

Adult Social Care in Prisons: A Strategic Framework

Health Services Management Centre

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EXECUTIVE SUMMARY

Research findings

This report describes the findings from a research project undertaken between December 2006 and June 2007 to identify the nature and extent of social care provision in English prisons. With a focus on older people, a survey of all prisons, prison site visits and stakeholder interviews have all contributed to the recommendations outlined for a strategic framework for adult social care in English prisons.

The prison sector is facing a major challenge in managing the increasing level of social care need due to the rising number of prisoners and more specifically, older prisoners. Some of the challenges they face reflect those in social care within the community. Our research demonstrates that despite a real enthusiasm and commitment from the workforce prisons are struggling to meet these challenges. Rather than being systematically addressed social care issues, as they relate to older people and those with disabilities, appear to be the province of committed individuals and not embedded in the mainstream.

Many prisoners with social care needs are not receiving the necessary level of support they require whilst in custody or on release. Equally, some are not receiving the same level of assessment and provision of care they would receive within the community.

The key factors for this appear to be:

- A lack of explicit policy and guidance that supports effective commissioning resulting in confusion across the system as to who is responsible for what.
- Poor level of engagement between prisons and local agencies
- A lack of funding directed towards the provision of social care in prisons
- Poor systems and procedures to support assessment and continuity of care
- Variable adaptation of the physical infrastructure to accommodate those with physical disability
- Inadequate training across the system to support effective assessment and service provision

A national strategic approach is required to improve the quality and consistency of care across the country. The contribution of social care to the

reducing re-offending agenda should not be ignored. Low levels of care in prisons that do not promote or maximise the potential in prisoners for independency and wellbeing create additional costs further along the offender pathway and can therefore be argued as a false economy.

Recommendation for change

The direction of travel towards jointly commissioned services for a community population taking into account the needs of the most vulnerable is clear from the recent White Paper and Commissioning Framework. In achieving, at minimum, equivalence between prisoners and those living in the community with social care needs that direction of travel needs to be followed.

Our full list of recommendations can be found in Appendix Two of this report. They are aimed at improving care for the individual prisoner and for creating some cost-efficiencies within the system that will enable existing resources to be used more effectively. They aim to highlight the areas where national policy needs to be clarified or developed and some of the actions that are needed in order to ensure that prisoners' social care need can be properly addressed, respecting the diverse prison population and the need to ensure decency of treatment.

Our key recommendations are:

- Establishing a governance framework that clarifies accountability for the quality and delivery of social care
- Ensuring policy and guidance explicitly supports effective commissioning of social care in prisons
- Making the PCT lead commissioner for both prison health and personal social care
- Establishing minimum standards of care in prison
- Workforce improvement, through a training programme, multi agency working, peer support models and a minimum specification of the DLO role
- Consideration given to developing regional teams (either actual or virtual) with a responsibility of supporting the prison sector in specialist assessment and co-ordination and providing appropriate interventions.

We believe these and our more detailed recommendations need to inform any future strategy. The strategy also needs to be supported by corresponding investment plans that acknowledge some of the cost-efficiencies that can be made within the system as well as the rising population of older prisoners with social care needs.

1. Introduction

The Health Services Management Centre (HSMC) was commissioned by CSIP West Midlands to develop a strategic framework for adult social care in prisons with a focus on older prisoners. One of the key drivers for this work was the report by Her Majesty's Inspectorate of Prisons (HMIP) 'No problems – old and quiet'¹ that found whilst there was some evidence of good practice within the prison sector there was also considerable scope for improvement. In addition, the report recommended that

'The National Offender Management Service, in conjunction with the Department of Health, should develop a national strategy for older and less able prisoners that conforms to the requirements of the Disability Discrimination Act and the National Service Framework for older people'. (pg 53)

Recent policy and strategy in the criminal justice field has generally focused on persistent youth offending and to a lesser extent issues relating to women prisoners. Given the increasing numbers of prisoners aged 60 and over,^{2,3} the increase in longer sentences,⁴ and the need to achieve cost-efficiencies within all care sectors it is timely to review and develop the extent to which the social care needs of prisoners are met. A social care strategy, and the development of a more equitable and coherent response to prisoners' social care needs, will mirror the developments in prison healthcare that have followed the transfer of responsibility from the Prison Service to Primary Care Trusts (PCTs).

Government reports have emphasized that, in a prison context, 'social care support is required' and underline the importance of prisoners receiving the same range of services as the wider community⁵. However, there remains little clarity regarding who should be providing routine social care to older adult prisoners. This principle of 'equivalence' is often used in describing the level of care that prisons should be aspiring to. However, as outlined in the recent Commissioning Framework⁶ prisoners will need special arrangements for commissioning and provision of care. The eligibility criteria for care that underpins commissioning plans for social care for offenders need to recognise the contribution of social care for vulnerable adults in reducing re-offending and the cost-efficiencies that this brings across the health and social care system

The prison sector is going through a period of reform and this report is written within the context of the implementation of the Offender Management Model. When fully implemented the Model should address, for some categories of prisoners, many of the issues that relate to assessment and continuity of care across the offender pathway. However, there still remain some significant issues that need to be addressed if all prisoners with specific social care needs are to receive the appropriate level and standard of care.

This report also acknowledges that no two prisons are alike due to differences in prison culture, the role of the prison, the demographics of the prison population, the age of the facility and the nature of the leadership. Therefore, a future strategy has to reflect these differences; especially the challenge of bringing about change when there will always be competing pressures for resources. In general we have not referred explicitly to the different categories of prisons but rather have highlighted the different roles and responsibilities that will particularly affect the provision for social care needs notably the need for assessments at reception and resettlement, and the impact of the prisoner's length of stay.

This report builds on a number of previous reports published recently relating to social care in prisons. In view of time and resource constraints HSMC has attempted not to duplicate work already undertaken but to add to the body of knowledge and issues that have been identified previously. These reports include:

- HMIP *'No problems, old and quiet'*¹
- Prison Reform Trust: *'No-one knows'*⁷
- NOMS; *'Reducing Re-offending Delivery Plan'*⁸
- CSIP: *'Pathways to care for Older Offenders'*⁹
- CSIP: *'Older and disabled prisoners in the South West'*¹⁰

The first two of those reports make comprehensive recommendations for the improvement of social care across the offender pathway but our research identified that none of the recommendations have yet been addressed in a systematic and universal manner. What is clearly absent is a cohesive national strategic framework for implementing change. The lack of a national strategy has led to an ad hoc development of local services dependent on the enthusiasm and skills of prison staff and practitioners within individual prisons and on the priorities set by each Governor.

Likewise due to resource constraints this report does not attempt to quantify need or include any of the economic modelling that would indicate where the greatest cost-efficiencies could be realised. This latter in particular is a much larger piece of work, in part due to the lack of sophisticated mechanisms within the sector at present to identify costs related to the provision of social care. What is clear from this research is that the rising level of social care need in prisons will need some significant funding and the source of that funding is unclear. Equally, some of the change required to improve care does not rely on additional funding but a change in the priority afforded to social care needs and in existing working practice.

We set out in this report the policy context of social care within prisons. We then set out our findings and the realistic, but necessary changes that need to be made if prisoners are to receive an appropriate level of care and prison staff are to receive the necessary support they require to provide it. We have included some relevant case studies that arose from our research but

acknowledge there were many more and these have already been identified within the literature.

We make a list of recommendations at the end of the report. They are broadly categorised into strategic recommendations and those that relate to the operational function within prisons. However, we are conscious that some will span the two.

This report has been written for an audience with prior knowledge of the criminal justice system. Therefore certain assumptions have been made about prior knowledge in this topic area.

1.1 Project Boundaries

A guiding principle that informed this project was that any strategy for care should focus on the *need itself* rather than the *origin* of need. This approach is increasingly being adopted by health and social care agencies outside prisons in that it does not 'segment' care by disease or by care group but by level and type of need required. As such, aside from the given focus on older people, we do not make reference specifically to the traditional care groups or categories such as gender, prisoners with a mental health problem, learning difficulty or ethnic background but by need only. However, where it is appropriate to make this distinction we have.

Whilst our focus has been predominantly the prison environment, we have attempted to ensure that this is within the context of the complete offender pathway and specifically the resettlement of prisoners back into the community. We acknowledge the limitations of focusing on one element of the pathway only and have attempted to make connections to other areas of development across the pathway such as the development of the Offender Management Model.

This report covers the prison sector (public and private prisons) in England. It excludes prisons in Wales.

1.2 Working definition of social care

As Dame Denise Platt states in her recent review¹¹ there is no generally agreed definition of the term 'social care' either within the service or beyond. She refers to the White Paper "Our health, our care our say" as having a broad definition of social care as:

"the wide range of services designed to support people to maintain their independence, enable them to play a fuller part in society, protect them in vulnerable situations and manage complex relationships."
(para. 1.29)¹²

As a contrast Platt refers to the public understanding of social care which concentrates solely on the provision of practical services. For example she refers to the BBC definition of social care as follows:

“.....it covers a wide range of services provided by local authorities and the independent sector to elderly people either in their own homes or in a care home. It also covers day centres, which help people with daily living. Services like help with washing, dressing, feeding or assistance in going to the toilet are also included, as are meals-on-wheels and home-help for people with disabilities.” (Pg 4)

It can be argued that the key elements of what is meant by social care (which are equally relevant in prisons as in the wider community) are about helping people through practical support to live ordinary lives – with an emphasis on the person who is being supported taking the lead (so far as is practical) in how this support should be provided. It is also clear from this definition that social care needs are different for each individual and have to be seen alongside and inseparable from their other major life-defining factors: health, accommodation, income, education and employment/activity.

We have used these elements in defining social care and the guiding principles to shape our proposals for the strategy: based on individuals' needs and promoting their independence rather than dependency; being linked with other services and support rather than standing alone; having a specific relevance for the prison environment generally and for the different roles and cultures of different prisons.

2. Methodology

Our approach to delivering the project had three distinct elements:

1. A literature review of the nature of social care in prisons to inform our approach
2. Field work research, including a survey of current practice in prisons, site visits and discussions with prison staff, and the views of other stakeholders
3. Testing our findings with a steering group including experts from the field of prison and social care.

2.1 Literature review

The full literature review is attached to this report. However, in summary a number of themes emerged from the literature that have informed the project.

1. There is strong evidence that there is an increasingly older prisoner population (with gender and ethnicity key variables) but a weak research base on which to develop strategy
2. Social care needs are linked to age, health, isolation, mental health, learning disability and substance misuse issues. Most prisoners needing social care support have other complex needs
3. Those complex needs require a collaborative response from the different agencies involved
4. The lack of collaboration and systematic care contributes to a deterioration of prisoners upon release
5. Prison facilities generally fail to meet social care needs
6. There is lack of clarity as to who is responsible for funding and delivery of adult social care to prisoners
7. There are examples of good practice but no national strategy
8. Arrangements between prisons and social care agencies are under-developed
9. Referral protocols and information sharing is patchy and variable in quality

2.2 Fieldwork research

Prison Survey

A full analysis of the survey is attached to this report.

A questionnaire was sent to 139 prisons (these included prisons in Wales) requesting information on various aspects of current practice. The response rate was 55% with all prison categories being fairly represented. Overall 81 responses were returned which corresponded with 77 establishments

The questionnaire covered a number of themes informed by issues identified from *Old and Quiet* and *No-one Knows*^{1,7}.

- Roles and responsibilities
- Leadership on social care
- Reception, induction and sentence planning
- The prison regime
- Resettlement and re-integration
- Identifying areas of good practice
- Priorities for change

The qualitative and quantitative data from the survey was used to inform the structure of field site interviews and the recommendations in this report.

2.3 Field work interviews.

To add to the richness of the survey results, the project team undertook a number of prison visits.

Prison Visits:

HMP Moreton Hall	HMP Norwich	HMP Kingston
HMP Dovegate	HMP Wymott	HMP Whitemoor
HMP Nottingham	HMP Leicester	HMP Channings Wood
HMP Risley	HMP Drake Hall	HMP Wakefield
HMP Holloway		

These sites were chosen to ensure fair representation of prison type and also to explore further prisons identified as delivering some aspect of good practice. Prison staff were interviewed and observations were made of the prison facilities where appropriate. A group of older prisoners was also interviewed at one site.

In addition to prison visits, the research team conducted interviews with stakeholder agencies to gain a broad perspective on the issues raised from the survey and from the literature. These included:

- PCT Commissioners
- Sainsbury's Centre for Mental Health
- Foundation for People with Learning Disabilities
- NACRO
- National Offender Management Service
- Disability Liaison Officers (DLOs)
- Voluntary Sector Organisations including Age Concern
- Local Authorities (LAs)
- Prison Reform Trust
- Probation Service
- Her Majesty's Inspectorate of Prisons

2.4 Project reference group

A group of experts related to the field of prison and social care was established to act as a reference group for the project team. Alongside assistance in shaping the research, the group participated in a workshop to test out the emerging themes and recommendations drawn the literature review, survey and interviews. The reference group are listed in Appendix One.

3. Policy and Guidance

The absence of a national policy or strategic response to the issue of adult prisoners and social care has knock-on effects for professionals and practitioners who operate largely without explicit guidance and standards. This section identifies extant guidance and policy with relevance to provision of social care support to prisoners, firstly looking at population-wide directives before considering prison sector-specific requirements.

3.1 Legislation and policy relating to the population in general, including prisoners

We have identified the major policy strands that should underpin the strategy to meet the social care needs of prisoner and specifically older prisoners and those with disabilities. The extent to which policy has been implemented is extremely variable across the sector ranging from some prisons that have made a number of adaptations to practice and infrastructure to those that have implemented very little.

3.1.1 *The National Health Service and Community Care Act 1990*¹³

This Act is the key legislation for community care and aimed to help support people to remain within their local community and avoid unnecessary residential care. The Act had both a population and individual focus. It required LAs to produce community care plans for their local community. Section 47 of the Act also made it a duty for LAs to assess '*any person for whom they may provide or arrange for the provision of community care services*'. The results of the assessment determine whether any care should be provided but any identified need is expected to be met in accordance with the LAs eligibility criteria and regardless of resources.

3.1.2 *The Disability Discrimination Act 1995*¹⁴

The Act (the DDA) requires service providers to make "reasonable adjustments" for disabled people. A service provider is required to take reasonable steps to change a practice, policy or procedure which makes it impossible or unreasonably difficult for disabled people to make use of its services; and to provide an auxiliary aid or service if it would enable (or make it easier for) disabled people to make use of its services. In addition, where a physical feature makes it impossible or unreasonably difficult for disabled people to make use of services, a service provider has to take reasonable steps to remove the feature; or alter it so that it no longer has that effect; or provide a reasonable means of avoiding it or provide a reasonable alternative method of making the service available.

3.1.3 National Service Framework for Mental Health¹⁵

The National Service Framework for Mental Health set national standards and defined service models for promoting mental health and treating mental illness in the five following areas: mental health promotion; primary care and access to services; effective services for people with severe mental illness; caring about carers; and preventing suicide. It aimed to ensure safe, sound and supportive services. The standard for preventing suicide included specific reference to ensuring support to local prison staff in preventing suicides among prisoners. The NSF noted that prisoners in England and Wales had very high rates of mental illness, substance misuse and personality disorder, and that specialist mental health services should increasingly provide in-reach services.

3.1.4 The National Service Framework for Older People¹⁶

This set new standards and models of care across health and social care. It was followed in 2006 by further guidance on implementation that developed ten programmes under three key themes of Dignity in Care, Joined-Up Care, and Healthy Ageing. In addition five implementation levers were identified: leadership; regulation and inspection; PSA targets; commissioning; CSIP support for service improvement and development.

3.1.5 Valuing People: A New Strategy for Learning Disability for the 21st Century¹⁷

This was the first white paper on learning disability for thirty years and set out an ambitious and challenging programme of action for improving services. The proposals are based on four key principles: civil rights, independence, choice and inclusion. Valuing People takes a life-long approach, beginning with an integrated approach to services for disabled children and their families and then providing new opportunities for a full and purposeful adult life. Its proposals are intended to result in improvements in education, social services, health, employment, housing and support for people with learning disabilities and their families and carers.

3.1.6 Our Health, Our Care, Our Say¹²

The White Paper sets out clearly in Chapter 4 the requirement for PCTs and LAs to work with other partners to ensure the social care needs of offenders are addressed. Whilst the explicit statutory responsibility for PCTs in commissioning health services to prisons within their geographical area is clear, the commissioning of social care is less clear.

However, the direction of travel towards jointly commissioned services for a community population is very clear. In achieving, at minimum, equivalence between prisoners and those living in the community with social care needs

the direction of travel set out in the White Paper for health and social care needs to be followed.

3.1.7 Commissioning framework for Health and Wellbeing⁶

In Chapter 3, the framework specifically directs the NHS and LAs to include prisons in their strategic needs assessments. More importantly, it identifies that this group is likely to need special arrangements and that this will require them to work in partnership with other stakeholders such as the police, the courts and offender management services.

3.1.8 Outcomes Framework for Performance Assessment of Adult Social Care¹⁸

The proposed outcomes for adult social care services have received favourable responses during the consultation period. It is useful to regard these as guiding principles when considering the aims of introducing social care support to the prison environment. The outcomes are appropriate to apply to prisoners and are based upon the general notion of well being rather than a narrower concept of personal social service. They involve: improved health and emotional well being; improved quality of life; making a positive contribution; choice and control; freedom from discrimination; economic well being; and personal dignity. Most of these factors are already well established within the overall regime of care and control of prisoners, and none of them could be seen as in any sense inappropriate.

3.2 Policies and requirements relating to the offender and prison population specifically

3.2.1 NOMS Reducing Re-Offending Action Plan⁸

The plan focuses on those factors which lead to re-offending and as such play an important part in the social care of offenders whilst in custody and on resettlement. The Plan identifies the partnership arrangements at all levels to ensure a multi-agency approach and accountability for the seven pathways out of re-offending. These pathways are the current framework for the assessment, commissioning and delivery of services for offenders but are, of course, primarily focused on public protection and reducing re-offending rather than personal social need.

3.2.2 PSOs and PSIs

PSO 2855¹⁹ deals with compliance with the DDA. Amongst other recommendations is the appointment of a member of staff to take the lead on considering the needs of older prisoners and a number of measures to support prisoners with learning difficulties. It specifies that:

It is good practice to contact local Social Services Departments in advance of release to identify what local older people services could be accessed. Age Concern ... can advise on issues affecting older people'

In addition to this, performance standards and an accompanying PSO²⁰ has been issued which deal with resettlement. This latter sets out requirements of the resettlement process for which the prison sector is responsible, and deals with expected liaison with other agencies. The need for a sensitive approach to sub-groups such as the older prisoner population is emphasized, including the importance of comprehensive assessment:

Some prisoners with disabilities, or who are elderly, may need to have a community care assessment by the Social Services Department for the area in which they will be living on release. Anyone working with a prisoner might identify such a need, which must be brought to the attention of the health care centre or the National Probation Service as it is their responsibility to work together to ensure that such referrals to Social Services Departments are made²⁰.

Social Services agencies are included as possible statutory bodies with whom the prison sector might liaise and as part of multidisciplinary Community Mental Health Teams²¹

More recently PSO 3050²² deals with managing continuity of healthcare for prisoners, focussing on entry into custody, leaving and re-entering prison for court visits, transfer between prisons and discharge from custody. It states that throughout this process information regarding prisoners' needs should be transferred and social care agencies should be included in case conferences. The protocol for making referrals for Social Services community care assessments is restated: these should go through the 'Health Care Centre' or the National Probation Service.

A specific PSO on working with voluntary and community-based agencies emphasises the importance of the latter in resettlement – notably of foreign nationals²³. It acknowledges the *ad hoc* and localised nature of many current relationships between prisons and non-statutory agencies and the need to formalise these and to involve prisons in broader partnership structures. This has been supplemented with good practice guidance for prisons²⁴ and guidance on involving volunteers²⁵.

Guidance on treatment of prisoners has been produced in relation to those receiving drug treatment and/or those at risk of self-harm²⁶. However, this makes no reference to the role of social care agencies in either support for prisoners or resettlement.

PSI 3500²⁷ brought the Older People's NSF to the attention of prisons in 2001, and emphasized the importance of liaison with social services at the point of resettlement. It also encouraged prisons to develop partnerships with local health services and local social services:

“Prisons with their duty to provide prisoners with access to the same range and quality of services as the general public receives need to develop their working relationship with local health services, social services and housing agencies. The aim should be to ensure that older prisoners with continuing health and social care needs get full access to all the services they need from all the agencies that have a duty to provide them.”

This quotation highlights the lack of clarity about where exactly the duty for addressing prisoner social care needs lies, with its reference both the duty of care of prisons to deliver “equivalence”, and its reference to “**all** the agencies that have a duty”, [our emphasis]

3.2.3 Social Care and Mental Health of Offenders

We have not highlighted specific mental health issues from this report as this is such a major issue in its own right within prisons. Prisoners with severe and enduring mental health problems may already benefit from social care inputs from the Mental Health In-reach Teams which are commissioned via Health. However, many of the support needs of prisoners with mental health issues remain similar to those of other prisoners with different histories. It is important to draw attention to the social exclusion aspect of mental illness. The Social Exclusion Unit report²⁸ on reducing re-offending by ex-prisoners set out the scale of the problem, examined the causes and made recommendations about ways to make the system work better. The report recommended a series of actions to improve the life chances of ex-prisoners: including closer working between the statutory agencies involved with health, education, and drugs.

4. Regulatory and performance management context

The Prison Service defines Key Performance Targets (KPTs) and Key Performance Indicators (KPIs) against which prisons must report, as set out in PSO 7100²⁹. There are no targets or indicators which address social care issues as such, although one recent target does address prisoner race equality issues as one aspect of diversity; none of the other facets of diversity are singled out.

The NOMS National Commissioning Framework for 07/08³⁰ in its section on Measuring Achievement describes a move towards a more locally agreed approach for many areas of performance, so that resources can be targeted towards areas of local need. While the measures set out in this document or its attendant Business Plan link closely to the KPTs and KPIs described above, and do not concern disability or social care dimensions as such, the Framework states that performance information will need to be analysed in

terms of race and ethnicity, gender, disabilities and age in order that the performance gaps can be understood more fully. A more comprehensive and outcome-focussed set of measures is to be developed which will align more closely with the NOMS priorities (one of which is Equality and Diversity). This may be a fruitful time to consider how other dimensions of diversity might helpfully be included within the performance management of prisons.

HM Inspectorate of Prisons for England and Wales undertakes an independent inspection of every prison at least once in every five years. Inspections are against a set of criteria, as set out in its Expectations guide³¹. The current version of Expectations has been informed by thematic reviews undertaken by the Inspectorate, most notable here being No Problems - Old and Quiet¹. Four key tests are used to establish the “health” of the prison, these being: safety, respect, purposeful activity and resettlement. There are many criteria within Expectations which prompt a review of social care interventions at varying levels of need; these are embedded throughout the document rather than put under a heading of Social Care, figuring most prominently in sections such as Diversity and Health Services.

While the criteria provide a powerful set of challenges, Governors are not obliged to accept the Inspectorate’s recommendations, and with a long inspection cycle this may be a slow stream, albeit crucial, lever for change.

Prison Health Performance Indicators: We are aware that there is current work on draft Prison Health Performance Indicators although we are not sure of the stage that has been reached. From the draft that we have seen we would suggest that there is scope for incorporating a Social Care reference of some sort in several of the proposed Indicators, e.g. 2. Health Needs Assessment, 7. Supporting Diversity, 10 Integration of Care Planning and Delivery, 23 Discharge Planning and 28 Corporate Governance.

In addition to these mechanisms the role of Independent Monitoring Boards (IMBs) whose members may support individual prisoners with concerns about their treatment, alongside campaigning organisations such as The Prison Reform Trust and the Howard League for Penal Reform should be acknowledged in the influence they can exert potentially upon social care delivery in prisons. The National Council of the IMBs has developed a Diversity Strategy through which training for IMB members is planned in the wider aspects of diversity; it might be expected that as their awareness increases IMB members may be better placed to advocate for the social care needs of prisoners.

5. Commissioning and provision of social care

Commissioning (by which we mean identifying needs and securing provision) for the social care needs of prisoners operates at both aggregate and individual levels — much as for the rest of the community. Each prison will at any one time require a range of facilities or provision to meet the likely needs of prisoners. These individual needs clearly lend themselves to a 3 stage assessment "pathway": prior to or at reception and induction; during the length of stay in the prison; preparing for and at release and resettlement.

We cannot avoid the thorny issue of which agency has the resources with which to commission care. PCTs may argue that health resources are being used inappropriately on social care interventions at present. Governors may hold that their funding does not reflect the increasing social care needs of the prisoner population. Social services may maintain that they do not have responsibility for prisoners other than for their own residents at resettlement.

Current policy is thought to be ambiguous with regard to LA statutory responsibility. Section 46 of the NHS and Community Care Act¹² states that each LA

'shall, within such period after the day appointed for the coming into force of this section as the Secretary of State may direct, prepare and publish a plan for the provision of community care services in their area;

The Act does not explicitly exclude prisons from this requirement but the common assumption during our research was that the 'ordinary resident' rule did not apply to prisoners within a LA geographical area. This was evidenced by the little contact outside MAPPA requirements that Social Services Departments and prisons had either strategically or on an individual prisoner basis. Subsequent Department of Health guidance on implementation of the Act refers to 'transient populations' but a lack of further detail and clarity as to how far the LA duty of care extends appears to have led to prisons not generally being accepted as a LA responsibility.

Therefore a common sense position needs to be negotiated at national level with the necessary funding adjustments made. Given the rising numbers of older prisoners and longer sentences the level of social care need and therefore the demand on services to meet routine and specialist needs is going to increase, addressing the future funding of care is a top priority.

The NOMS Commissioning Framework for 2007/08³⁰ focuses on public protection and reducing re-offending. Of the 28 targets outlined in the Framework only one (Target 14 relating to educational achievements) comes close to supporting social care for health and wellbeing of the prisoner. The plan set out four priority areas that were to be negotiated within Service Level

Agreements with the prison sector; one of these was Diversity and Equality in order to

“deliver greater equality of access to services provided for offenders in prison or supervised in the community, irrespective of their race, gender or other characteristics to achieve greater parity of outcomes...”

While this type of statement offers the possibility of interpretation to address issues of social care need arising from old age or disability, it does not lend specific impetus to them.

Therefore the nature and extent of social care provision in prisons seems to be determined by the prison itself in the manner that it implements policy and PSOs and in how it interprets its overall duty of care to prisoners. Strategic planning and allocation of resources for social care appears to be ad hoc and subject to local leadership and priorities.

Provision of social care in prisons falls into two broad areas: personal social care for people who need assistance with activities of daily living (e.g. mobility, hygiene) and care that supports health and wellbeing through ensuring access to literacy schemes, training, advocacy support, physical activities, social activities and acquisition of further development of life skills. The needs of any one individual may be simple and easily recognised or more complex requiring specialist intervention at both assessment and response stages.

Unlike prison healthcare, there is a lack of effective policy and procedure to support the effective commissioning of care whilst in custody or on release. This is particularly true for personal social care and the more specialist levels of care or adaptations that are required. Common examples of this were the assessment and provision of equipment that are readily available to adults within the community. Some prisons such as HMP Birmingham and HMP Nottingham had very good arrangements with local therapy services and were able to obtain equipment when required. Others found it very difficult to access the same type of equipment.

The wheelchair came from a benevolent fund...but it's not fit for purpose...there's no funding to secure decent equipment.

Deputy Governor

We found in practice that personal social care needs were often 'provided by default' by PCTs through their prison healthcare team where available. Care was usually delivered by prison-based health care assistants who undertook personal social care tasks such as assistance with bathing and dressing.

The PCT commissioning model for healthcare and the associated funding formula would appear to fit well with the commissioning of personal social care. PCTs under the National Partnership Agreement³² are responsible for:

- Commissioning health services for prisoners
- Securing resources for the effective delivery of the aims and objectives of the Partnership Agreement
- Monitoring the performance against the standards set out in the SLA
- Acquisition and maintenance of non-fixed, freestanding items e.g. furniture and specialist medical equipment

(Section 3)

Health care and personal social care needs are often difficult to distinguish between (and some would argue this is inappropriate anyway) and given that the numbers in each prison requiring support with personal care are generally small it would not make practical or economic sense to establish a parallel system of commissioner and provider. As one Healthcare Manager remarked *“we could do without this health and social care debate”*.

We would therefore propose that PCTs are given responsibility for commissioning personal social care. In making such a suggestion we are concerned that this should not reinforce a medicalisation of social care needs, but should represent a move toward more appropriately joined-up care for people with complex needs. It also avoids the need for to bring in LAs and add to the complexity of the process.

Case study: HMP Nottingham

The prison has a 24-hour healthcare service. A team of qualified nurses and healthcare assistants provide a comprehensive assessment and care service to those prisoners with identified health needs. They also provide personal social care assistance to those with identified needs. This includes help with toileting, bathing and dressing and assistance with mobility. For those who require aids and adaptations to meet their social care needs, the team are able to access this equipment on prescription. The team adopts a neighbourhood approach by encouraging other prisoners to support the delivery of care where appropriate.

Given the relatively low critical mass of those with a higher level of specialist need in the majority of prisons the provision of such care needs to be provided in an effective manner. The current ad-hoc basis on which this level of care is currently provided may not be the most cost efficient form of provision.

Consideration should be given to developing regional teams (either actual or virtual) with a responsibility of supporting the prison sector in specialist assessment and co-ordination and providing appropriate interventions.

6. Leadership of social care issues within the prison sector

6.1 Leadership of social care issues at National level

This section considers the overall “message” which may be received from the centre by prison staff at all levels. As far as we can observe from our research “Social Care” does not feature as a “headline” within the prison sector, either at a national or institutional level. It is instead more likely to be found as an implicit strand of “Diversity”, and be referred to within the context of the “Decency” agenda.

The respective Prison Service Website statements state: on Decency,

We are committed to ensuring that staff, prisoners and all those visiting prisons or having dealings with the Prison Service are treated fairly and lawfully irrespective of their race, colour, religion, sex or sexual orientation.

and Diversity:

“Fairness in prison implies consistency and certainty. In a diverse society, this can only be achieved if all are treated fairly and equally, no matter what their colour, race, religion, sexual orientation or disability. I am clear that prisons with the best relationships will be the most secure, orderly and safe, for prisons, staff and visitors.” (Phil Wheatley, Director General)

It is notable that disability does not appear in the first, and age is not mentioned in either, though the findings at prison level suggest that these dimensions are often considered. Aspects of social care are seemingly addressed as part of the prison establishment’s overall duty of care toward its prisoners.

The race equality dimension was described as dominating Diversity by the Governors and other staff we interviewed during the site visits. The large notices at prison gates and in other key locations emphasise Race Relations more loudly than they do Diversity, though this headline did also feature, less prominently, in some of the prisons visited.

Prison staff described how a central drive towards focusing once more on race issues had drawn attention away from the development of the different “strands” of Diversity. This was attributed to the need to address serious issues of institutional racism as highlighted by the Mubarek Enquiry³³. Key performance targets and impact assessments have since focused strongly on race issues making other aspects of Diversity “effectively optional” in the words of one Governor, though probably still supported as the “right thing to do” in many establishments. Many prisons appear to have Diversity Managers, some on Senior Management Teams and others at more

operational grades. However, there is much to be done to bring social care issues into the mainstream of prison sector thinking.

6.2 Conformity with population-wide policy and guidance

In terms of the adoption of national care-related strategies our survey found that the Mental Health NSF¹⁵ had reasonable penetration at nearing 70%, possibly attributable to the mental health in-reach service available to prisons, faring better than other care group-related strategies. While PSI 3500²⁵ brought the Older People NSF to the attention of prisons in 2001, and highlighted the role of social services department in meeting older prisoners' needs awareness of this strategy was low outside healthcare services. We did visit two prisons, HMP Norwich and HMP Risley, where we heard of nurses being designated to care specifically for older prisoners, but the partnership working between health and social care, as exhorted by the NSF and reinforced by the PSI, was rarely in evidence. HMP Wakefield is piloting the use of the Single Assessment Process, having modified the paperwork to be relevant to older prisoners.

Only 11 respondents to the survey thought that their prison had a specific policy regarding Our health, our care our say¹². Valuing People¹⁷ has had little impact with only 8 respondents being aware of any prison policies relating to it. This is concerning given what is known about the prevalence of learning disabilities within prison populations. A corresponding desire among prison staff for greater awareness of the specific needs of this group was evident in our fieldwork. The recently published CSIP Handbook "Positive Practice, Positive Outcomes"³⁴ may help to redress this by translating the Valuing People principles and approaches into criminal justice settings.

6.3 Leadership of social care issues at prison level

The survey indicated that while many prisons have a clear lead for social care issues (42% - though probably not explicitly described as such) these are slightly more likely to come under a range of governors' responsibilities (44% of respondents). The most frequently cited job title was Head of Healthcare, but also cited were Senior Probation Officer, Diversity Manager, and Head of Residential. This is on the one hand appropriate, in that social care considerations potentially permeate all aspects of prison life, together with the drive towards successful resettlement, but may also mean that the social care agenda lacks focus in its own right and is effectively lost. A few survey respondents and interviewees volunteered an opinion that there should be a more strategic and focussed approach to social care issues at senior management team level, pulling together pockets of good practice in different work streams such as Resettlement, Healthcare or Residential.

Rather than being systematically addressed social care issues as they relate to older people and those with disabilities appear to be the province of committed individuals and not embedded in the mainstream. Often these champions work at operational level rather than senior management level,

and some have taken a personal interest as a result of their own or a family member's disability. We encountered some supportive Governors who have allowed individuals to develop further or formalise roles that they have created through personal interest, and some notable pockets of "gifted amateurism" can be found, as will be described later.

*(The Elderly and Disabled Wing) runs on the goodwill of the
Prison Officers working outside their remit...they're not trained.*
Head of Offender Management

We heard in some establishments that the influence of the NHS taking on the commissioning of prison healthcare has been to strengthen the caring dimension within prisons. The tension between balancing security and risk concerns against this more caring approach remains, though the tenor of the survey responses and visits demonstrated a willingness to address caring issues as far as possible, within the constraints of a secure environment.

The importance of the tone set by the Governor was emphasised to us during the site visits. HMP Wakefield was able to produce a current policy entitled "Quality of Life for Elderly Prisoners and Prisoners with Disabilities" which had been signed by the Governor and a range of senior staff at the establishment, and also the Prison Service Area Manager. In a few of the other prisons visited we gained the impression that governors took an interest in this area only to the extent that they were absolutely required to by law. The Governor's Duty of Care as it relates to prisoners with disabilities and special needs is clearly subject to significant interpretation.

Case Study: HMP Wymott

I Wing is run as a community for elderly and disabled prisoners with 64 places. It is likened by prison managers to a sheltered housing environment and relies to an important degree on the commitment and goodwill of prison officers and the mutual support of prisoners. The wing provides a calm setting with furnishings and fittings. Although not originally designed for prisoners with dependency needs these have grown as the population has aged and the staff help as best they can. A part time healthcare assistant has been appointed but demand far outstrips supply. A number of specialist resources were acquired (e.g. baths) but there are now no funds to employ trained staff to enable them to be brought into use.

The commitment of funds and dedicated staff time was highlighted strongly also as essential to developing an active approach to supporting prisoners with disabilities and special needs. At present the wider range of practice observed may reflect the absence of a specific steer from the centre, the varying levels of commitment of Governors, the current pressures caused by prison overcrowding, and a scarcity of resources for funding sufficient staff time, building adaptations and aids, and lack of expert advice and support from external agencies.

More specifically, if the Offender Management Model is to succeed there needs to be recognition of the prison role in ensuring that social care interventions outlined in the Sentence Plan established by the Offender Manager are delivered.

6.4 Strategic Liaison with Social Services

The majority of prisons responding to the survey (67%) did not have any senior level liaison on a regular basis with Social Services. Where this did occur it appeared to relate either to the needs of specific prisoners or to public safety (MAPPA or Child Protection meetings). The opportunities for senior level alliances to promote social care awareness and to support leadership of the agenda within prisons would seem few and not surprising given the lack of clarity regarding LA responsibility in service planning. This issue is particularly important for Local Prisons that receive most of their prisoners from the surrounding area and subsequently released to the same area. There is a clear need for an effective dialogue to be developed between Prison Governors and Directors of Adult Services perhaps at both national and regional levels. At the individual prison level this relationship is likely to be best served as part of the prison's overall relationship with its LA – often this is likely to be through the Local Strategic Partnership – as part of the local strategic needs assessments that are to be introduced. It may be significant that in the current Prison Service Corporate Plan and Business Plan neither the National level nor local level stakeholder maps include Social Services or even LAs in any overt way. They are not on the map.

7. Operational arrangements at prison level

7.1 Assessment and sentence planning

We're not very good at looking at individual needs. We may have the broad policies but how well are they being implemented?...Who should we be liaising with?

Head of Resettlement

The majority of prisons (70%) responding to our questionnaire indicated that all prisoners were screened at reception or induction for social care needs. However, this relatively impressive position was not confirmed by prison managers during our visits, where the picture emerging was of at best rudimentary screening of assessment for social care needs and the acknowledgement that many important aspects were missed or not properly acknowledged. The problems in recognising incoming prisoners with learning disabilities has been recently identified such as a lack of accompanying information at reception of the prisoner, only very ad hoc procedures for identifying learning disability, lack of staff awareness training, not knowing where to refer to for specialist assessment support⁷. Failure of individual

assessments and sentence planning to recognise the specific social care needs of older people has also been identified by service users¹².

Social Services could help with “advanced assessments” e.g. for learning disabilities.

Prison Healthcare Modern Matron

There was little evidence to demonstrate that the necessary expertise was in the Prison Sector to assess when prison staff (including healthcare) should seek specialist social care assessment input. Or, if that assessment had been made how and from whom to access that contribution.

Just over a half of respondents indicated that they were sensitive enough to the needs of incoming prisoners to modify induction arrangements to take account of their special needs e.g. because of a disability. However, on site visits this was acknowledged as something that happened if the manpower was available.

The benefits of OASys and the Offender Management Model should improve the assessment and continuity of sentence planning for some categories of prisoner. The concept of Sentence Plans managed by the Offender Manager was acknowledged by some as being a positive way forward but there was a level of uncertainty as to how well this would function without the necessary technology available in every prison to support video-conferencing or without reducing the caseload numbers of each Manager.

'the information we get from OASys is about three months late. By that time, the prisoner has moved on or has been released. We are expected to input the data ourselves but this is time consuming and we can't cope with the number we have coming through the door' Prison Officer, Local Prison

The continuity of care in terms of translating assessment into an agreed Sentence Plan was agreed by those interviewed as poor due to lack of manpower resources and volume of prisoners coming through the system. This was particularly true for local prisons where throughput is high. There was a feeling that spending time on sentence planning and arranging for service provision was not productive given the prisoner would either be moving onto another prison or be released.

'by the time we've set everything up we're starting to arrange their transfer or release and then they (local agency) get frustrated with us'
Head of Residential

At present, there is no mechanism for ensuring personal social care needs are identified before custody. This is important for those who have disabilities that impact on their activities of daily living such as those with mobility problems requiring a wheelchair. Data collection on OASys for Pathway

Three, Health, does not at present require this level of personal need to be assessed

There were some examples of good practice where the responsibility for sentence planning was undertaken by a designated lead such as Head of Residential or Head of Resettlement but the outcome of this providing the support required was variable. The majority of respondents reported that prisoners with mobility problems (84%) and with communication/learning difficulties (77%) were supported to attend sentence planning boards in person. However, that still means that a significant minority may not be and this needs to be addressed.

More working together through a multi disciplinary approach and more focus on the needs of the individual were key themes to emerge as the suggested way forward. This has to involve the health and disability (diversity) functions within the prison working closely together. Having the relevant information available was also stated as important but several times on our visits we heard from well intended and committed prison staff that “we don’t know what we don’t know”. It was emphasised by one Governor during a visit that prisoners’ needs really had to be properly understood from the earliest possible timing and on a properly informed basis so that the all those involved in the prisoner’s career had the full picture rather than a superficial one.

Staff are good at recognising that something is wrong and then passing them on...staff on the Wing get an intuition.

Head of Human Resources

(We need a) locally based Social Services intervention team working flexible shifts, assessing and referring.

Governor

7.2 Transfer of prisoner information

The transfer of information relating to individual prisoners can only be described as poor. This includes information accompanying the prisoner from the courts, from another prison establishment following transfer or between individual departments within one prison. This results in prisoners undergoing multiple assessments that duplicate resources in terms of time and greatly inhibit a continuity of care. A number of reasons were given for this; poor information technology systems, reluctance for prisoners to carry their own information on transfer, staff culture not to share information and increased workloads due to current service pressures.

There were many examples of prison staff feeling frustrated at not knowing what services a prisoner had already been receiving and at having to repeat a process that had already been undertaken. This was particularly true for open prisons that received prisoners from other prisons.

Case study:

A prisoner with severe learning disabilities was transferred from one prison to another four days before release. This was in response to the volume of prisoners in the first prison. No information regarding resettlement plans transferred with the prisoner and therefore he was released, a long distance from home without the appropriate social care support in place. The receiving Local Authority would not know about his release until he returned home. His disability was such that a prison officer had to accompany him to the train station to ensure he got on the correct train to his home town.

Having accurate and up to date information has long been seen as a key element in meeting social care needs effectively and efficiently. This should include information from all assessments as well as a record of services received and their effectiveness. Such a system relies upon the individual having only one set of records that follow his/her pathway through the system and that are used by all practitioners involved. The information should be recorded and stored in ways that are easily accessible to whoever has a right to them – including the user, in this case the prisoner.

Stuart Ware, as a result of his work with older offenders suggests that each prisoner should hold an 'individual passport', held by the prisoner that contains basic information relating to that prisoner. Whilst this suggestion would need to be worked up thoroughly in terms of confidentiality, security and accuracy it offers a relatively simple solution to a complex issue with many potential benefits including a reduction in the duplication of assessment. It would also reflect health and social care practice within the community in developing client held records.

7.3 Training and development

Staff training and awareness is key to get at the “invisible disabilities” – maybe on a “pass or fail” basis.

Governor

The increasing older population challenges the prison sector to consider what sort of regime may be appropriate for older prisoners, especially those with no prospect of release. The needs of such special groups will require prison staff at both senior and operational level to have a much greater understanding of the social care outcomes as set out in Independence, Wellbeing and Choice, such as personal dignity, and not least to have an understanding of the need and approaches to sustaining prisoners' independence. This may require cross agency planning to ensure that social care considerations inform the design of new approaches.

The need for a more structured and formalised training and development programme for prison staff at operational level was identified as a high priority in our research. While some of the survey respondents were concerned to understand disability issues generally, and the role of the DLO,

others saw a need for training around particular groups of needs, such as learning disabilities, mental health and older people. There could usefully be a national approach to the design of training packages in conjunction with health and social care. How to find funding for training was another concern of survey respondents.

Case Study: HMP Kingston

Healthcare run an Educational Prisoner Programme for 10 prisoners at a time of varying ages and different chronic conditions, aimed at helping them to take control of their health and achieve quality of life improvements. The Programme is based on the Expert Patient Programme and contributes to the life sentence planning process for each prisoner. The Programme is presently being piloted and it is hoped that it will progress to accredited status.

7.4 The role of the Disability Liaison Officer

Over 90% of respondents in the survey had the required DLO, although the role was often part of another such as Diversity Officer so the time allocated to it was difficult to quantify. Only 14 prisons had specific facility time “profiled” for the role; a few described an “as required” approach. In terms of the actual amount of time devoted to the role the majority spent one day a week or less, with a handful clustering around half time, and only 4 citing a full time position. In response to the question about the ideal amount of time needed for the role 22 prisons wanted more time; while many of these felt that about one day a week or less would be adequate a significant number wanted between 2 and 3 days a week, and 11 considered full-time posts to be appropriate. This range of response may suggest that different places have different interpretations of the role or potential role of the post, or that needs are much higher in some prisons than in others.

The visits provided a view of some extremes: from a full time officer who had effectively developed the role herself then secured governor commitment to formally funding it full-time, to an officer who had also been assigned the role having shown an interest, but who had no time “profiled” to undertake it and a considerable backlog of prisoners to interview, some of whom might have already moved on elsewhere before they could be given enough space from operational duties to follow up their disability disclosure forms.

It was clear that unless the DLO role has senior recognition and adequate protected time it is difficult to provide sufficient support and advice and to secure more expert inputs as required. Many officers are undertaking this role out of personal interest and commitment and making huge efforts to provide personalised support to individuals without any protected time. However, it was apparent that the full-time officers we met had been able to achieve far more, even without having significant budgets to spend, simply by having sufficient time to develop the role both in its hands-on dimension, and also in terms of spreading awareness and developing appropriate policies for the prison.

The DLOs that we spoke with stressed the importance of having more clarity of the role as well as having the skills and competencies to undertake it. They clearly valued the current (rather limited) access to training and networking with fellow DLOs.

7.5 Disability Forums

Respondents were asked whether there was a forum where disability issues were regularly addressed, and how effective this was, as a marker of the importance of this agenda to more than just the DLO. Nearly 79% of prisons had such a forum, and many of these included prisoner representatives. The types of meeting at which social care/disability issues were addressed were titled as follows: Disability, Diversity, Race Equality, Equal Opportunities, Safe Custody, Decency, Health and Safety. Respondents were asked for examples of any real changes the forum had brought about and how influential they thought it was. While there was a broad spectrum of opinion on the latter, more often than not they were considered to have at least moderate influence; some noted that it was still too early to tell. The types of changes brought about were many and varied, and were more often than not modifications to improve access to facilities for prisoners or visitors, and provide aids and adaptations for prisoners with mobility problems or hearing and sight impairment. Some also noted that awareness was raised through the group and multi-disciplinary working was enhanced.

7.6 Operational liaison with social services

The general position regarding social service staff coming into a prison is that it happens only occasionally – there were some reported instances of occupational therapy support, one reference to a personal carer having been recruited and during one visit an acknowledgement that the local Social Services Department had been helpful when asked to assist with complex assessments.

There were various reasons given as to why Social Services did not get involved in assessments. These tended to be quite basic ones such as the prisoner was far from home (and thus the relevant Social Services), absence of any links and a questioning of whether they had even been approached. One response mentioned that *“they charge the prison”* and this had been a deterrent. For at least one prison this was just a low priority *“not core business”* and for another *“the healthcare department can pick up these needs”*.

Only around 30% of respondents described any regular contact between prison staff and social services at practitioner level, and from the experience of our visits “regular” may be an overstatement in many of these. However, many described ad hoc input around specific prisoners, mainly concerning resettlement. One prison had access to telephone advice. During the site

visits the view that social services input was the exception and ad hoc at best was reinforced.

One healthcare team had developed a productive relationship with a social worker who had been lined up to visit regularly to provide advice and support in a prison with a significant older population. However, this was stopped in its tracks by senior management as being outside the LA's remit. The overall impression we received was of prisons mostly "consuming their own smoke" as opposed to otherwise seeking assistance from either social workers or home care assistants from outside.

In addition to the arguments about the eligibility of prisoners in terms of local residency, the *Fair Access to Care* criteria were also thought to be a barrier to prisoners accessing support on release. The guidance³⁵ describes the seriousness of the risk to independence or other consequences if needs are not addressed. The four eligibility bands are critical, substantial, moderate and low. Due to financial constraints, many LAs are providing care to those that fall within the first two criteria. This is thought to exclude most prisoners at the time of release. Whilst fair access to care must mean just that, it could be argued that not making 'special arrangements' for some prisoners so that they are eligible for an increased level of support ignores the potential for that extra level of support from LAs in contributing to the reducing re-offending agenda. In line with a consistent approach to assessment for routine and specialist care there is also a need for a consistent view and approach to eligibility for care.

The impression we received was that social care input was highly valued when available, and moreover, the average prison might not need much involvement overall, other than at the resettlement stage when it is already slightly easier to get help and with the relatively rare "complex care" prisoners. As one Healthcare Manager expressed it, there might need to be some initial catch-up work, but after that the level of input needed to advise on her prison's significant number of older long-term prisoners might not be great.

Social services were most often secured via the healthcare team or came as part of joint agency teams such as mental health in-reach or substance misuse services (CARATS). Social workers attended child protection meetings in three prisons. It appeared that the most explicit social care inputs were in the Young Offender Institutions: one noted a dedicated seconded full time Senior Practitioner/ Social worker experienced in disability issues, and another likewise employed a social worker. As might be expected the mother and baby unit at Holloway Prison had social worker input on two days per week. While in the past Prison Probation Officers may have been able to take a more holistic, welfare-oriented approach, with the transition to NOMS, the increased pressure of numbers, and the emphasis upon risk, we did not find social care dimensions featuring strongly in their priorities. This is further discussed with the Resettlement section below.

Liaison with Social Services was not only in relation to prisoner need. We identified in our research that for some, particularly older and female prisoners

there was a need to have contact to manage family care situations back home. This type of need is important to be addressed in terms of the health and wellbeing agenda of the prisoner and should be explicit within a Sentence Plan.

7.7 Liaison with the voluntary sector

For some prisons at least local voluntary organisations were an important source of a wide variety of help and advice for individual prisoners but this was clearly a far from consistent situation and on our visits we heard that the good contacts that did exist were often the result of an individual member of staff's efforts and sometimes did not survive after they moved on. Local volunteers could be important sources of assistance and advice but these could take years to build up and often required co-ordination that was difficult to provide. Again, some of these relied on the enthusiasm of the individual and the support was withdrawn by the agency when that individual moved on.

A range of examples of more formalised schemes was given by respondents such as the Listener programme, Samaritans, Meet and Greet, Toe to Toe (literacy scheme), Buddy system, Peer Mentor scheme and Drug support workers (via CARATS). Chaplains and Prison Visitors were also noted during our visits as important sources of psychological support. Age Concern provided a significant input to prisons although the extent of support depended on the nature of the local branch.

An issue that was commonly reported was the lack of information prison staff had about local services and support available. This appears to be inhibiting the extent to which the voluntary sector gets involved and therefore the range of care provided. It is also a factor in resettlement in that prison staff found it difficult to signpost prisoners to services within their local area.

7.8 Prisoners as carers

Our research identified a very positive response from the prison sector in supporting prisoners to be trained in providing a basic level of social care for other prisoners. This is of course with appropriate safeguards in place and at the discretion of prison staff. There was some resistance among a few to developing this concept in terms of the potential risk of abuse to vulnerable prisoners and scepticism that prisoners would be able to use the training for employment purposes on release.

With lower levels of need, such as needing help with fetching meals, cleaning cells or pushing wheelchairs, the survey revealed instances of prisoners supporting each other, as might close neighbours in the community. This 'neighbourhood' approach was adopted in some prisons in as much as the level of care a person with social care needs would receive from family, friends or neighbours outside of prison should be encouraged within the prison community and this would seem to be a sensible approach.

Over 30% of respondents noted either some or significant informal support between prisoners, while more gave practical examples of the types of help given. One respondent stressed the importance of peer support as a means of encouragement, and another noted how several young offenders in a YOI were learning British Sign Language to support a hearing impaired prisoner on their wing. On one visit we met an older wheelchair user in the process of being supported informally by a younger prisoner. In some cases prisoners may be better equipped than staff to undertake duties; discussions at one prison revealed that all prisoners were trained in manual handling procedures during their gym induction, while only those staff who had received Advance Control and Restraint training had covered this adequately. PCTs were a source of training in some cases.

While some of the prisoner roles above may be paid and others not, we found examples of formalised paid carer roles within 9 prisons. These came under a range of titles such as Diversity Orderlies, Disability Helpers, and Peer Support Workers. One noted a carer's facility and another described wing trustees as taking on a formal caring role. The degree of formalisation could include vetting, training and a formal job description.

The overwhelming message from survey respondents was that prisoner to prisoner support was both appropriate and vital, and 84% considered that an accredited scheme for training prisoners in delivering aspects of social care would be very positive, if not "excellent". Many at the same time expressed concerns that this should be carefully set up with rigorous risk assessments, and that it should also entail proper training, preferably leading to recognised qualifications such as a NVQ in Social Care, and explicit prisoner consent. This is an area that could usefully be explored with the Learning Skills Council with the possibility of a joint agency initiative to design and commission appropriate training. For younger prisoners carer work could also contribute to national schemes such as Millennium Volunteer or Duke of Edinburgh awards.

7.9 Regime modifications and "reasonable adjustments"

Survey respondents were asked to complete a table indicating the degree to which reasonable adjustments were made to support prisoners with a range of daily living activities. The table asked for what happens in the mainstream prison regime to be differentiated from the experience of those subject to a modified regime, such as living on a Vulnerable Prisoners wing, or located in Healthcare or Segregation. It would appear from the responses that older and disabled prisoners might fare less well in modified regimes, having fewer adjustments made, when compared to being in the mainstream, pointing to a need to consider the support given to "vulnerable" prisoners, particularly where they are considered vulnerable as a result of particular disabilities, rather than by the nature of their offence as such.

Two of the activities we questioned on scored consistently low for both mainstream and modified regimes, these being "finding constructive daytime occupation for retired prisoners" and "retirement planning for older prisoners".

The visits confirmed how variable practice may be between different prisons. In one prison a group of retired and disabled prisoners expressed their concern at having to remain in their cells all day as they did not work. In another not only could retired prisoners (who were assessed as suitable risk-wise) be unlocked during the core day, but a range of structured and unstructured activities was available to them on the wing. Likewise, in one establishment prisoners with poor mobility could not access the library at all as it was situated upstairs on the vulnerable prisoner wing, while in others a service was available ensuring that everyone could have access to reading material regardless of their mobility.

More general regime adjustments included the provision of work or education within the cell, tailored education programmes including peer support, “personal movement” to work and activities i.e. at prisoners own pace. One survey respondent described how employment in a charity workshop was available for people with emotional problems to provide a less demanding environment. Staff in some of the prisons we visited had implemented the Walking the Way to Prison Health initiative to focus on the fitness of older prisoners and potentially address social problems by encouraging people out of their cells. We also found several examples of the way in which gyms may modify their programmes to meet the needs and wishes of older and disabled prisoners alongside their health remedial programmes.

More examples of adjustment related to the provision of physical aids and adaptations than they did to regime modifications, and these were very much focussed around compliance with the DDA. There was an emphasis upon building adaptations such as ramps, lifts, disabled cells, physical aids such as grab rails, shower seats, wheelchairs or even electric beds in one prison, alongside smaller scale aids including adapted food trays and keyboards. One prison had successfully tackled issues of wheelchair procurement and maintenance, and another was preparing to train staff to push them - with Prison Officer Association approval. Approximately 20% of respondents gave examples of aids for visually impaired prisoners and a similar proportion cited adaptations for hearing impairment. Several examples were given of how individual care plans had been constructed around people with specific disabilities, and our visits confirmed how staff would make considerable efforts to meet the unique needs of individuals.

However, counterbalancing this picture, 20% of survey respondents either did not provide examples, stated that no modifications had been made, or indicated that the question was not applicable - but did not reveal whether this was because their buildings were already compliant with the DDA and/or because they did not at the time have any prisoners with special needs/disabilities. A small number also specifically stated that there had been no regime modifications. Discussions during visits explored this further and raised the question of how motivated prisons would necessarily be to work at DDA compliance, unless they had the challenge of adapting to the needs of specific individual prisoners, alongside the allied tasks of ensuring compliance for staff and visitors.

7.10 Resettlement

Clearly the resettlement and reintegration issues for older prisoners and those with disabilities affect different prisons differently – for some it is (or should be) a key task for others it is a relatively rare event.

Resettlement planning prior to custody or on arrival did not appear to be common practice. The quality of resettlement appeared to be higher for those prisoners who had been at the same prison for a reasonable length of time as long as they weren't transferred immediately prior to release.

The most frequent factors never considered in resettlement planning were all connected with aspects of social care: ability to shop and cook, support in caring and parenting, the need for social services assessment and support, and personal care and hygiene issues.

Most respondents assessed prisoners for any particular difficulties in re-establishing themselves outside prison; for just under a quarter this always included a joint health and social care dimension. However, acting on those assessments in terms of liaising with local agencies proves to be a stumbling block in continuity of care. On our visits we heard that when (for example) a piece of equipment had been identified as important as a result of an assessment it was often impossible to obtain it if funds were not available.

For release plans there were also relatively low incidence of social services involvement on a regular basis but the majority did state that there was intermittent involvement, with a similar involvement of relevant voluntary organisations. There was no indication of any sort of systematic engagement for social care assessments. It seemed more likely that social services might be involved if the prisoner was being released to a local setting. If the release was to another local authority area or if a foreign national was involved the position seemed particularly grim. This was a particularly concerning situation as it did not appear from the information that we received that the Probation Service was now in a position to pick up the social care needs of prisoners at resettlement.

There is a case that each “receiving” local authority should accept responsibility for assessing the needs of older and disabled prisoners prior to their release and with an agreed common approach to the Fair Access to Care criteria for this population. There should be a process for liaison between Adult Services and the local Probation Service where it would appear that the input of social care support would reduce the risk of re-offending.

8. Conclusion and Recommendations

8.1 Conclusion

Our findings confirm those of other studies in identifying increasing levels of social care need in prisons and a variable response to those needs. Our research demonstrates that despite a real enthusiasm and commitment from the prison workforce prisons are struggling to meet the challenge of a rising older population and that increase in demand for social care. Some of the issues we have highlighted such as the assessment process are also issues for social care outside prison. However, there appears to be a significant inequality between the care provided in prisons and that within the community to the detriment of individual prisoners and the efficient use of existing resources.

The key factors for this appear to be:

- A lack of explicit policy and guidance that supports effective commissioning resulting into confusion as to who is responsible for what.
- A lack of funding directed towards the provision of social care in prisons
- Poor systems and procedures to support assessment and continuity of care leading to significant duplication of resources
- Insufficient and variable adaptation of the physical infrastructure to accommodate those with physical disability
- Inadequate training across the system to support effective assessment and service provision

8.2 Recommendations

Our full list of recommendations can be found in Appendix Two. They aim to highlight the areas where national policy needs to be clarified or developed and some of the actions that are needed in order to ensure that prisoners' social care need can be properly addressed, respecting the diverse prison population and the need to ensure decency of treatment. The broader recommendations are:

- Establishing a governance framework that clarifies accountability for the quality and delivery of social care
- Ensuring policy and guidance explicitly supports effective commission of social care in prisons

- Making the PCT lead commissioner for both prison health and personal social care
- Establishing minimum standards of care and performance measures
- Workforce improvement, through a national training programme, multi agency working, peer support models and a minimum specification of the DLO role
- Consideration given to developing regional teams (either actual or virtual) with a responsibility of supporting the prison sector in specialist assessment and co-ordination and providing appropriate interventions.

If a future strategy is to have any credibility within the prison workforce, it needs to be supported by robust investment plans taking into account where cost-efficiencies can be made. Some of our recommendations will require a commitment of new funding which acknowledges the rising older population in prisons and some require only a change in custom and practice.

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Appendix One

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Appendix Two

Recommendations

Strategic

1. Social care within prisons will need to focus more explicitly within national population wide policies and strategies to ensure that prisoners receives an equivalent degree of focus as people with social care needs within the community.
2. A governance framework for prisons with explicit performance measures for the delivery of minimum standards should be established.
3. The accountability of LAs and their areas of responsibility with regard to adult prisoners with social care should be clarified in terms of different types of prisoner and potential interventions at different stages of the offender pathway. This should preferably establish at minimum a responsibility for providing timely assessments and advice for convicted prisoners with complex needs, regardless of their local authority of origin, and according to agreed prisoner-adjusted eligibility criteria.
4. The issue of who should fund personal social care within prisons should be resolved, taking into account the rising level of need particularly around older prisoners.
5. The strategy must build a social care dimension into existing prison sector workstreams and initiatives rather than adding more complexity to the system i.e. underpin the NOMS resettlement pathways and action plans to further the NOMS Diversity priority.
6. Robust economic modelling and investment plans need to support the strategy if it is to have any credibility within the prison sector. A number of improvements can be made without any additional resources by changing custom and practice. However, additional funding may be required for: personal care provision to meet rising levels of need, buildings adaptation, DLO time; training and development, only some of which may be achievable from within existing prison resources.
7. Consideration needs to be given within the strategy for ensuring that where appropriate, the needs of the older prisoner and those with a disability are not unduly marginalised by the security agenda; that people can have access to essential aids and adaptations and can retain their dignity while participating in the prison regime.

8. PCT commissioning responsibility under the National Partnership Arrangement should be extended to include the procurement of personal social care especially for those prisoners with complex needs requiring a range of coordinated responses. This will require clarity regarding where the money is in the system at present to fund this.
9. PSOs relating to healthcare such as 3050 should be extended to include personal social care
10. The social care dimensions of the NOMS pathways to resettlement should be explicitly drawn out and incorporated into the pathway guidance, emphasising the importance that addressing people's needs may have in reducing re-offending.
11. Prison service communications and policies should highlight more explicitly social care issues, and should make specific reference to older and disabled people.
12. Local Strategic Partnerships and Local Area Agreements should be the mechanisms for ensuring a multi-agency approach to strategic planning for prisoners social care needs.
13. LAs should provide support and advice to prisons within their community to support the social care (and related) agenda and common eligibility criteria need to apply.
14. Within the LAA, the LA commitment to delivering their part of the seven pathways and how that commitment is exercised should be explicit.
15. Each Adult Social Services Department that has a prison in its area to nominate a "prison liaison officer" for initial contact on policy and practice matters.
16. The contribution of the voluntary sector needs to be explicit within the LSPs. The commissioning and funding of their services within prisons needs to be developed as part of the commissioning arrangements for health and social care within the community.
17. The possibility of developing an accredited carer qualification such as an NVQ for prisoners who are assessed as suitable should be explored with the Learning and Skills Council (LSC) with potential for a joint agency initiative (Prison service/LSC/Social Services). For older prisoners such a qualification could be linked to their requirements for resettlement where other employment opportunities are not available.
18. A training and development programme for the prison sector on social care need should be developed and implemented. Where possible, training should be integrated with existing training within the community.

Operational

19. The Common Assessment Framework should apply to the assessment of prisoners. The principles behind the Offender Management Model in promoting continuity of care should be applied to the process of assessment and sentence planning for all prisoners where appropriate. The framework should include triggers that identify the need for specialist intervention
20. Specialist regional intervention teams that could assist with the assessment of complex cases as and when they occur should be piloted.
21. Assessment of personal social care need should be explicit within data collection for Pathway 3 on OASys. This information can then be transferred to prison staff immediately on, or prior to reception.
22. Prisoner records should document previous social worker involvement to aid the resettlement process and the continuity of care between prisoner and social worker, depending on the length of sentence, needs to be integral to LA responsibilities.
23. Minimum standards for the flow of prisoner information should be established. An audit against these standards should be undertaken.
24. Consideration should be given to the development of the 'individual passport', held by the prisoner to support transfer of information relating social care need and provision
25. In order that the age and disability dimensions of Diversity and Decency have greater status an identified member of the Senior Management Team should have the remit for leading the development of social care within each prison. This role should co-ordinate the activities of each Department to ensure cohesion of approach and communications relating to all aspects of social care.
26. A standard Job Description and Personal Specification should be developed for the DLO position with a recommendation on the number of hours allocated per number of prisoners/levels of need. The JD should as a minimum cover the following points:
 - A referral point and source of information and advice for staff and prisoners
 - Ensure that all prisoners who have disclosed a disability are properly assessed and that plans are designed and implemented
 - Advise Governor and SMT on needs and make recommendations for regime adjustments and adaptations to buildings

- Advise staff on specific issues including when specialist assessment is required
- Keep records and monitor individual and aggregate needs, contributing to audits
- Raise awareness, design/contribute to training, disseminate information and promote initiatives in line with national policies
- Keep up with legislation
- Attend regional and national network and other events
- Liaise with external agencies to obtain specialist advice and interventions