auditor General

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Sir Amyas Morse KCB
Comptroller and Auditor General
National Audit Office

26 June 2017

This report looks at the provision of mental healthcare in prison, and efforts to maintain prisoner well-being. We also considered routes out of prison, including continuity of care into the community and transfer to secure hospital.

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Key facts

**Circa
£400m**

is the estimated amount NHS England spent in 2016-17 providing mental and physical healthcare in adult prisons in England

31,328

people in prison who report having mental health or well-being issues at any one time, based on HM Inspectorate of Prisons surveys (37% of the average monthly prison population)

7,917

people recorded by NHS England as receiving treatment for mental health illnesses in prison in England in March 2017

- 84,674** is the average monthly adult prisoner population in England and Wales in 2016-17
- 202,099** arrivals into prisons in 2016 (this includes people arriving in prison for the first time, being recalled into prison, and moving between prisons)
- 120** self-inflicted deaths in prisons in 2016, the highest number on record
- 40,161** self-harm incidents reported in prisons in 2016, the highest on record
- 40%** of prisons did not provide refresher mental health awareness training to prison staff in the three years leading up to October 2016

Summary

1 Around one in four adults are diagnosed with a mental illness during their life and many more will experience changes in their mental well-being. Most research suggests that people in prison are more likely to suffer from mental health problems than people in the community. Complex social and personal issues such as 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. Prisoners are less able to manage their mental health because most aspects of their day-to-day life are controlled by the prison. Many prisoners also move in and out of prison, or between prisons, which makes the job of providing healthcare more difficult. Prisoners whose mental health needs are not addressed may be more likely to reoffend.

2 Rates of self-inflicted deaths and self-harm have risen significantly in the last five years, suggesting that mental health and well-being in prison have declined. The number of self-harm incidents rose by 73% between 2012 and 2016. In 2016 there were 40,161 incidents of self-harm in prisons, the equivalent of almost one incident for every two prisoners, although some prisoners will self-harm multiple times. There were 120 self-inflicted deaths in prison in 2016. This was almost twice the number in 2012, and higher than any previous year on record. In 2016, the Prisons and Probation Ombudsman found that 70% of prisoners who had taken their own life between 2012 and 2014 had been identified as having mental health needs. In February 2017, the Royal College of Psychiatrists stated that “rising deaths and other harms show there are failures in reaching prisoners who need general medical and specialist mental healthcare”.

3 Until 31 March 2017, the National Offender Management Service (NOMS), was responsible for prisons. On 1 April 2017 NOMS was replaced by a new executive agency called Her Majesty’s Prison and Probation Service (HMPPS). HMPPS retains NOMS’ responsibility for the operational management of prisons, but the Ministry of Justice will take on NOMS’ responsibility for prison policy and commissioning. This report refers to NOMS, as NOMS was the responsible body at the time of fieldwork and writing, but makes recommendations to HMPPS.

4 Responsibilities for mental health and well-being in prison are outlined in a partnership agreement, signed by NOMS, NHS England and Public Health England. It contains six objectives for health services in prisons, of which four relate to mental healthcare services:

- Prisoners should receive an equivalent health and well-being service to that available to the general population, with access to services based on need.
- Health and well-being services in prison should seek to improve health and well-being, tackle health inequalities and wider determinants of health and contribute to protecting the public and reducing reoffending.
- Prisoners should expect to experience improvement in their health and well-being.
- Prisoners should expect continuity of care between custodial settings and between custody and community (including across the border with Wales).

NOMS (now HMPPS) is also responsible for ensuring that the prison environment is safe, secure and decent.

Our approach

5 This report follows our April 2016 publication *Mental health services: preparations for improving access*.¹ It focuses on the mental health and well-being of prisoners in adult prisons. It covers services that were commissioned by NOMS (in England and Wales) and NHS England (in England only). The responsibility for prisons in Scotland and Northern Ireland, and for healthcare in public prisons in Wales is devolved and so not included in our scope.

6 Our findings are based on methodologies including: analysis of national data, reviewing documents, interviewing officials and visiting ten prisons. We also surveyed all prison governors in England and Wales, and healthcare managers in prisons in England. Further detail on our methodology and evidence base is in Appendices One and Two.

7 This report covers:

- an introduction to mental health in prisons (Part One);
- commissioning mental healthcare in prisons (Part Two); and
- delivering mental health and well-being services in prisons (Part Three).

¹ Comptroller and Auditor General, *Mental health services: preparations for improving access*, Session 2015-16, HC 492, National Audit Office, April 2016.

Key findings

On the system for providing mental healthcare in prisons

8 NOMS, NHS England and Public Health England have set ambitious objectives for providing mental healthcare in prisons, but it is not clear how they will achieve these in practice. The partnership agreement outlines their responsibilities and shared objectives for the system overall, but some objectives are not well defined, and do not take account of the complexities of the prison environment. For example, the partners aim to provide an equivalent service in prisons and the community, but are not clear what an ‘equivalent service’ means in practice or how this could be measured. For other objectives, it is not clear how they could be achieved in some prisons. For example, there is an objective to improve offenders’ health while they are in prison, but it is not clear how this can be done, or measured, particularly in local prisons that receive and release large numbers of offenders each day (paragraphs 2.18 to 2.19).

9 Government does not collect enough, or good enough, data about mental health in prisons, which makes it hard to plan services and monitor outcomes. There are no reliable data on the prevalence of mental illness in prisons. The most commonly used estimate is that 90% of the prison population are mentally unwell, but this figure dates from 1998 and uses a broader definition of mental illness than many clinicians would recognise. NHS England collects information on the number of people in treatment for mental illness, which currently amounts to 10% of the prison population in England, but there may be more people in treatment who are not captured in these data. NHS England uses health needs assessments to understand need, but these are often based on services that have been provided in previous years, and it does not collate information from prisoner health screening to understand if there is unmet need. NOMS, NHS England and Public Health England do not collect the right data to measure whether they are achieving their objectives. The data NHS England collects do not measure outcomes for prisoners, continuity of care or service quality. NOMS does not monitor the quality of healthcare it pays for in the six privately managed prisons it oversees (paragraphs 2.5, and 2.21 to 2.26).

10 NHS England’s approach to contracting mental healthcare in prisons limits its ability to achieve value for money. NHS England does not know how much it spends on mental healthcare in prisons. We estimate that the total spend on healthcare in adult prisons in England in 2016-17 was circa £400 million but this includes both mental and physical healthcare. NOMS does not know how much it spends on healthcare in the six prisons it pays for because it monitors spend against the contract for each prison as a whole, and not the costs of different services within it. In most prisons, NHS England selects one provider to deliver all healthcare services. This approach is intended to ensure that services are joined-up, but it reduces the numbers of providers able to bid for the contract, and means that bids are not always subject to strong competitive pressure. Additionally, because NHS England pays a fixed amount for a whole healthcare service, providers are not incentivised to adapt services if the level of need changes (paragraphs 2.11, 2.14 to 2.16, and 2.28).

11 NOMS has not given NHS England enough notice when it has made changes to the prison estate, but it is now working to improve this.

Changes to a prison's population can alter the level and type of mental health need. All of the commissioners we spoke to gave examples of changes to the prison estate that had impacted on need, but where they had not been given enough notice to make changes to the healthcare provision. For example at Downview Prison, NHS England was in the process of commissioning health services for a male prison when NOMS decided to open it as a female prison instead. When we visited six months after it opened, the prison was still developing a healthcare service that could meet the needs of the female population. Operational factors constrain how far in advance NOMS can announce some changes to the estate, although it has started to engage NHS England and Public Health England in joint planning boards as part of the Prison Estate Transformation Programme (paragraphs 2.12 and 2.13).

12 The prison system is under considerable pressure, making it more difficult to manage prisoners' mental well-being, though government has set out an ambitious reform programme to address this.

NOMS' funding reduced by 13% between 2009-10 and 2016-17, and NOMS has reduced staff numbers in public prisons by 30% over the same period. Prisons have struggled to cope with reduced resources. When prisons are short-staffed, governors run restricted regimes where prisoners spend more of the day in their cells, making it more challenging for prisoners to access mental health services. The challenges that NOMS faces are compounded by the ageing prison estate, over a quarter of which was built before 1900 and without modern healthcare in mind. In November 2016, the then government published a white paper on prison safety and reform, which included proposals to recruit more prison officers and to empower prison governors, including giving them shared responsibility for commissioning healthcare. The Ministry's Prison Estate Transformation Programme plans to replace the ageing estate with modern buildings. It takes some account of how the prison environment can affect health and well-being and notes that factors such as access to outside space, and reduced noise can increase self-discipline, reduce stress and improve psychological outcomes. The Ministry, NHS England, Public Health England and NOMS have also undertaken work to identify interventions to reduce suicide and self-harm in prisons. For prison staff, NOMS (and now HMPPS) has delivered communications to staff to provide guidance and share good practice on tackling suicide and self-harm. From May 2017 HMPPS has also provided more detailed training to new prison officers. It is too early to assess the impact of these interventions. Other interventions, including training for existing staff and changes in staff numbers and roles have been planned but not yet implemented (paragraphs 2.3, 3.17, 3.19, 3.22 and 3.29).

Mental health and well-being in prisons

13 While clinical care is broadly judged to be good, there are weaknesses in the system for identifying prisoners who need mental health services. Prisoners are screened by prison and healthcare staff when they arrive in prison, but screening does not always identify mental health problems. Staff do not have access to GP records, which means they do not always know if a prisoner has been diagnosed with a mental illness. NHS England is in the process of linking prison health records to community GP records to address this. It is also developing revised screening questionnaires, and plans to pilot these from summer 2017. Once in prison, prison officers may detect changes in a prisoner's mental health. But staffing pressures make this difficult, and officers do not receive regular training to understand mental health conditions. HM Inspectorate of Prisons reports find that the quality of clinical care is generally good, but there are shortages in primary care and counselling services (paragraphs 3.7 to 3.22 and 3.32).

14 Eligible prisoners should wait no more than 14 days to be admitted to a secure hospital, but only 34% of prisoners were transferred within 14 days in 2016-17. Of prisoners transferred in 2016-17, 7% (76 people) waited for more than 140 days, and we were told of one example of someone who had waited for more than a year. Delays can have a negative impact on prisoners' mental health and they may be kept in unsuitable conditions such as segregation units. The process of transferring prisoners is complex. NOMS and NHS England do not know how many prisoners are currently waiting to transfer to a secure hospital (paragraphs 3.35 to 3.37).

15 Prisoners do not routinely receive continuity of care on release, making successful rehabilitation more challenging. It is important that prisoners have good continuity of care between prison and the community. Over half (57%) of prisoners sentenced in 2016 were sentenced to less than one year, and most will serve half their sentence in prison, and half in the community. It can be challenging for prison healthcare and Community Rehabilitation Companies to establish links with community health teams, particularly when a prisoner is released far from their home or at short notice. Health information is not routinely shared with Community Rehabilitation Companies which makes it difficult to plan for release. Neither NOMS nor NHS England monitor whether continuity of care is provided. We have seen some good examples of healthcare teams working with community GP practices, but this is easier in the prisons that have a lower turnover of prisoners (paragraphs 3.4, 3.38 and 3.40 to 3.43).

Conclusion on value for money

16 Providing appropriate and effective mental health services is an essential part of supporting the rehabilitation of prisoners. But the rise in prisoner suicide and self-harm, with self-harm incidents increasing by 73% between 2012 and 2016, suggests a decline in mental health and well-being overall. While the quality of clinical care is generally good for those who can access it, only 34% of eligible prisoners were transferred to a secure hospital within the recommended time frame of 14 days. The data on how many people in prison have mental health problems and how much government is spending to address this is poor. Consequently NOMS, NHS England and Public Health England do not know the base they are starting from, what they need to improve, or how realistic it is for them to meet their objectives. Without this understanding it is hard to see how government can be achieving value for money.

17 The prison reform agenda presents a valuable opportunity for the Ministry of Justice, HMPPS, the Department of Health, NHS England and Public Health England to work together to improve the mental health and well-being of prisoners. If they refocus their efforts on some clear and achievable objectives, and collect the information they need to manage their performance against these, they will have a greater chance of making progress in this important area. Currently around 10% of the prison population is recorded as receiving treatment for mental health problems, but this may be higher. Most estimates of the number of people in prisons that suffer from mental health problems are far higher. If these estimates are an accurate reflection of need, then improving the mental health of those in prison will require a step change in effort and resources. The Ministry of Justice, HMPPS, the Department of Health, NHS England, and Public Health England need to determine the scale of the challenge as a matter of urgency.

Recommendations

18 Addressing the mental health and well-being of prisoners in the current prison environment is challenging. While the prison reform agenda offers opportunities for improvement, there remains a need for collaboration between all those involved in delivering services. Our recommendations aim to improve joint working to achieve better outcomes for prisoners as they move through the prison system:

- **The Ministry of Justice, HMPPS, the Department of Health and NHS England should improve their understanding of mental health needs in prison.** It is essential that partners understand the scale of the challenge they face. NHS England should combine screening, referrals and, when available, GP data to create an accurate picture of the number of people in a prison who need support with their mental health. The Department of Health, NHS England and the Ministry of Justice should use this information to review the level of mental health support they currently provide at a national level. At a local level, NHS England and HMPPS should use this information to inform co-commissioning within individual prisons.
- **The Ministry of Justice, HMPPS, NHS England and Public Health England should set measurable and achievable joint objectives, underpinned by an understanding of cost, and performance information that demonstrates whether they are meeting them.** NHS England, HMPPS and Public Health England are revising the Partnership Agreement. They should ensure that the new agreement clearly states what they are setting out to achieve, and partners should prioritise spending against these goals, and measure progress in achieving them. NHS England needs to improve its understanding of the cost of providing mental healthcare services and align performance measures for front-line staff and providers with its objectives. Providing integrated care to patients, where all services seek to meet the particular needs of patients with mental illnesses, may make it impractical to seek to capture the cost of all activities that support mental health. However, a better understanding of the cost of the core services is essential in allowing NHS England to improve and demonstrate value for money.
- **NHS England should ensure that contracts for mental health services are underpinned by appropriate performance management mechanisms.** NHS England needs to ensure it robustly validates performance data to identify and address areas of poor performance. Contracts should enable providers to respond to changes in need, and should be underpinned by mechanisms to measure and incentivise good performance against agreed standards. NHS England should look at measures used for acute physical healthcare in hospitals, such as payment by results or payment by unit of treatment, and consider whether some of these could also apply to prison mental healthcare.

- **HMPPS and NHS England should ensure effective information sharing between health, prison and probation staff that takes account of the need for patient confidentiality and consent, as well as prisoner safety and the need to provide integrated support, within a prison and on release.** If partners do not share information appropriately there is a risk they will not manage mental health and well-being effectively. In some prisons there are protocols for gaining prisoner consent to sharing information, but this is not consistent. NHS England's ongoing work to produce guidance on information sharing between prison and health staff is a good start. HMPPS and NHS England should ensure this guidance is implemented.
- **The Ministry of Justice and NHS England should review the process for transferring prisoners to hospital.** The Ministry of Justice and NHS England should routinely report how many prisoners are waiting to be transferred to hospital, and start to move prisoners who have been waiting longer than 14 days as quickly as possible. They should review procedures for transferring prisoners, identify reasons for the delays, and put work in place to simplify the process so acutely unwell people are not held in unsuitable conditions for prolonged periods of time in future.
- **The Ministry of Justice, HMPPS, the Department of Health, NHS England and Public Health England need to address the rise in incidents of suicide and self-harm in prisons, as a matter of urgency.** Partners should build on the work by the Prison Safety and Reform Programme, and the joint Suicide and Self Harm Project Board to deliver evidence based interventions to support a reduction in suicide and self-harm, including improved training and an enhanced role for prison officers. Partners should publish an action plan which addresses problems identified and establishes clear protocols for prison governors and healthcare providers. This should happen as a matter of urgency in an effort to avoid preventable fatalities.

Part One

Introduction to mental health in prisons

1.1 Around one in four adults are diagnosed with a mental illness during their life and many more will experience changes in their mental well-being. The World Health Organization defines mental health as “a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”. Mental health conditions cover a broad range of disorders of varying severity, which can range from common conditions such as depression, to severe but less common conditions such as psychosis.

1.2 Mental health conditions can have a significant impact on all aspects of the lives of those affected. People with poor mental health are more likely to claim Employment Support Allowance. For those who are in employment, mental health problems can have a significant detrimental effect on their ability to work. Poor mental health costs the economy an estimated £105 billion per year.

1.3 The available evidence suggests that people in prison are more likely to suffer from mental health problems than the general population, though there are no up-to-date data on the number of people with mental illnesses in prison. Most of the statistics quoted in research and policy papers are based on a study published in 1998, which estimated that 90% of the prison population were experiencing mental health problems. However, this paper takes a wider definition of mental health than many clinicians would recognise, and the data are 20 years old. A 2005 survey of 1300 prisoners who had recently arrived in prisons found that 49% reported being at risk of anxiety and depression, though again this was not based on clinical assessments.

1.4 When they are screened on arrival at prison, 23% of prisoners report that they have had some prior contact with mental health services. But this does not provide a full picture as the data may be incomplete and people may develop mental health problems after they arrive in prison. In March 2017, the National Institute for Health and Care Excellence (NICE) recommended that research should be undertaken to determine the prevalence of mental health and associated social problems for those in contact with the criminal justice system. NHS England collect data on some, but not all, mental health conditions. Its data show that 10% of the prison population in England are in treatment for mental health conditions at any one time, but there may be more prisoners in England receiving mental health treatment who are not accounted for in these data.

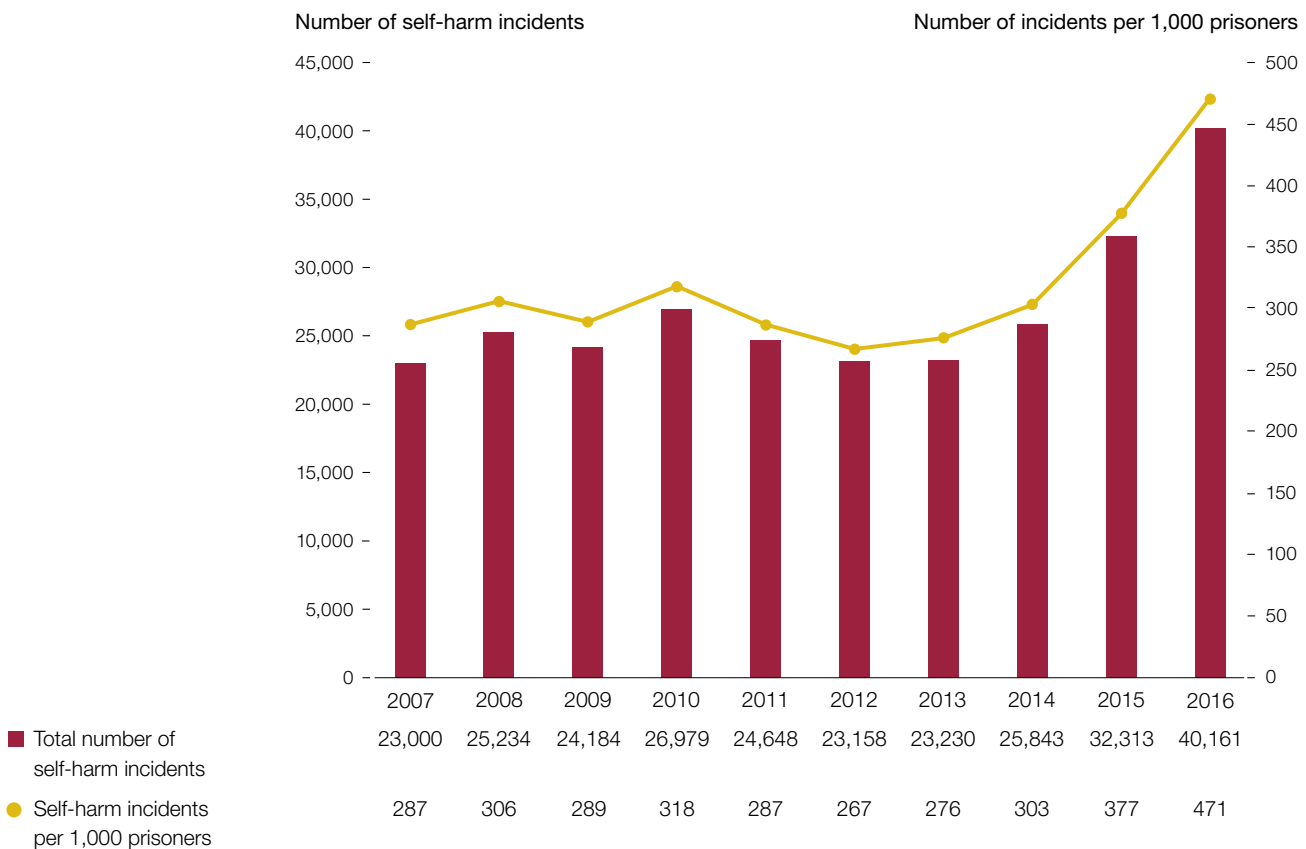
1.5 Suicide and self-harm are also more common in prison than in the community, and complex social and personal issues such as substance misuse or histories of trauma are more common among the prisoner population. Prison can exacerbate mental health problems through separation from family and friends, boredom and loss of autonomy.

Why is addressing mental health in prison important?

1.6 While there is no accurate measure of mental well-being among prisoners, a rise in self-harm rates indicates a decline. The number of self-harm incidents rose by 73% between 2012 and 2016. In 2016, there were 40,161 incidents of self-harm in prisons, the equivalent of almost one incident for every two prisoners, although some prisoners will self-harm multiple times (**Figure 1**).

Figure 1
Incidents of self-harm in custody in England and Wales, 2007 to 2016

Rates of self-harm have been on the increase since 2012 and are now at a record high



Notes

- 1 Data show the total number of self-harm incidents and self-harm incidents per 1000 prisoners in each year.
- 2 Data include incidents at HM Prison and Probation Service run Immigration Removal Centres.

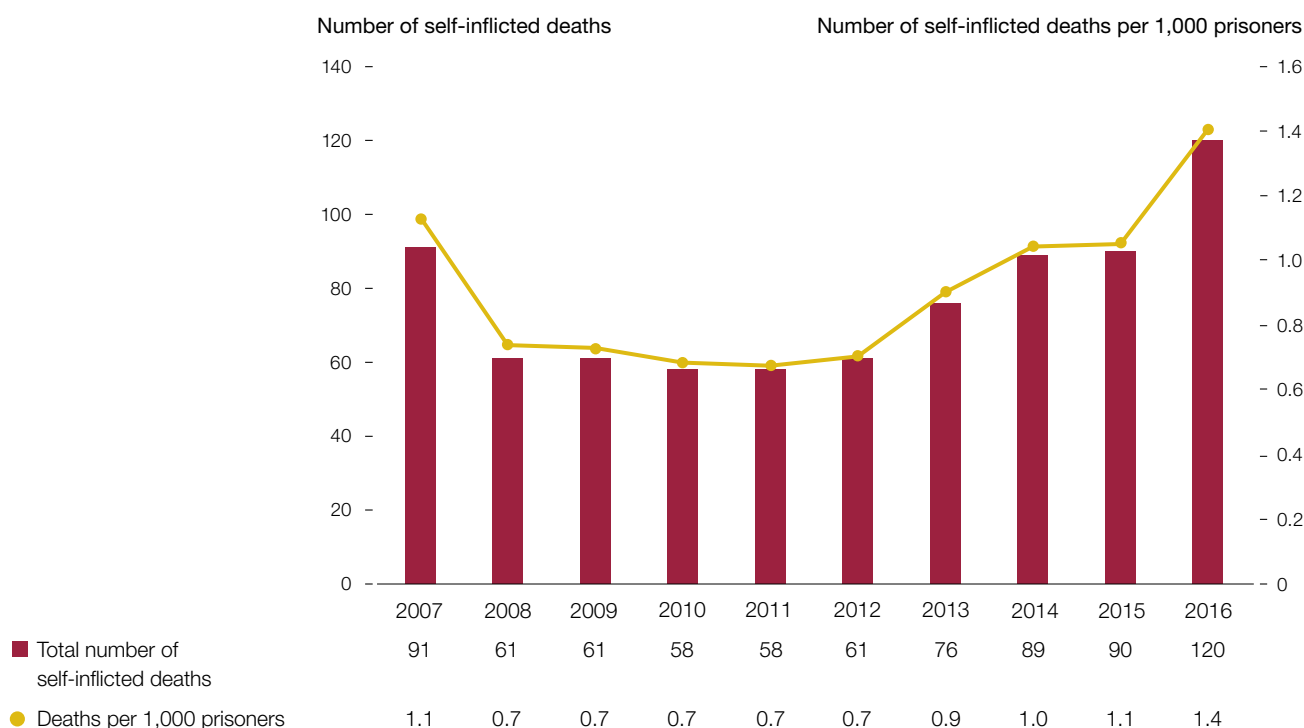
Source: Ministry of Justice, *Safety in Custody Statistics*, National Statistics, 27 April 2017, available at: www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-december-2016--2

1.7 In 2016, the Prisons and Probation Ombudsman found that 70% of prisoners who had taken their own life between 2012 and 2014 had been identified as having mental health needs. In February 2017, the Royal College of Psychiatrists stated that “rising deaths show there are failures in reaching prisoners who need general medical and specialist mental healthcare”. There were 120 self-inflicted deaths in prison in 2016, (1.4 per 1,000 prisoners) which is almost twice the number of self-inflicted deaths in 2012, and higher than any previous period on record (**Figure 2**).² In 2015 there were ten times more self inflicted deaths per 1,000 people in custody than there were suicides per 1,000 people in the community. Men in prison were six times more likely to take their own life than men in the community, and women in prison were 24 times more likely to take their own life than women in the community.

Figure 2

Self-inflicted deaths in custody in England and Wales 2007 to 2016

Self-inflicted deaths have increased since 2012 and are now at a record high



Notes

- 1 Data show the number of self-inflicted deaths and deaths per 1,000 prisoners in the calendar year (January to December inclusive).
- 2 Data include incidents at HM Prison and Probation Service run Immigration Removal Centres.
- 3 Data on the graph are mapped to three decimal places, data in the table are rounded to one decimal place.

Source: Ministry of Justice, *Safety in Custody Statistics*, National Statistics, 27 April 2017, available at: www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-december-2016--2

- 2 The Ministry of Justice defines self-inflicted deaths in custody as any death of a person who has apparently taken his or her own life irrespective of intent. The Ministry of Justice uses this classification because it is not always known whether a person intended to take their own life. Ministry of Justice data are available up to the end of December 2016. The National Statistics definition of suicide includes all deaths from intentional self-harm and also deaths where the intent was undetermined. National Statistics data available up to the end of December 2015.

Responsibility for mental health and well-being in prisons

1.8 Prison can present an opportunity for prisoners to access services that help to prevent reoffending, but people with mental health problems might find it harder to engage with these services. The route most prisoners take from court, through prison and to access healthcare is shown in **Figure 3**.

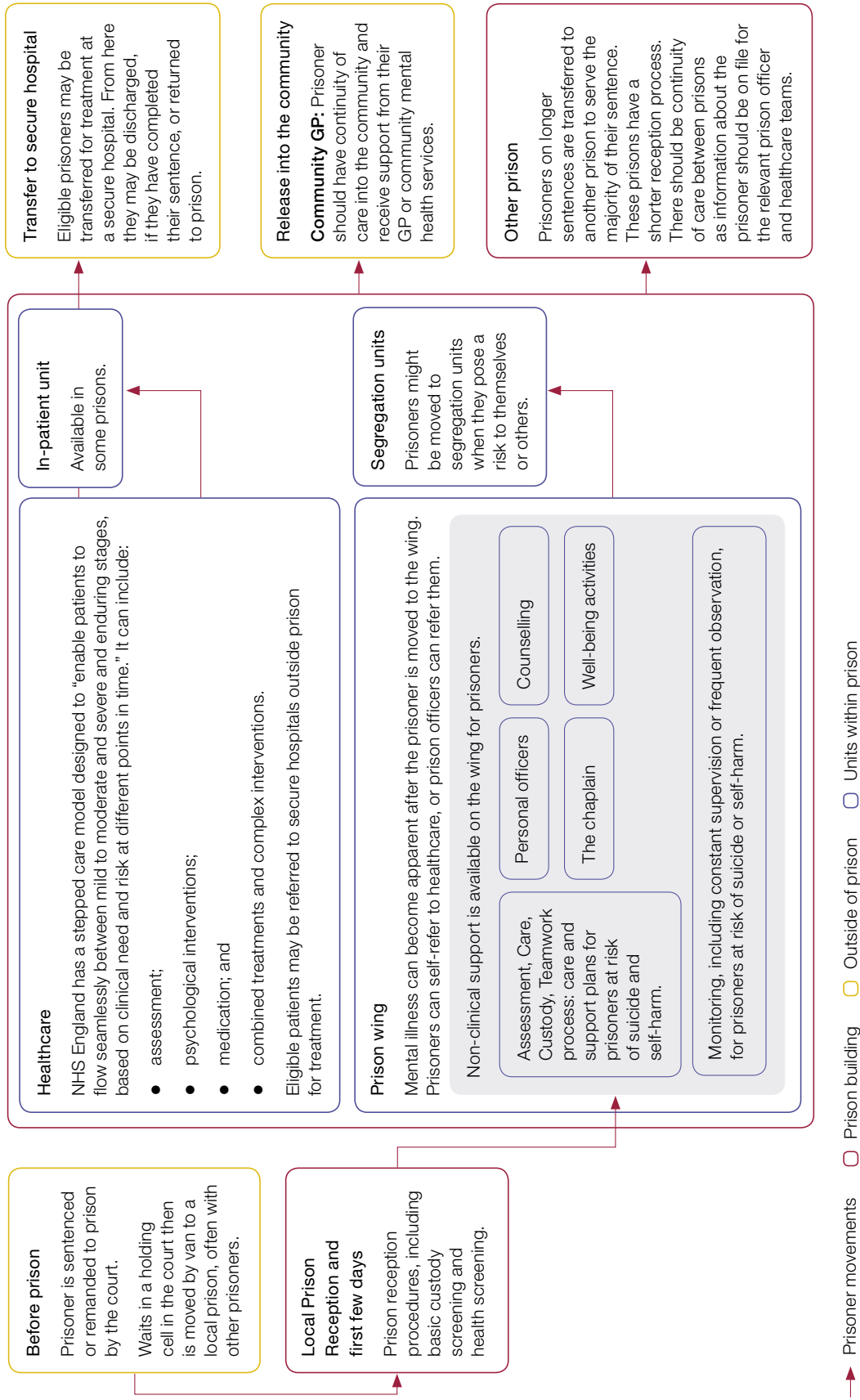
1.9 Three government bodies have committed to collaborate and cooperate to achieve their shared delivery commitments and aims, while recognising their respective statutory responsibilities and independence (**Figure 4** on page 18):

- the National Offender Management Service (NOMS) was, at the time of fieldwork, the executive agency of the Ministry of Justice responsible for prisons;
- NHS England is sponsored by the Department of Health and commissions healthcare in prison; and
- Public Health England is sponsored by the Department of Health and provides support and guidance to the Department of Health, NHS England and NOMS.

From 1 April 2017 NOMS ceased to exist and some of its functions transferred to the Ministry of Justice and some to the newly formed HM Prison and Probation Service. HMPPS has retained responsibility for the operational management of prisons, but responsibility for commissioning and policy has moved into the Ministry of Justice. It is not yet clear how this will work in practice. The body of this report refers to NOMS, rather than HMPPS, as NOMS had responsibility at the time of fieldwork and writing. Our recommendations are addressed to HMPPS and the Ministry of Justice as they have taken on NOMS' responsibilities.

1.10 Prisons used to be responsible for providing healthcare to prisoners. Budgetary responsibility for all prisoner healthcare was transferred from the Prison Service to the Department of Health in 2003. This was, in part, to help ensure prisoners received care that was equivalent to that available from the NHS in the community. NOMS retains responsibility for providing healthcare in six privately managed prisons, where contracts pre-date the transfer of responsibilities.

Figure 3
Route through prison and access to mental healthcare

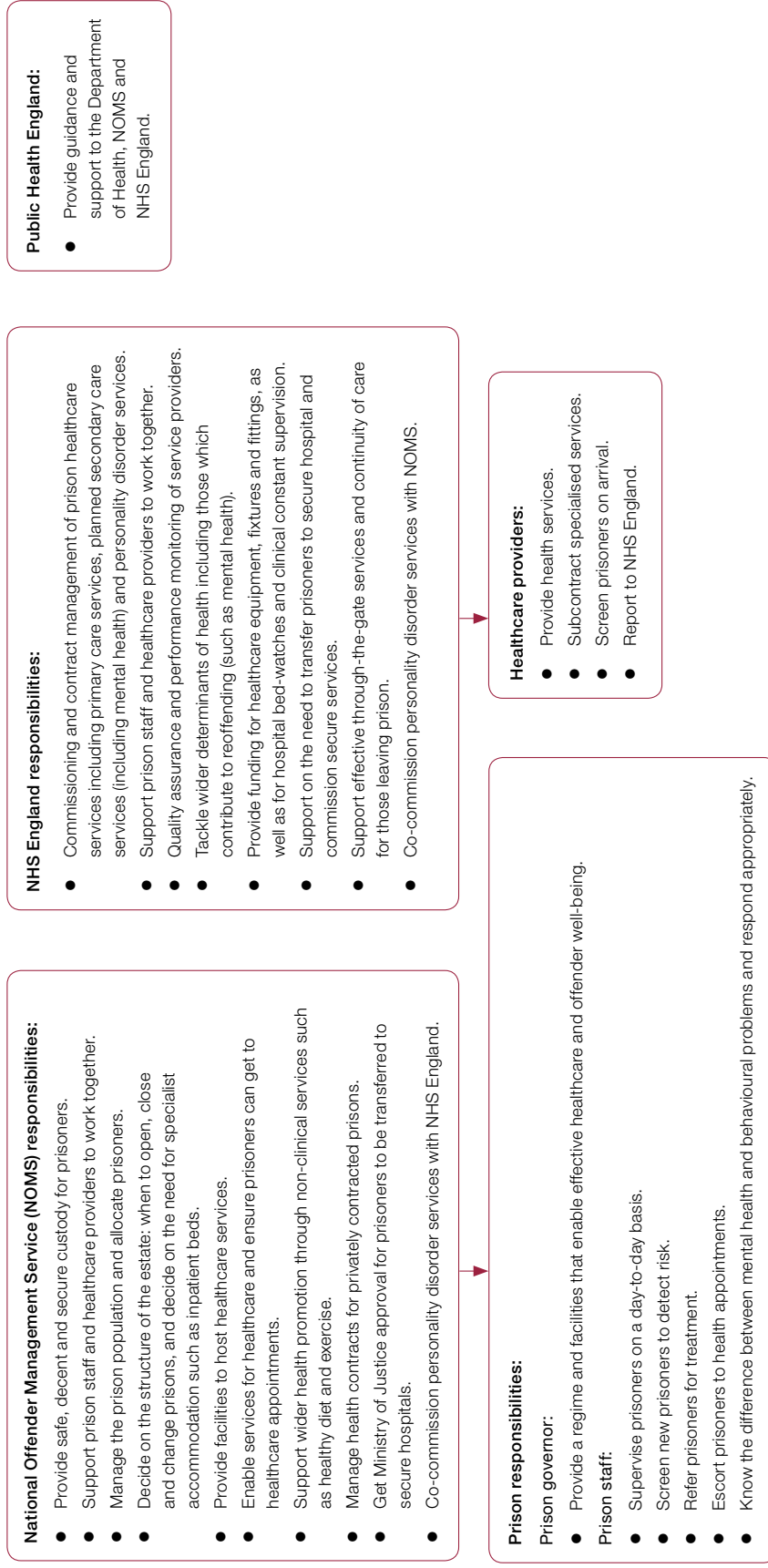


Note

1 The assessment, care in custody teamwork process (ACCT process), brings together the prison and healthcare teams to support prisoners who have self-harmed or are at risk of harm to themselves or others.

Figure 4
Overview of main responsibilities for mental healthcare in prisons

Commissioners and service providers have to work together to deliver healthcare services



Notes

- 1 This figure shows a summary of the main responsibilities for mental healthcare as listed in the *National Partnership Agreement between: The National Offender Management Service, NHS England and Public Health England for the Co-Commissioning and Delivery of Healthcare Services in Prisons in England, 2015-2016*.
- 2 NHS England has a specific role to commission public health services and to hold to account providers to ensure that they deliver the contracts that have been agreed. The Department of Health is the overall steward of the health system. Direct commissioning of public health services by NHS England is based on national service specifications. Public Health England contributes to developing the specification, which is agreed with NHS England, drawing on the best evidence in order to provide the public with evidence-based, safe and effective services.

Source: National Audit Office analysis of the *National Partnership Agreement between: The National Offender Management Service, NHS England and Public Health England for the Co-Commissioning and Delivery of Healthcare Services in Prisons in England, 2015-2016*, available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/460444/national_partnership_agreement_commissioning-delivery-healthcare-prisons_2015.pdf and *NHS public health functions agreement 2016-17: Public health functions to be exercised by NHS England*, NHS December 2015, available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/486444/S7A_1617.pdf

1.11 NOMS, NHS England and Public Health England have entered into a partnership agreement that sets out their shared objectives for health services in prisons.³ The objectives align with the NHS *Five Year Forward View*, recognise the specific constraints of operating in prison, and set out the different roles and responsibilities for the three bodies.⁴ The objectives that are relevant to mental healthcare in prisons are:

- Prisoners should receive an equivalent health and well-being service to that available to the general population with access to services based on need.
- Health and well-being services in prison should seek to improve health and well-being (including parity of esteem between services that address mental and physical health), tackle health inequalities and wider determinants of health and contribute to protecting the public and reducing reoffending.
- Prisoners should expect to experience improvement in their health and well-being, particularly in respect of recovery from substance misuse, mental health problems, management of long-term conditions and access to public health interventions to prevent disease and illness.
- Prisoners should expect continuity of care between custodial settings and between custody and community (including across the border with Wales).

1.12 These objectives appear in the partnership agreement for 2015-16, which was extended until April 2017. The departments are currently updating the shared agreement to reflect the change from NOMS to HMPPS, and future priorities. As part of this work they intend to review what is meant by equivalent care.

3 *National Partnership Agreement between: The National Offender Management Service, NHS England and Public Health England for the Co-Commissioning and Delivery of Healthcare Services in Prisons in England, 2015-2016*, available at: www.gov.uk/guidance/healthcare-for-offenders

4 NHS England, *Five Year Forward View*, 2014, available at: www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

Part Two

Commissioning mental healthcare in prisons

2.1 In this part we examine the system for commissioning mental healthcare services in prisons. This includes the government's role in commissioning services that meet the level of need in prisons, joint working to ensure healthcare works within the prison, and monitoring performance.

2.2 The process of commissioning services can be broken down into five stages of a continuous cycle (**Figure 5**). We examined NHS England's approach to commissioning against this cycle. We found that there are limited data to help commissioners assess need, and a small number of providers large enough to deliver the contracted services. This makes it hard for commissioners to source providers, and ensure they are getting services at the right cost. NHS England contracts do not incentivise providers to change services to meet changes in need, and the data it uses to understand need for future commissioning cycles are incomplete.

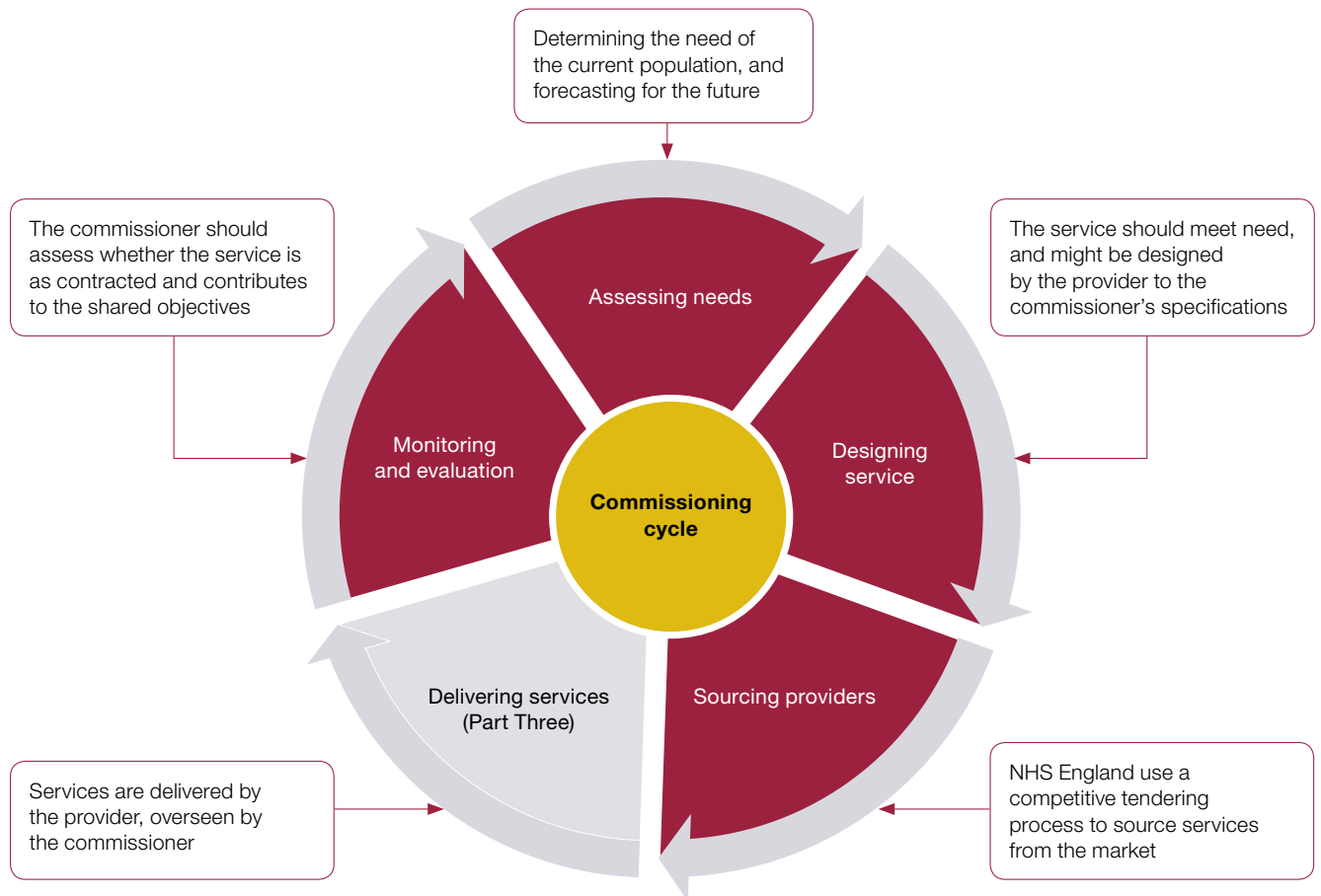
2.3 Governors have no contractual responsibility for healthcare, but some are involved in designing health service requirements, choosing providers and evaluating performance. The level of involvement governors have in healthcare varies, and is often informed by the interest individual governors take in health and well-being. The white paper on prison safety and reform set out the then government's intention for prison governors to co-commission healthcare with NHS England commissioners.

2.4 This part of the report covers four of the steps in the commissioning cycle in more detail; and Part Three covers delivering services.

Figure 5

The commissioning cycle

Commissioners should apply a five-stage continuous cycle

**Notes**

- 1 This model is based on the *National Audit Office Successful Commissioning Toolkit*, available at: www.nao.org.uk/successful-commissioning/introduction/nao-model-of-commissioning-and-civil-society/
- 2 Delivering services is dealt within Part Three of this report.

Source: National Audit Office analysis

Assessing the mental health need in prisons

2.5 It is important that the National Offender Management Service (NOMS), NHS England and Public Health England understand the level of mental health need nationally and within individual prisons, so that they can plan services to meet prisoners' needs. This requires:

- national data on mental health needs to help plan spending on mental healthcare; and
- an understanding of mental health needs at each individual prison to know which services to provide.

2.6 NHS England, NOMS and Public Health England do not have reliable, current data that enable them to understand the prevalence of mental ill-health at national level. In March 2017, NHS England's performance monitoring data showed that 7,917 prisoners, or 10% of the adult prison population in England, were receiving treatment for mental health problems although there might be people receiving treatment who are not included in these data. The number of prisoners with mental health or well-being problems is likely to be higher, because some people may not be receiving treatment. During prison inspections conducted by HM Inspectorate of Prisons, 37% of the prison population in England and Wales reported having emotional well-being or mental health problems. Public Health England has carried out a rapid evidence review of international research on health outcomes in detained settings, which will be used to inform future prioritisation in this area.⁵

2.7 NOMS, NHS England and Public Health England have access to data that could improve their understanding of need. Both prison staff and healthcare staff screen prisoners on arrival to identify mental health needs. NOMS collates screening data nationally, but the data set is incomplete because prison staff leave some questions unanswered (paragraph 3.10). Screening conducted by healthcare staff is more comprehensive, but NHS England does not collate the data at national level. Prison healthcare staff do not have access to prisoners' health records. NHS England is in the process of linking prison health records to community GP records, which could provide an additional source of data on the prevalence of mental ill-health. Part Three covers screening arrangements in more detail.

⁵ Public Health England, *Rapid review of evidence of the impact on health outcomes of NHS commissioned health services for people in secure and detained settings to inform future health interventions and prioritisation in England*, October 2016.

2.8 At prison level NHS England uses health needs assessments to plan services, but these are not always conducted at the right time or to a high standard of quality. In 2014, Public Health England published a toolkit to provide a consistent approach for producing a health needs assessment in prisons. Health needs assessments should be used to understand the level of need within a prison, however NHS England had commissioned healthcare services without a recent health needs assessment for two of the ten prisons we visited. In one of these prisons there had been significant changes to the population since the last health needs assessment, so there was no good evidence base for commissioning services. In the prison we visited where the Ministry of Justice commissioned services, there was a significant change to the population but NHS England had not commissioned a health needs assessment.

2.9 There are weaknesses in the way NHS England conducts prison health needs assessments. All of the ten prisons we visited use the number of prisoners currently in treatment as a baseline for the level of need, but this does not include unmet need. Healthcare staff raised concerns about the quality or completeness of the needs assessments in five of the ten prisons we visited:

- In two prisons, the healthcare managers told us that problems with historical baselines meant that the health needs assessment did not accurately reflect need.
- In one case, the health needs assessment stated that mental healthcare was “thwarted by chronic staff shortages”, particularly in nursing, but this had not resulted in more nurses being provided when NHS England renewed the contract.

Designing services

2.10 Once NHS England understands need, it should design services to meet this. NHS England uses a stepped-care model, which commissioners and providers can adapt to meet the needs of each prison. NHS England outlines five steps that prisoners should take, from primary care, through planned secondary care, and to crisis support for the most at risk. This is intended to help patients move easily between treatments as the severity of their condition changes.

2.11 NHS England mostly uses a prime provider model to provide healthcare in prisons. In the prime provider model, the commissioners let one contract for all healthcare (both mental and physical) in a prison or group of prisons, and pay a single fixed price for the whole contract. The provider that wins that contract (the prime provider) can subcontract elements to other organisations. This is different to the model that NHS England uses in acute physical health services in hospitals, where it commissions specific services and pays (in most cases) by unit of care provided. NHS England and NOMS consider that a prime provider model makes it easier to ensure that all services within the prison work effectively together, and helps to ensure it is clear who is accountable. However, there are fewer providers large enough to deliver a full healthcare service in a prison than there are providers able to provide specialist services (see paragraphs 2.15 and 2.16).

2.12 When NOMS plans changes to the prison estate, it does not always tell NHS England early enough. In four of the ten prisons we visited, healthcare needs had changed as a result of changes NOMS had made to the estate. The commissioners and healthcare teams in these four prisons told us that they had not been given enough notice of these changes, or had struggled to accommodate the changes within the existing contract. For example, when we visited HMP Downview, NOMS had recently changed it from a male, to a female prison. NHS England had already started commissioning services for a male population when NOMS notified it of this. NHS England had five months to put appropriate services in place to serve the female population before the prison opened in May 2016. The healthcare service was still being developed when we visited the prison in November 2016, and some facilities were not ready.

2.13 Operational constraints affect how much notice NOMS can give commissioners and providers of changes to the estate. Once NOMS announces that a prison will close, staff may start to look for other jobs, which can make it difficult to maintain safe staffing levels. NOMS committed to working more closely with NHS England to plan changes to the estate. NHS England and Public Health England now sit on planning groups as part of the Prison Estate Transformation Programme, and NOMS is working to ensure that NHS England can plan services to meet need in new prisons.

Sourcing providers

2.14 Once NHS England has designed a suitable service, it must find and contract with a provider to deliver this at the optimal price to achieve value for money.

2.15 NHS England's commissioning model relies on competitive pressure to get the optimal price, but the prime provider model limits the number of providers able to bid. When NHS England puts a service out to tender, providers outline the specific service they will offer and the cost of that service. NHS England chooses the provider that offers optimal value, from those proposals that meet its minimum service specification. All of the five heads of commissioning teams we spoke to told us that the market for prison healthcare was thin. In four of the ten prisons we visited, there were only two bidders able to meet the basic specification for health services. In one case only one bidder met the basic specification and in another the existing contract had to be extended because there were no bidders for a new contract.

2.16 Some NHS England commissioners are working to strengthen the market of mental healthcare providers to encourage more bidders. In one area, the commissioners had moved away from the prime provider model and were encouraging specialist providers to bid for specific services across several prisons in the region.

Monitoring and evaluation

2.17 There are three reasons why the government should monitor and evaluate services:

- **evaluating progress** – to understand whether it is achieving its objectives;
- **managing contracts** – to evaluate whether it is getting what it pays for; and
- **improving services** – to identify and address poor performance, and share good practice.

Evaluating progress

2.18 NOMS, NHS England and Public Health England have a partnership agreement for healthcare in prisons, with an ambitious set of shared objectives that cover: providing equivalent care between prison and the community; tackling health inequality; improving individual prisoners' health; and continuity of care. But the partners have not defined measurable outcomes for these and do not currently measure progress against them, for example:

- It is not clear how partners can assess whether healthcare in prisons is equivalent to healthcare in the community. More people in prison have a mental health need and some metrics, such as waiting times, are influenced by the prison environment as well as the availability of care. NHS England plans to start measuring mental health appointment waiting times from April 2017.
- It is hard for partners to show they are tackling health inequality, because there are no data on the prevalence of mental health in prison. NHS England measures the prevalence of mental health in the community every 7 years, using the Adult Psychiatric Morbidity Survey, but it does not have comparable data for people in prison.
- NHS England could ask providers to report prisoners' health on release, to measure whether their health has improved, but it does not do this, and would be constrained in doing so by the rapid movement of some prisoners through the system.
- NHS England could ask providers to report on continuity of care, but it does not. The then government's white paper on *Prison Safety and Reform*, published in November 2016, outlined plans for joint working between partners to improve how they measure mental health outcomes, and to start measuring improvement in prisoner mental health.

2.19 NHS England also does not know how much it spends on mental healthcare in prisons, which means it cannot know whether it is providing value for money. We estimate that the total spend on healthcare in adult prisons in England in 2016-17 was circa £400 million. This includes both mental and physical healthcare, it is not possible to separate the cost of physical health services in prisons, from mental health services in prisons, because most contracts cover both. Further details on the methodology for this estimate are in the methodology appendix.

Managing contracts

2.20 Managing providers' performance is a core principle of good contract management. It enables commissioners to assess whether they are getting the services they pay for and achieving the right outcomes.

2.21 NHS England's commissioning teams monitor how many prisoners are receiving mental healthcare. Since inheriting many of the existing healthcare contracts in 2013, NHS England has developed a standardised set of measures called the health and justice indicators of performance (HJIPs). HJIPs contain the only national level data on mental health care in prisons. Some local commissioners collect additional information but this varies from area to area.

2.22 HJIPs do not contain any measures of quality, or outcomes such as improvement in a prisoner's health. The indicators reported to NHS England contain: the number of prisoners in treatment; how long prisoners waited for transfer to a secure hospital; the number of prisoners on constant supervision; suicide and self-harm prevention; care programmes; and the number of people who have left prison with a summary of their healthcare to give to their GP. HM Inspectorate of Prisons reports show that the quality of mental healthcare is generally good, but NHS England does not centrally collect any data on the quality of treatment or whether treatment improves health outcomes. NHS England, with the support of Public Health England, has updated the HJIP measures for 2017-18. NHS England's draft quality reporting template includes a measure of patient experience and the percentages of mental health referrals which were accepted or rejected by health teams.

2.23 Data reporting has improved since the indicators were introduced in 2015, however there are still inconsistencies in the quality and completeness of the data. Healthcare providers submit data to regional commissioning teams on a quarterly basis, but there is no national guidance for providers on how they should enter data into the system. This means that data requests are interpreted locally and data are entered differently in different prisons. Regional commissioners should review the performance data to ensure that it is complete and consistent, but there were gaps in the data for 2016-17 which had not been identified during these checks. NHS England is conducting a series of data audits at each prison to improve data quality, and a new IT system is foreseen for late 2017 which should automate data reporting.

2.24 Commissioners use additional measures to understand provider performance against their contracts. We reviewed contracts covering the nine prisons we visited where NHS England commissioned services and all of them used the health and justice indicators of performance to measure performance. All nine of the prisons collected additional data, including numbers of people in treatment and, in some cases, the length of time prisoners waited for assessment. Only three of the contracts asked for the provider to measure service user satisfaction.

2.25 Three of the five healthcare commissioners we spoke to told us that death in custody reviews undertaken by the Prisons and Probation Ombudsman (PPO) inform their understanding of performance. It is important that healthcare commissioners, providers and prisons learn lessons following a death in custody, but they should have performance mechanisms in place that enable them to identify and act on poor performance before there is a fatality. The PPO reports highlight a number of failings in areas that commissioners, providers and prisons do not routinely track through performance indicators. These include:

- prisoners whom healthcare teams identified as having mental health problems, but who did not receive treatment;
- prisoners who should have been on constant supervision or frequent observation due to their risk of suicide, but had not been;
- assessment, care, custody, teamwork processes that did not involve input from healthcare teams (this is a mandatory requirement for the first case review); and
- screening processes that did not correctly identify a mental health need.

2.26 NOMS does not scrutinise healthcare providers' performance in the six privately managed prisons that it is responsible for. The five private prisons in England report data to NHS England, but NHS England does not hold the contracts and therefore does not have a mechanism for responding to under-performance. The private prison in Wales does not send performance data to NOMS.

Improving services

2.27 Where performance falls below standard, NHS England should use its contractual levers to improve performance and, where appropriate, penalise providers. Some contracts we reviewed contained provisions for the use of financial penalties where providers were underperforming. We saw two examples, including one of the ten prisons we visited, where commissioners had continued to pay for a service that was not provided, and had not acted to recoup any costs. 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; in another case the commissioner had paid for a full service when the prison was holding significantly fewer prisoners than it was contracted to provide for.

2.28 The payment system for health services in prison is less mature than for acute physical health services in hospitals, and does not enable the provider to change provision to meet need. NHS England pays a fixed amount for a whole healthcare service in prison (including physical and mental health), and providers are contracted to provide services for all prisoners. The prices are set locally, defined within each individual contract, and do not include payments per unit of treatment, or payment by type of care. This means that providers cannot change the level of provision, and do not have a financial incentive to meet additional need if it is higher than foreseen in the contract. There are also no mechanisms built into the contracts that create an incentive to provide a better standard of care. Our report *Mental health services: preparations for improving access* reported that most health services were paid per unit of care with prices set nationally, but mental health services were generally paid for separately under block contracts.⁶ Paying per unit of care worked well to incentivise providers to increase activity where needed, and reduce waiting lists. NHS England can amend the contract if needed, for example to provide additional funding for a specific piece of work.

2.29 Monitoring and evaluation can also help to identify and promote good practice. During our prison visits we saw many innovative approaches to facilitating and providing mental healthcare and well-being services in prisons, such as specialist dementia care, education courses on well-being, specialist gym classes in cases where exercise could help with mental health problems, and family counselling, which sought to improve relationships between prisoners and their children. But these are developed locally and not routinely shared with other prisons.

⁶ Comptroller and Auditor General, *Mental health services: preparations for improving access*, Session 2015-16, HC 492, National Audit Office, April 2016.

Part Three

Delivering mental health and well-being services in prisons

3.1 This part of the report examines how the National Offender Management Service (NOMS) and NHS England commission and deliver services for prisoners as they move through the prison system. This includes both clinical healthcare services, and non clinical services which may have an impact on a prisoner's mental health and well-being.

Providing health and well-being services in prison

3.2 NOMS expects prisons to provide an environment that is safe, secure and decent. Enabling prisoners to maintain a good state of mental well-being supports this aim but is challenging to achieve.

3.3 The NHS has defined steps to mental well-being which include connecting with people, being active, learning new skills, and being mindful of the world around you. Prisoners might find it difficult to take these steps while in prison. Prisoners are separated from family and friends, their activity levels are dictated by time out of cell and access to outside space, and the environment is sometimes noisy and disruptive. Other factors that have an impact on mental well-being, such as sleep and diet, are also harder for a prisoner to control.

3.4 The quality of clinical care in prison is generally judged to be good (paragraph 3.32). But, for several reasons, the prison estate, and prisoner movement around the estate, make it harder to provide healthcare and for prisoners to maintain a good state of well-being:

- 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. In these prisons, healthcare is provided in improvised and adapted spaces.
- Poor well-being may be exacerbated by crowded conditions. NOMS defines crowding as a prison cell shared by more people than it was originally designed to hold. During 2015-16, 24.5% of prisoners were held in crowded accommodation.
- Prisoners are first sent to a local prison once they are remanded or sentenced. After some time in a local prison, they are sent to another prison to serve the majority of their sentence. Prisoners are more likely to take their own life or to self-harm during the early stages of custody.
- Prisoners do not always have time to complete treatment before leaving a prison. Just over half of people entering prison (52%) are on remand, and 58% of prisoners sentenced in 2016 were sentenced to less than 12 months, half of which is served in the community.

3.5 Recent changes within the prison estate have had an impact on prisons' capacity to ensure that prisoners maintain good mental well-being, and to support prisoners when their well-being declines; for example:

- Prisons have struggled to cope with reduced resources, and prison governors often cope by running a restricted regime where prisoners spend more of the day in their cells (paragraph 3.15 and 3.17).
- Psychoactive substances (previously known as legal highs) have become more prevalent in prisons in recent years. HM Inspectorate of Prisons has found evidence that these drugs are linked to self-harm, bullying and violence.

Identifying mental health problems

3.6 There are two ways in which healthcare teams identify prisoners who need mental health treatment:

- Healthcare staff or prison staff identify the prisoner's mental health need when they arrive in prison, through screening procedures.
- A prisoner reports concerns about their own mental health, or prison staff refer prisoners who show signs of a mental health problem to the healthcare team. Other prisoners can also raise concerns about an individual's mental health, with either prison or healthcare staff.

Screening prisoners on arrival at prison

3.7 The following screening procedures identify risk of suicide or self-harm, and identify mental health or well-being concerns when a prisoner arrives at prison:

- Prison officers screen prisoners within 72 hours of their arrival at prison. Screening questions address a prisoner's immediate risk of suicide and self-harm, and whether the prisoner has had contact with mental health services in the past.
- Healthcare staff conduct an initial health screen of prisoners when they arrive to detect immediate needs. They should offer a more comprehensive assessment within a week of arrival.

3.8 Local prisons receive remanded and sentenced prisoners from the courts. These prisons receive an average of 14 prisoners each day, compared with three prisoners at other prisons. The busiest prison, Wandsworth, receives an average of 24 new prisoners each day.⁷ Prisoners usually arrive in groups from court, often in the evening after the courts have finished sitting, and each prisoner goes through a lengthy reception process (**Figure 6** overleaf). Although the prison population was 84,674 in 2016-17, there were 202,099 prison receptions in 2016. This was made up of 86,258 new arrivals into the prison system, 20,711 recalls to prison and 95,130 transfers between prisons. A full screening is not carried out for transfers from other prisons, as information should travel with the prisoner.

3.9 Prison staff screen each prisoner using a basic custody screening questionnaire which contains over 120 questions. These cover details such as name and age, as well as more complicated assessments such as the risk of suicide or self-harm. Some 35% of the screening questions are optional, including those on suicide and self-harm.

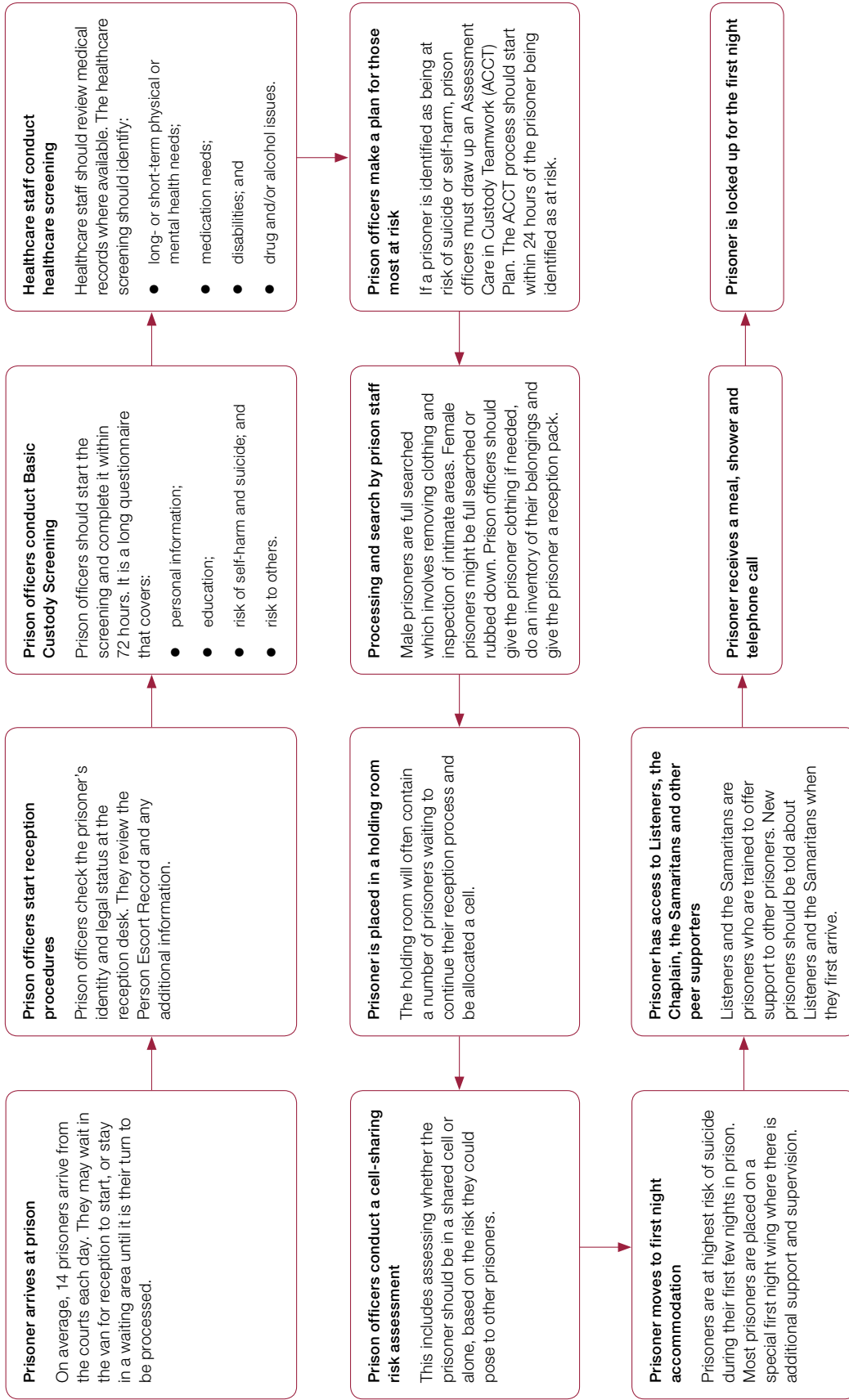
3.10 Prison staff screen every prisoner when they enter the prison system, but records do not give a complete picture. Staff did not enter data on the 'risk of suicide' in 68% of screening records, or on the 'risk of self-harm' in 59% of records. The question on 'previous contact with mental health teams' is mandatory and was completed in all cases.

3.11 Healthcare professionals also screen every prisoner, but this screening does not always identify existing mental health illnesses. In the absence of GP records, health staff rely on prisoners disclosing existing mental health conditions, but this does not always happen. A general nurse usually conducts healthcare screening, and it covers all types of healthcare information including mental and physical health. Prisoners do not always engage well with first night screening as they may be tired, scared, or in shock at having been sentenced to prison, and healthcare staff have limited time. This could affect the effectiveness of the screening process. For example, a death in custody report by the Prison and Probation Ombudsman found that "although [the prisoner] scored very highly in tests for anxiety and depression, [the nurse] did not think that his distress was out of the ordinary for prisoners" and did not refer him to mental health teams.

⁷ This is based on a total of 46,164 prison receptions (including remand and transfers) in quarter 3 of 2016. The data cover 32 local prisons and 76 non-local prisons in England included in NHS England data. The total for each prison was divided by the 66 week days (excluding weekends), because most prisoners are sentenced, or remanded on Monday to Friday.

Figure 6 Activities conducted by prison and healthcare staff when a prisoner first arrives at a local prison

New prisoners go through a lengthy process when they arrive in prison



Source: National Audit Office summary of the procedures outlined in National Offender Management Service' Prison Service Instruction: *Early days in custody – reception, first night in custody, and induction to custody*, PSI 07/2015, issued 1 February 2015

3.12 NHS England is working to improve the quality and availability of medical information for healthcare teams. It plans to roll out a new health and justice information system which should make community GP records available to health staff in prisons.

Identifying mental health problems on the wing

3.13 Prisoners can self-refer to healthcare if they think they need help with their mental health. Some prisons provide information and support to prisoners to help them recognise changes in their mental health, such as leaflets, posters or books from the library.

3.14 Prison officers have a responsibility to identify prisoners who may have mental health needs and to help them access healthcare services. This is part of the prison officers' responsibility to safeguard prisoners from neglect, which is defined as "a failure to identify and meet the needs of a prisoner, for example by ignoring medical, emotional or physical care needs, failing to provide access to appropriate healthcare and support ...".⁸ Prison officers also have the most contact with prisoners, which means that they are best placed to notice changes in behaviour that may be indicative of an underlying mental health problem. When this happens, prison officers can refer prisoners to healthcare teams for assessment. NOMS is responsible for ensuring that prison officers are equipped to help prisoners access the support they need, including mental health support.

3.15 It is more difficult for prison officers to notice changes in a prisoner's mental health when they are under pressure, because they have less time to spend with prisoners and may be working on detached duty with prisoners they know less well. The funding NOMS received from the Ministry of Justice fell by 13% between 2009-10 and 2016-17. During this period NOMS reduced operational staff numbers in public prisons by 30%, while the prison population remained broadly stable at between 83,852 and 87,080 over the same period (**Figure 7** overleaf).

3.16 In 2012, NOMS introduced a benchmarking exercise to improve efficiency across the prison estate, which reduced staff to prisoner ratios. This impact is compounded because many prisons have fewer staff than their benchmark allocation. On 31 December 2016, 80 of 83 public prisons had fewer staff than the benchmark and there was a total shortfall of 2,177 staff across these prisons. The prison with the largest shortfall was working with 78% of its intended number of staff (**Figure 8** on page 35).

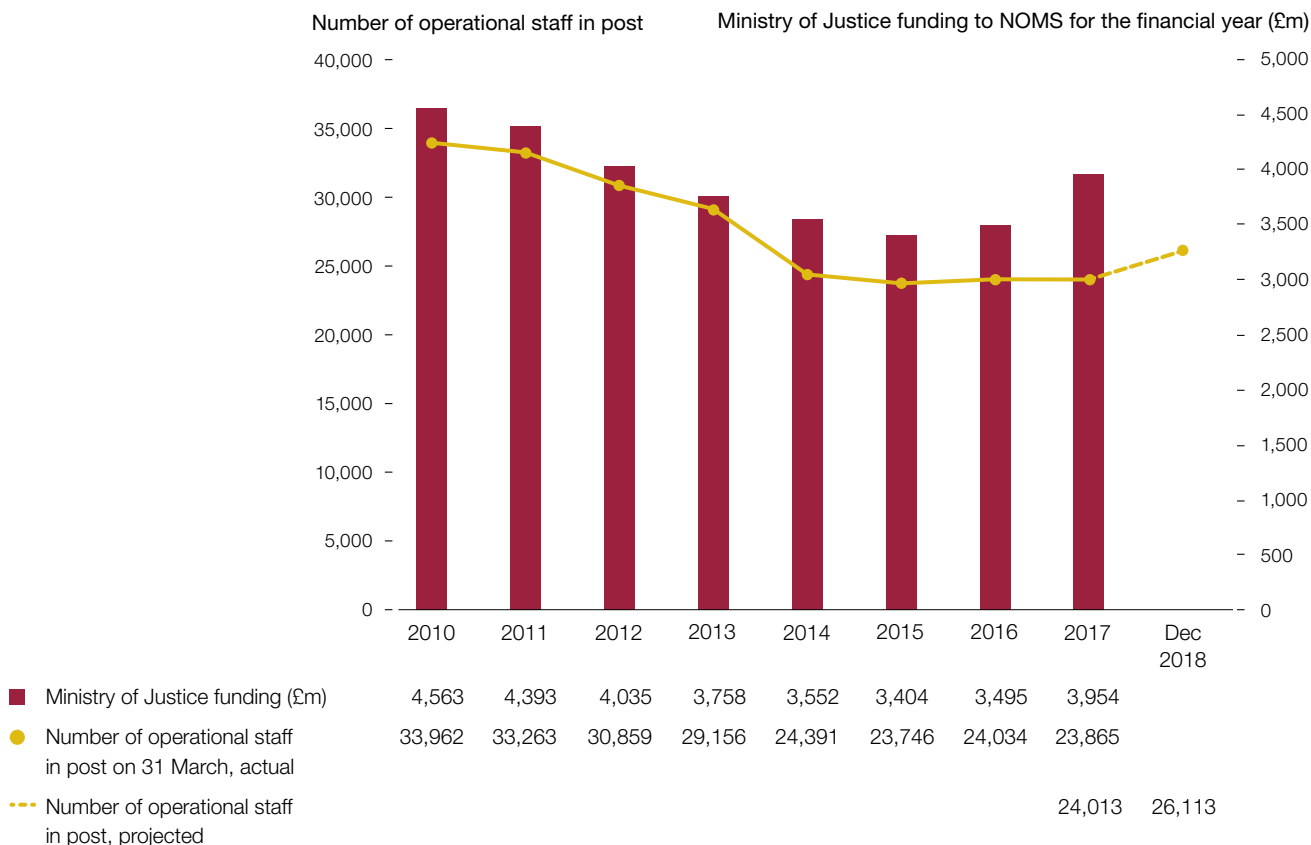
3.17 To address staff shortages, many prison officers work overtime, often in different wings, or on detached duty at other prisons. This makes it difficult for officers to form relationships with prisoners and notice changes in their mental health. NOMS has a personal officer scheme but it does not have resources to make this compulsory, and in two of the prisons we visited, staff told us there were not enough staff to have personal officers. The most recent prisoner surveys conducted by HM Inspectorate of Prisons found that 55% of prisoners reported having a personal officer, and 29% reported that a member of staff had checked see how they were getting on in the week before the survey.

⁸ National Offender Management Service, Adult Safeguarding in Prison, PSI 16/2015, 16 December 2015.

Figure 7

NOMS funding and operational staff in post from 2009-10 to 2016-17, with staff projections until the end of 2018

NOMS funding and operational staff numbers have declined since 2009-10, but staff numbers are expected to rise with the addition of 2,500 prison officers by the end of December 2018 compared with September 2016

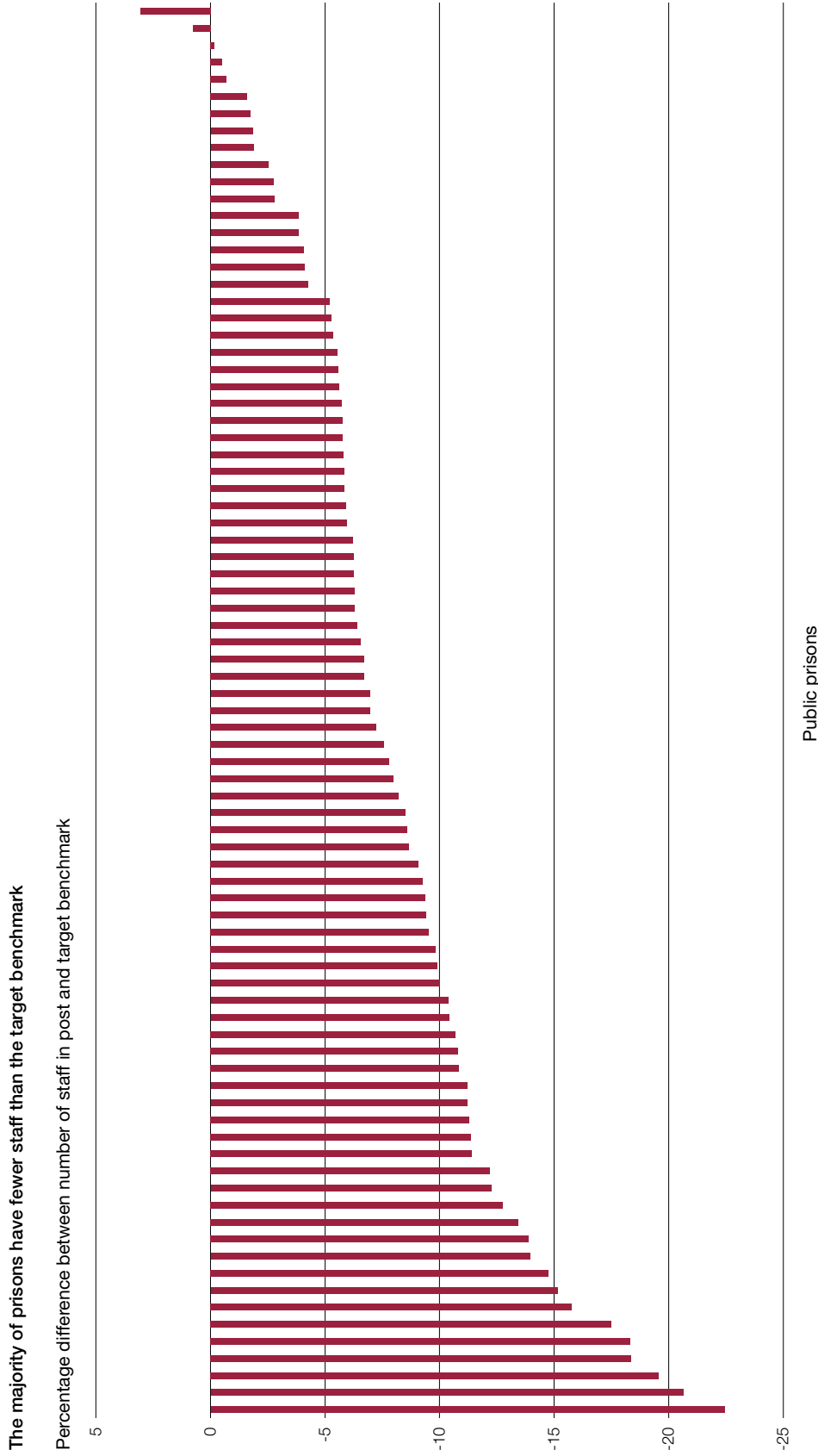


Notes

- 1 Funding shows the total net funding received by NOMS from the Ministry for each financial year ending in March. This includes funding for all of NOMS' activities, not just for prisons. Figures for prison service operational staff in post during the financial years from 2009-10 to 2016-17 are taken from the NOMS Workforce Statistics Bulletin, March 2017, available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/614643/noms-workforce-tables-march-2017.xlsx
- 2 Operational staff includes prison officers, supervising officers, custodial managers, operational managers and operational support grades, at public custodial centres including immigration removal centres.
- 3 There were 23,613 operational staff as of 30 September 2016. In the white paper for Prison Safety and Reform, the then Secretary of State announced that 400 additional operational staff were expected to be in post by March 2017, providing a March 2017 estimate of 24,013 officers. In total, 2,500 additional staff are expected to be in post by the end of 2018, providing a total of 26,113.
- 4 From 1 October 2016 policy responsibility for education and training provision for those subject to adult detention in England transferred from the Department for Education to the Ministry, to be overseen by NOMS. This funding was worth £143 million in 2015-16, almost all of which was committed to existing contracts which transferred, with employment and careers advice staff employed by contractors not by NOMS\HMPPS (they are not therefore included in the staff figures above). The funding is included in the funding provided to NOMS by the Ministry in 2016-17 in this figure.

Source: National Audit Office analysis of National Offender Management Service annual reports and accounts, and workforce data

Figure 8
Staff numbers in public prisons as a percentage of the target benchmark, by prison, December 2016



Notes

- 1 Figure shows data for all staff (full-time equivalent) in public adult prisons as at 31 December 2016.
- 2 Data on staff in post and benchmarking staffing levels are taken from the NOMS Workforce Statistics Bulletin, 31 December 2016, available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/592220/noms-workforce-statistics-tables-december-2016.xlsx

Source: National Audit Office analysis of NOMS workforce data

3.18 In November 2016 the then government published its white paper, *Prison safety and reform*, which set out plans to recruit an additional 2,500 prison officers, to help address the shortfall. The white paper stated that increasing the number of prison officers makes “staff more available to prisoners for regular contact and interaction”. The Ministry of Justice (the Ministry) is planning to reform its approach to offender management by introducing a new Key Worker Officer role. The Key Worker will provide enhanced support and challenge for offenders, and this combined with improved training (paragraph 3.22) offers scope to improve prison officers’ ability to identify when someone may need additional support with their mental health and well-being.

3.19 Not all prisoners referred to healthcare teams are assessed as meeting the threshold for treatment. In 69% of cases, governors responding to our survey thought some prisoners in their care should have been receiving treatment, but were not. In five of the prisons we visited, prison staff had referred prisoners to healthcare teams who did not think these prisoners were mentally unwell enough to receive treatment.

3.20 Some prisons have sought to build relationships between prison and health teams to ensure that staff can respond to prisoners’ needs. In one prison we visited, a member of the prison management team was responsible for overseeing prisoner health. The purpose of this role is to ensure there is a shared understanding between prison staff and healthcare staff about how to help prisoners in need.

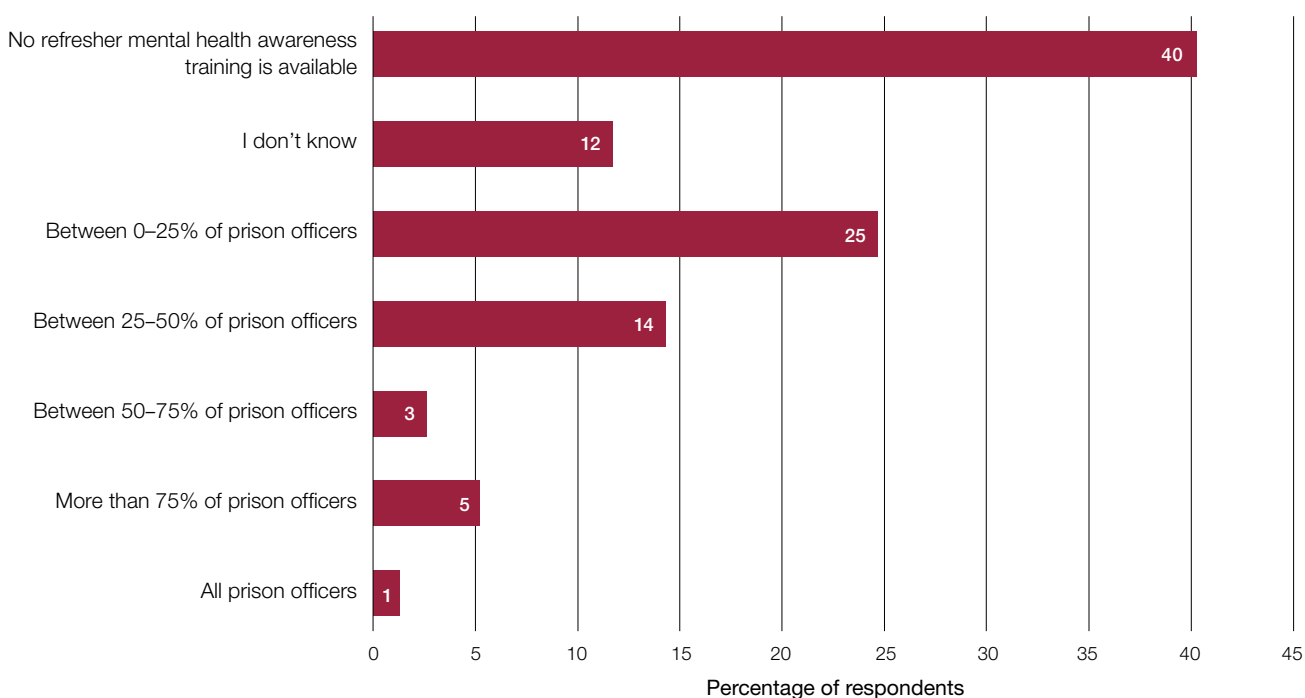
3.21 The training NOMS provides to prison officers to detect and manage prisoners with poor mental health has been inadequate. Prison officers receive basic training on mental health when they are hired, but our survey revealed that 40% of prisons did not provide any refresher mental health training (**Figure 9**). There is no official guidance on how frequently staff should receive mental health training, but they should be able to safeguard prisoners from neglect, which includes spotting mental health concerns (paragraph 3.14). Staff in seven of the prisons we visited told us that prison officers need more mental health awareness training to fulfil this duty. In four of these prisons, staff told us that where further training could be provided, there is often not enough capacity to release prison officers from their normal duties to attend it.

Figure 9

The proportion of prison officers that attended refresher mental health awareness training in prisons during the last three years

Forty per cent of prisons surveyed did not provide refresher mental health awareness training

Response given by the prison governor

**Notes**

- 1 We asked prison governors in October 2016 whether refresher mental health awareness training (or similar) was available for uniformed staff. For those who responded yes, we asked what proportion of staff have received refresher training in the last three years.
- 2 This considers refresher training only; 30% of prisons surveyed also provide induction training when a prison officer starts employment.

Source: National Audit Office analysis of survey responses provided by 77 prison governors

3.22 The November 2016 white paper, *Prison safety and reform*, set out the then government's plans to improve training available to front-line prison staff to enable them to provide better one-to-one support for prisoners. This could help prison staff to identify when there is a decline in prisoner mental health and make appropriate referrals to healthcare staff. The Ministry has developed a staff training programme which includes a 4-hour introduction to mental health, as well as topics including 'how to approach a conversation with a vulnerable person' and 'when and how to refer prisoners to other services'. From May 2017, all new prison officers undergo this training. HMPPS plans to deliver training to existing staff who have not received other relevant training. Not all training for existing staff will include all modules. Prison governors will decide what training to offer at each prison taking account, amongst other things, of their capacity to free up staff to attend it. In addition, NOMS and the Ministry have sought to raise awareness and share good practice on mental health and suicide and self-harm prevention through communications including guidance to prison staff, articles on the intranet, and events for senior staff. It is too early to evaluate the impact of this work.

Supporting mental health and well-being in prisons

Access to clinical care

3.23 Once a prisoner is identified as needing clinical care for their mental health, it is important that they can access appropriate healthcare services. It is not possible to know what proportion of requests for healthcare appointments are fulfilled or how long prisoners have to wait, because NHS England does not collect these data. Prisoners usually have to request an appointment with a paper application, but these are hard to track and need to be manually entered on the system. In some prisons, prisoners can request appointments through a kiosk on the wing, or through an in-cell computer screen that is registered directly on the system.

3.24 Once they receive appointments, prisoners do not always attend them, though neither NOMS nor NHS England collect data on missed mental healthcare appointments (paragraph 2.24). Our survey of healthcare managers found that prisoners did not attend 18% of planned secondary mental health appointments in September 2016. Some prisoners choose not to attend appointments, though the reasons for this are not well understood. When prisoners want to engage with healthcare services, the main reasons for not attending appointments are:

- the prison regime and availability of staff – in a regime where prisoners cannot move freely around the prison, there may not be enough prison officers to escort prisoners to the healthcare centre; and
- conflicting appointments – the appointment time may mean that prisoners miss work, the gym or other activities.

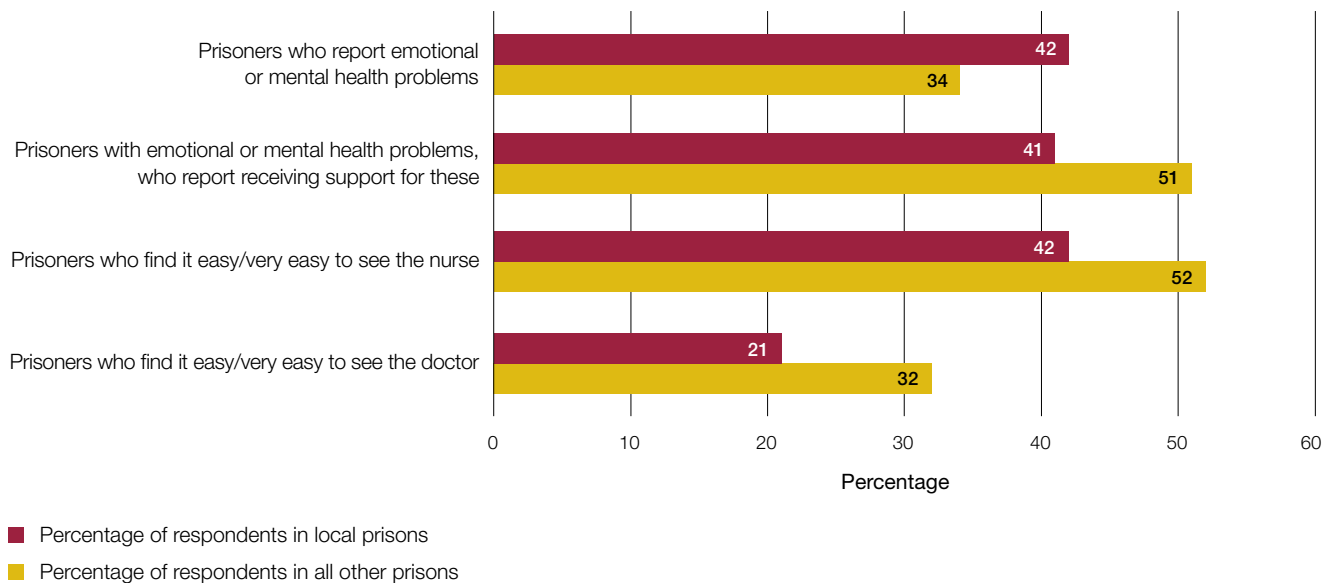
3.25 We saw some innovative approaches to increasing healthcare attendance rates. Some prisons enable prisoners to move between the wing and healthcare more freely in a managed way. HMP Parc had appointed a healthcare liaison officer, who worked with prisoners to encourage better attendance at healthcare appointments. NHS England has revised the health and justice indicators of performance from April 2017. Service providers should now report on the number of mental health appointments booked, attended and cancelled by patients, as well as waiting times for mental health appointments. Providers must also now report on the percentage of appointments which are cancelled due to prison operation issues, and those which are cancelled due to healthcare issues.

3.26 Local prisons have a higher turnover of prisoners, and find it harder to provide access to healthcare. An average local prison effectively replaces its entire population in around three months. The remaining prisons in the estate, which do not perform a local function, replace an average of 38% of the population over three months. Analysis of HM Inspectorate of Prisons' surveys shows that prisoners in local prisons were more likely to report emotional well-being or mental health problems, were less likely to receive support for these problems, and found it harder to access healthcare (**Figure 10**).

Figure 10

Prisoner responses to HM Inspectorate of Prisons' surveys

Prisoners in local prisons find it harder to access health services

**Notes**

- 1 National Audit Office and HM Inspectorate of Prisons analysis of 122 surveys for 34 local prisons and 88 prisons with other functions. Results of each survey are weighted to enable valid comparison between establishments.
- 2 The analysis covers the most recent inspectorate report published for each prison as at 7 November 2016.

Source: National Audit Office and HM Inspectorate of Prisons analysis of HM Inspectorate of Prison survey results

Variation in services

3.27 The services available to prisoners with mental health and well-being problems vary between prisons. Broadly, the services cover:

- non-clinical support for prisoners with mental health problems;
- clinical services for mental illnesses in prison; and
- transfer to secure hospital for acutely unwell prisoners.

Non-clinical support for prisoners

3.28 Prisons provide a number of services that support mental well-being, and the level of support varies between prisons. Prisons provide a chaplaincy service and most provide listener services (Listeners and Samaritans) and peer support. Some prisons provide self-help booklets on anxiety and depression, and some provide specific activities to promote mental health and well-being.

3.29 Some prisons provide enhanced regimes and environments which can have a positive effect on mental well-being. For example, some prisons have Psychologically Informed Planned Environments (PIPEs) to support continued progress by offenders who have received treatment for example for personality disorders or behavioural difficulties, and some have NOMS-accredited offender behaviour programmes for prisoners with long-standing emotional and relationship difficulties that link to their offending. The Centre for Mental Health found that stakeholders hold these services in high regard, and that it was advantageous for the whole prison (rather than individual wings) to be psychologically informed, reflecting that many prisoners have mental well-being issues. The Prison Estate Transformation Programme recognises that the built environment can have an impact on safety and well-being. The programme aims to replace some of the ageing estate with new modern prisons. It notes that factors such as access to outside space, appropriate lighting and reduced noise can increase self discipline, reduce stress and improve psychological outcomes.

3.30 Concerns about confidentiality can restrict healthcare teams from sharing information with prison staff on a prisoner's mental health needs, which makes it difficult for prison officers to respond. Staff at one prison told us that they addressed this issue by asking patients to consent for their information to be shared with prison staff.

Clinical care

3.31 The services that NHS England commissions vary between prisons. The health and justice partnership agreement states that NHS England will commission GP services and planned secondary services including secondary mental healthcare. In some prisons it commissions Improving Access to Psychological Therapies (IAPT) programmes which provide evidence-based treatments for people with anxiety and depression. Some providers are contracted to provide a 'stepped care model' which brings together a range of secondary mental health care, enabling the prisoner to step through stages of treatment. In March 2017 the National Institute for Health and Care Excellence (NICE) published guidelines on the mental health of adults in contact with the criminal justice system, including prisoners.

3.32 HM Inspectorate of Prisons and the Care Quality Commission find that secondary mental health services are generally good, but there are gaps in primary care, professional counselling and talking therapies across the estate. These services could help prisoners who are suffering with poor mental well-being, but who do not meet the threshold for secondary mental health treatment. When the Prisons and Probation Ombudsman reports on mental health services, he often finds failings in access to services, gaps in service, and failure to follow-up on mental health concerns.

3.33 There are examples of good practice across the estate. For example, one prison we visited has proposed a new approach to designing healthcare services that could have a positive impact on mental health and well-being: NHS England commissioners, the prison governor and Public Health England have put forward a business case to NOMS for a community health and well-being centre at a women's prison. The proposed facility would take a more holistic approach to mental health and well-being, and encourage women to take responsibility for their own health.

3.34 NOMS and NHS England have worked together to design an integrated approach to care for prisoners with serious personality disorders. The Offender Personality Disorder Pathway Programme, jointly commissioned by NHS England and NOMS provides personality disorder services for offenders who have a severe personality disorder and who pose a risk of harm to others. The pathway aims to provide joined-up and continuous care for offenders that follows them through sentencing, prison and into the community on release. It provides treatment within prisons, rather than in secure hospitals.

Transfer of prisoners to secure hospitals under the Mental Health Act

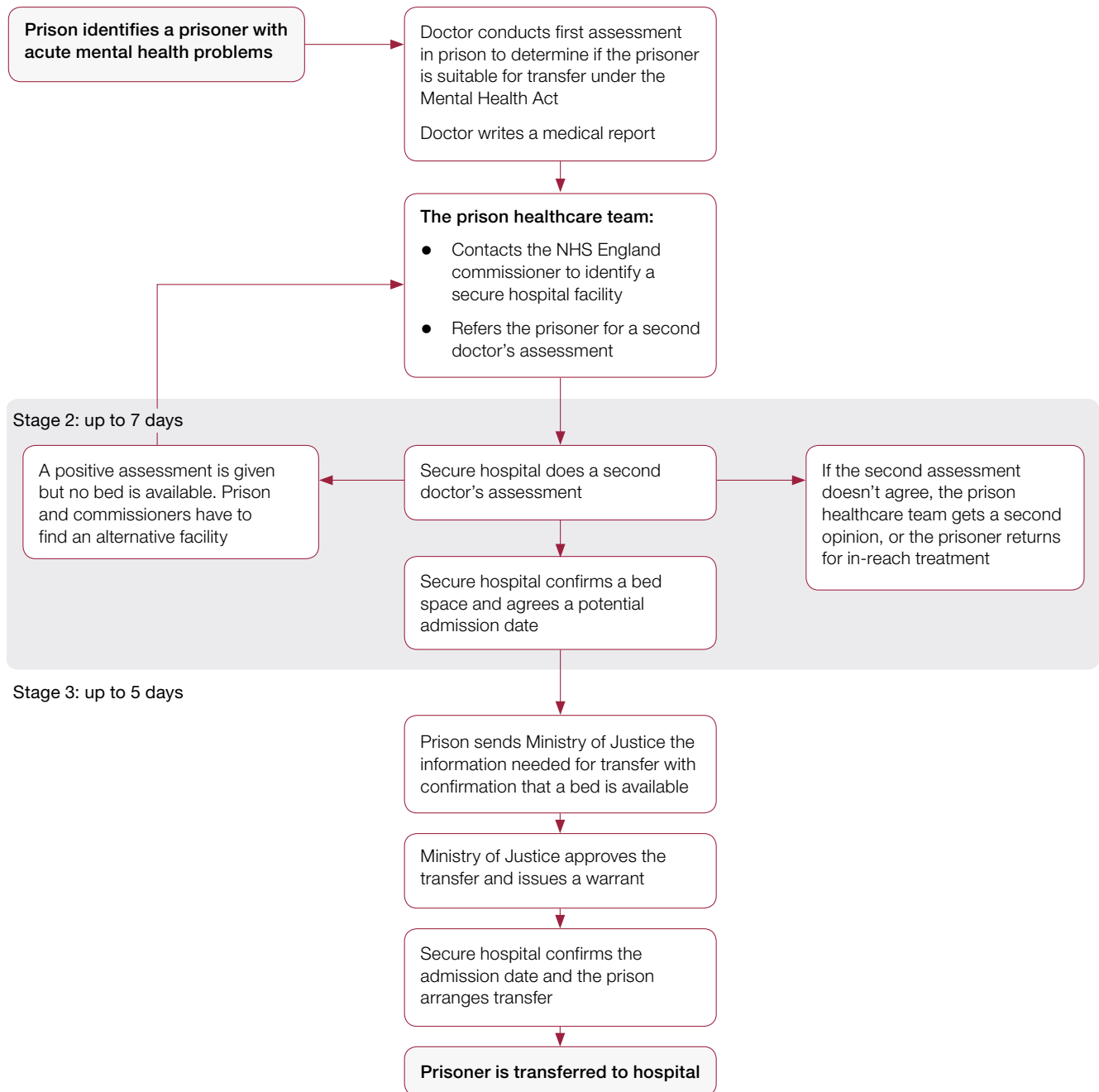
3.35 The Department of Health recommends that eligible prisoners with acute mental health problems should wait no more than 14 days to be admitted to a secure hospital, but most wait longer than this. If a prisoner is too unwell to be treated in prison, healthcare providers can initiate a transfer to a secure hospital which must be agreed by the Secretary of State for Justice. **Figure 11** overleaf shows the transfer process. In England, 1,081 mentally ill prisoners were transferred to secure hospitals in 2016-17. Approximately one third of prisoners were transferred within the Department of Health's recommended 14 day time frame and 7% waited more than 140 days (**Figure 12** on page 43). Delays can have a negative impact on the mental health and well-being of prisoners. Prisoners will often be kept in unsuitable conditions, for example those in prisons without inpatient facilities either wait on the wing, or in isolation in the segregation unit. The Chief Inspector of Prisons found that prisoners who had been identified as at risk were being held in segregation without adequate justification in half of prisons he reported on in 2015-16. Not all of these cases will relate to mental health.

Figure 11

The process to transfer a prisoner to a secure hospital

The Department of Health recommends that prisoners should transfer to secure hospitals within 14 days

Stage 1: within 2 days

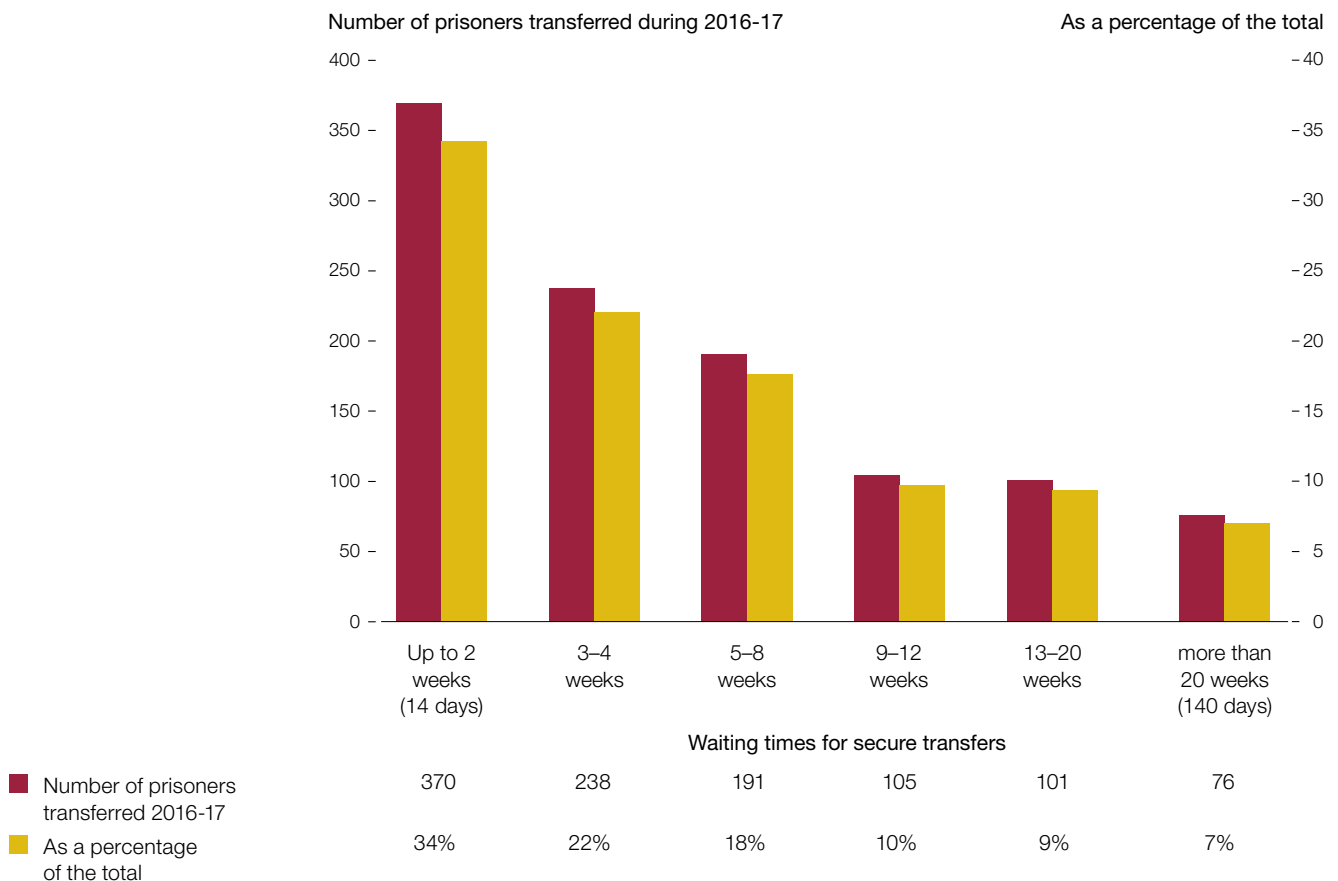


Source: Department of Health, Good Practice Procedure Guide, *The transfer and remission of adult prisoners under s47 and s48 of the Mental Health Act*, available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/215648/dh_125768.pdf

Figure 12

Transfer times to secure hospital during 2016-17

Sixty-six per cent of prisoners waited longer than the recommended 14 days to transfer from prison into a secure hospital

**Note**

1 Data covers transfers of prisoners in England.

Source: National Audit Office analysis of NHS England's health and justice indicators of performance data for 2016-17

3.36 To be eligible for transfer, prisoners must be assessed by two doctors, and the Secretary of State for Justice must agree to the transfer. The Secretary of State cannot agree a transfer until a hospital place with appropriate security is found and confirmed. The prison healthcare team is responsible for the prisoner's first assessment, and identifying a suitable hospital. The second assessment is carried out by a doctor from the hospital with a bed available. If the doctor decides the patient is not suitable for admittance, the process starts again with the prison health team trying to locate a bed and then secure an assessment. This process is complicated by the fact that the two elements of the process, prison healthcare and secure hospitals, are commissioned by different parts of NHS England and neither has overall responsibility for meeting the 14 day recommended time frame.

3.37 We heard of examples of patients receiving multiple assessments from different hospitals without being able to secure a bed, but there are no data to show how widespread this is. NHS England and NOMS does not routinely track how many people are awaiting transfer, or how long they have waited. In October 2016, NHS England and NOMS did a stock take of the number of prisoners awaiting transfer and found that prisoners had waited an average of 47 days for their first assessment, a further 36 days for their second assessment, and a further 13 days for the Secretary of State to sign the warrant for them to move to a secure hospital.

Continuity of care for prisoners

3.38 One of the objectives in the partnership agreement is that prisoners will receive continuity of care between prisons and on release. Continuity of care between prisons and on release is important because not all prisoners will be able to complete a course of treatment in their prison. If prisoners with mental health problems receive the support they need on release from prison, they may be better able to address underlying causes of offending, such as finding housing and employment.

Continuity between prisons

3.39 Prisoners transferring between prisons may experience disruption in their care. When a prisoner transfers between prisons, healthcare staff should review their previous medical history in the prison IT system, but this does not always happen and the data are not always complete (paragraph 2.22). Different prisons also provide different services, which means that some prisoners may have to change or stop treatment when they move prison. Some prison healthcare teams have different prescribing policies for medication, and some prisoners told us that they did not get the same medication after transfer.

Continuity between prison and the community

3.40 HM Inspectorate of Prisons has set out its expectations for the minimum standards of support to all prisoners leaving prison. This includes active links into services that can assist them with other needs, for example substance misuse and mental health services. Public Health England has worked with other stakeholders to produce, in January 2017, a framework to aid collaboration between different parts of the justice system. The framework aims to improve health outcomes, reduce health inequality, and reduce the risk of reoffending.⁹

3.41 NHS England's care programme approach supports continuity of care between healthcare in prison and the community, but only for prisoners with severe and enduring mental illness. NOMS commissions community rehabilitation companies to support and supervise most ex-prisoners on their release from prison. NHS England is responsible for their healthcare, which is provided through local clinical commissioning groups.

9 Revolving Doors Agency, Public Health England, Home Office: *Rebalancing Act*, January 2017.

3.42 It can be difficult to provide continuity of mental healthcare between prison and the community for a number of reasons:

- **Distance from home**

When people are released from a prison a long way from their home, it can be more difficult for prison healthcare and community rehabilitation company staff to establish links with local health services. NOMS is restructuring the prison estate in part to ensure that in future, more people are released closer to where they live.

- **Information-sharing**

Community rehabilitation companies are not routinely told if an individual who has just been released from prison has mental health problems. This makes it difficult for them to support people who have been released from prison. For example when people with mental health problems leave prison they are eligible for some supported housing schemes, but if the community rehabilitation company is unaware of their health problems then it cannot arrange this.

- **Lack of notice**

Remand prisoners are usually in custody for short or unpredictable periods of time. They may appear at court at a hearing and be released from prison the same day, which makes it hard to plan for release.

- **Inability to prepare for release**

People leaving prison can find it difficult to register with a GP or access primary services on release. NHS England is currently implementing a GP registration scheme which should enable staff to refer a prisoner to a GP and provide a probation office address as a substitute if a prisoner's address is not confirmed. We have seen some good examples of healthcare teams working with community GP practices to ensure continuity of care, but this is easier in prisons with a more stable population.

- **Availability of services in the community**

In February 2016, the Mental Health Taskforce concluded that "... many people living with mental health problems struggle to get the right help at the right time, and evidence-based care is significantly underfunded". This makes it difficult for people who have left prison to access the services that they need.

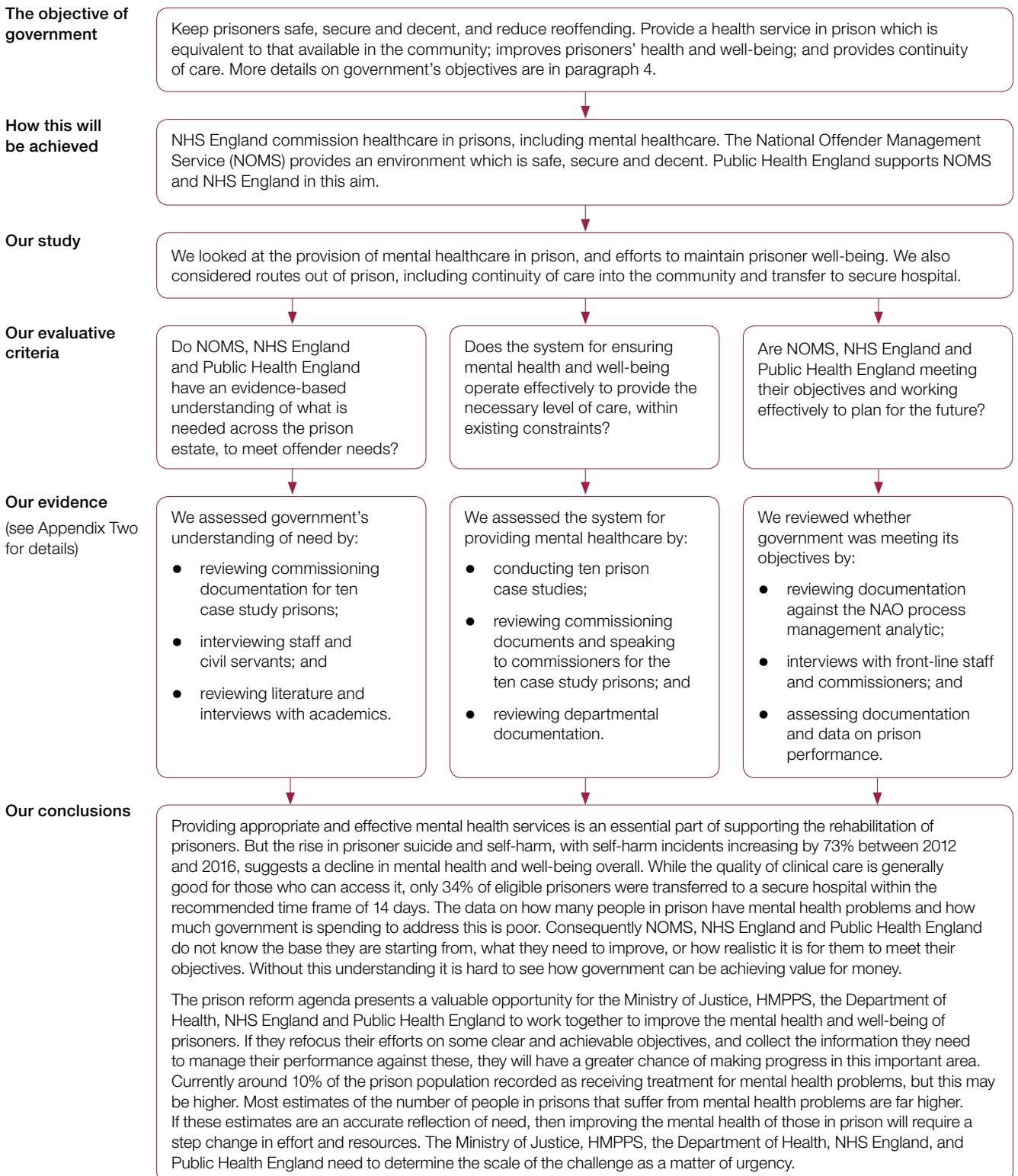
3.43 There is currently no routine follow-up to assess whether people who have received mental healthcare in prison continue to receive care on release. Community rehabilitation companies are assessed against a number of measures for successful rehabilitation, but these do not include continuity of healthcare.

Appendix One

Our audit approach

Figure 13

Our audit approach



Appendix Two

Our evidence base

1 Our conclusions on whether the National Offender Management Service, NHS England and Public Health England are well placed to deliver value for money for prisoners with mental health and well-being problems were reached following our analysis of evidence collected between May 2016 and March 2017.

Our approach is outlined in Appendix One.

2 We assessed whether government has an evidenced-based understanding of the level of mental health need across the prison estate, to plan overall investment and provision in individual prisons:

- we reviewed health needs assessments for nine case study prisons to understand if need was assessed effectively;
- we conducted semi-structured interviews with NHS England commissioners to understand if they were basing their commissioning decisions on a clear understanding of need;
- we conducted semi-structured interviews with healthcare managers and staff in ten case study prisons to understand if the provision within the prison reflected the perceived level of need;
- we conducted a survey of prison governors and healthcare managers. Our survey was sent to the governor or director of every prison in England and Wales, and the healthcare managers of all prisons in England;
- we reviewed academic literature and interviewed academics to assess whether there were national level data available, and to take a view on the usefulness of existing data; and
- we interviewed civil servants, to understand if they linked their decisions to a clear understanding of the level of need.

3 We estimated spend on health services in prisons in 2016-17. We did this by compiling a list of all contracts that include an element of healthcare in prisons and then adding up the amount spent on each of them in 2016-17. Some health service contracts also include services for other facilities, for example Young Offender Institutions. NHS England provided a best estimate of the share of costs spent in adult prisons. It is not possible to separate the cost of mental and physical healthcare. Our best estimate therefore includes all health services for the adult prison estate.

4 We assessed the system for providing healthcare:

- we used the National Audit Office commissioning analytic, as a framework to understand whether the commissioning process reflected best practice;
- we conducted case studies of ten prisons. We visited the prisons and interviewed prisoners, prison staff, healthcare staff, governors and healthcare managers. We walked around the prisons, speaking to staff informally and observing prison processes, such as the reception process;
- We reviewed commissioning documents for the ten case study prisons, including the contracts, health needs assessments, tender documentation and performance data; and
- We reviewed departmental documentation covering the provision of healthcare, including the national tender specifications and partnership agreement.

5 We reviewed whether government is meeting its objectives:

- we used the National Audit Office process management analytic tool to assess whether the objectives were workable, and whether there was a clear link between the organisational strategy and expectations of the services which are delivered on the ground;
- we reviewed the objectives outlined in the Partnership Agreement;
- we conducted semi-structured interviews with commissioners, healthcare managers and healthcare staff to check if they understood the national objectives, their role in achieving them, and how they measured progress and improved performance; and
- we reviewed performance information to understand if the information collected linked to the national objectives.

6 We sought to establish how well individual prisons were performing against a variety of metrics:

- we conducted a rapid qualitative review of the most recent HM Inspectorate of prisons reports for every prison in England and Wales at October 2016;
- we used analysis of HM Inspectorate of Prisons survey results for every prison in England and Wales to October 2016. HM Inspectorate of Prisons survey a representative sample of the population of each prison establishment just prior to the inspection. We used the latest survey data for each establishment at November 2016. Most data was published in 2015 and 2016, but some surveys were older. The oldest survey in the data set was published in December 2012. We looked at surveys of 34 local prisons and 88 other establishments which included training prisons, open prisons, high secure, and establishments holding women or young adults. There was more than one survey for five of the prisons, covering multiple functions. After initial analysis by the NAO HM Inspectorate of Prisons weighted and tested the results. The data presented in the report has been weighted by HM Inspectorate of Prisons to enable valid statistical comparison between establishments, or across the estate as a whole;
- we reviewed Prison and Probation Ombudsman reports published in the 12 months between November 2015 and November 2016; and
- we reviewed data held by the Ministry of Justice and NOMS.

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