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| <p>Title of Paper:</p> <p><u>Population Rise in Northern Ireland Prisons and Impact on Service delivery</u></p> | <p>For Discussion</p> <p>Requires consideration and debate.</p> |
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1.0 Background

South Eastern HSC Trust (SEHSCT) is commissioned to provide healthcare to prison population, across the 3 prison sites in Northern Ireland. At the point of transfer from the Department of Justice in 2008, daily population regionally was approximately 950 people.

In the 2019, RQIA Review of services for vulnerable persons detained in Northern Ireland Prisons highlighted the significant underfunding of services of approximately 50% compared to UK, approximately £4 million

2.0 Key Issues

Daily Population

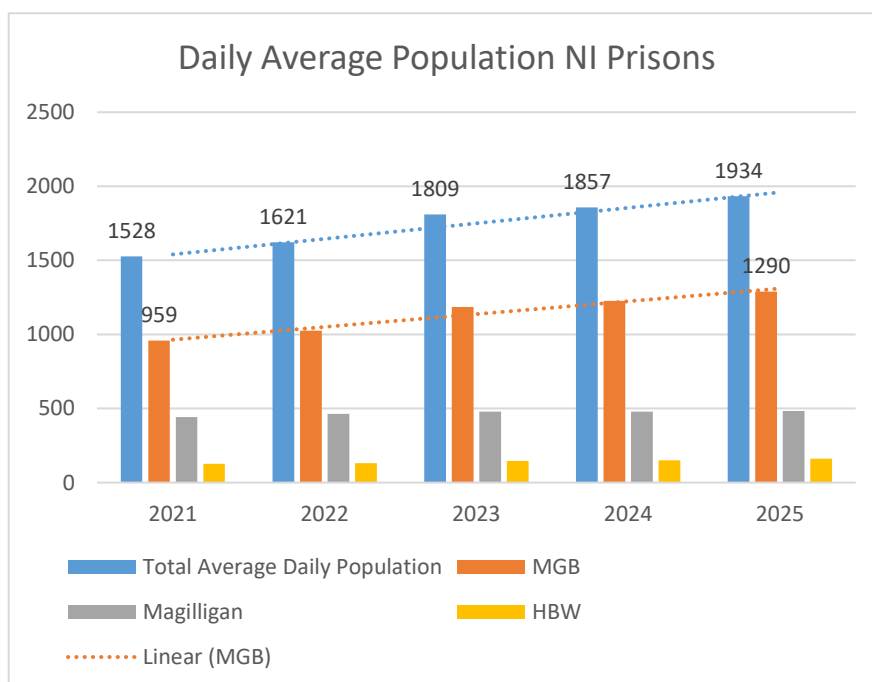
Since 2021, there has been a sustained increase in the average daily prison population. Initially this was felt to be due to courts addressing post COVID backlogs, but this persists and is anticipated by Northern Ireland Prison to continue to rise until 2028.

This is most acutely felt in, HMP Maghaberry the main adult reception prison whose safe operational capacity of 950 has been exceeded since 2021.

The overall average daily prison population in 2019/20 was t **1516 people**.

At the beginning of May 2025, was **2005** people.

A rise of **32% (489 patients)** since 2019 and **111% (1055 patients)** since 2008.



To accommodate this rise, previously decommissioned residential premises have been opened by the Northern Ireland Prison Service (NIPS), with most patients now sharing cells. This has also increased the geographical spread of patients across sites, challenging service delivery.

NIPS have been supported by Department of Justice, to recruit additional staff. Healthcare in Prison (HIP), have escalated the service pressures and risks to Department of Health. There has been no additional core funding received to offset the additional demand, increasing risk.

Healthcare in Prison, have escalated the risk relating to capacity to meet service demand, specifically in relation to Addictions in September 2024 to the Corporate risk register. This was following the judicial review judgement that HIP contravened Human Rights of 2 patients who were waiting longer in Prison than in the community. The court advised that lack of available resources are not a defence against breaches of human rights. An appeal is pending to this judgement.

Committals and Releases

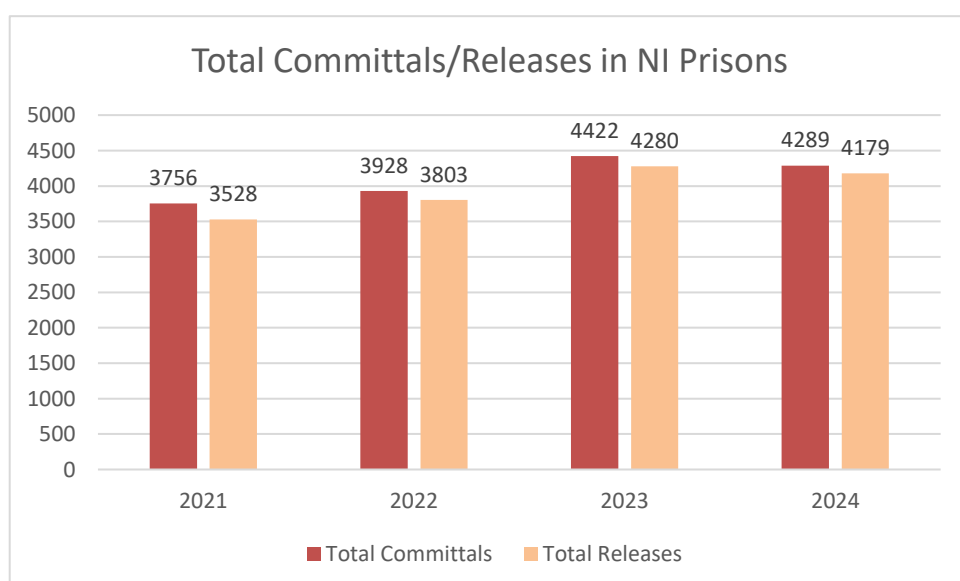
HMP Maghaberry and HMP Hydebank Wood College are the main reception prisons. Since 2021, there has been a sustained rise in the number of committals and releases.

For each patient that enters prison, in accordance with NICE guidance, they receive a 3-stage committal assessment, initial nursing assessment, comprehensive nursing assessment and Mental Health screening assessment.

The disruption rate (% of the population that enters prison or leave prison) indicates the dynamic nature of the population, the churn.

In March 2025, 1900 daily average population, 739 patients either entered or left prison, giving a disruption rate of 39% of the prison population. In HMP Maghaberry, this was 48%.

Remand rate (sentenced) across Northern Ireland, is the highest across the UK at 39% across the prisons, and 50% of HMP Maghaberry. Both remand rate and disruption rate, impacts on services ability to deliver a safe and planned transition into community.

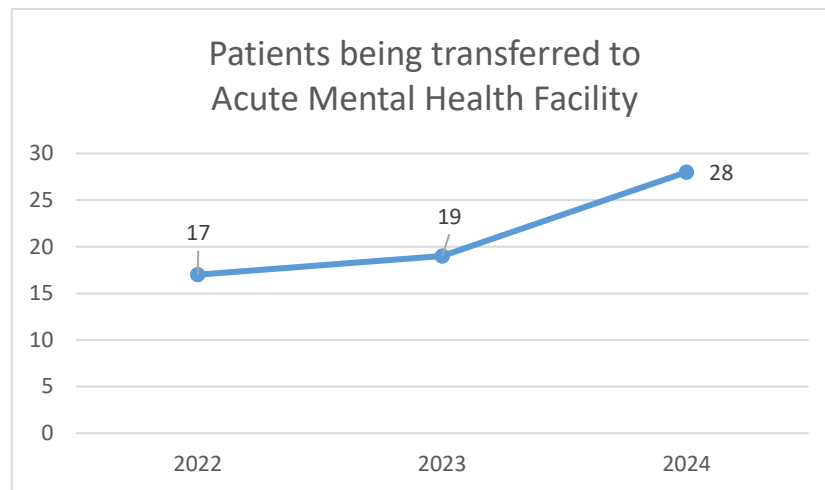


Complexity of Demand

Compounding the pressure of increased volume and disruption rate of the prison population, there has been a change in the needs profile of the population.

Mental Health

There is a rise in the number of patients who are entering/living in prison with acute/enduring mental illness. Those patients who are assessed in prison as requiring a transfer to an acute inpatient facility, has steadily risen. This combined with the uncertainty of release, increases the risk of a patient needing detained at the gate on release, with challenges due to availability of Approved Social Workers and acute beds.



Physical Health

The fastest growing cohort across UK prisons is those over the age of 55, who are defined as elderly. These patients present with multiple co-morbidities and diagnosis, increasing complexity. The challenge in meeting these patient's needs, are increased due to a lack of policy/commissioning decision between DOH and DOJ regarding responsibility for Social Care. SEHSCT are commissioned to provide healthcare alone, and not social care. Currently, due to this vacuum patients in prison are not receiving the same level of social care that they have access to in the community, raising risk of legal challenge based on equivalence. At the Justice Committee, where a progress report paper was presented on the Improving Healthcare in Criminal Justice Strategy on 16th May 2025, it was commented by the chair ;

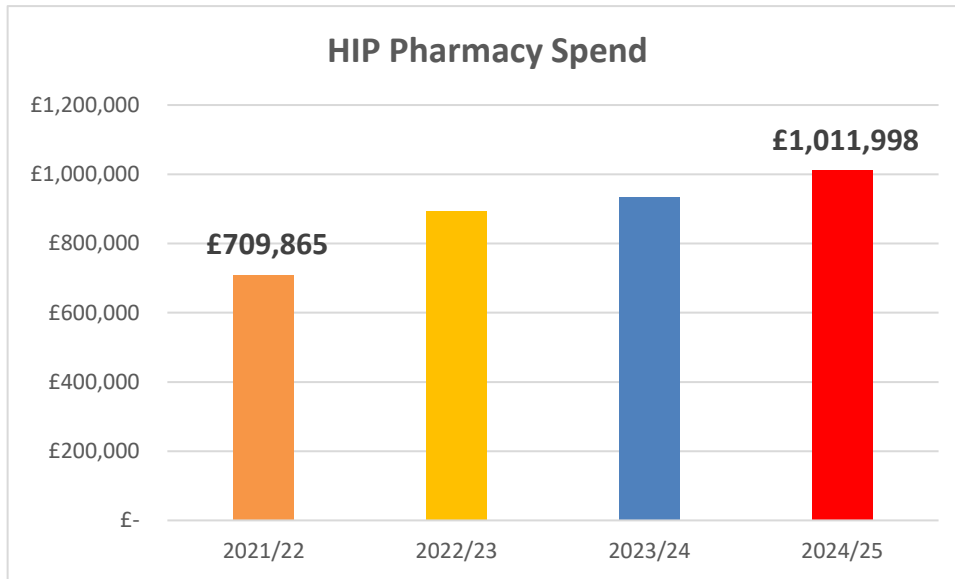
“ (Im) Seriously concerned about dispute between both Departments and who is responsible for social care and fact that there are people not receiving social care “

3.0 Resources Implications (inc Organisational, Financial, Human Resources)

Demands on the service, based upon volume and complexity of patient population , without additional resource increases the risk to trust, service, staff and patients.

There has been additional core funding provided to service despite these challenges, to recruit additional staff.

In addition to the above issues, there are inescapable costs of service delivery outside of workforce which challenge ability of the service to work within budget. Drug spend for HIP, is provided from within its own flat Pharmacy budget unlike in the community. >80% of patients in prison are on medication.



HIP are sequenced to Go Live with Encompass in November 2025 , will require staff time to build , prepare and train on the background of significant service demand.

4.0 Impact on Safety, Quality and Experience (SQE)

- Potential inability for service to comply with NICE and other professional guidance
- Delays in all waiting lists and risk of legal challenge
- Increased response time for critical incidents, due to staff covering wider geographical areas and poorer outcomes for patients
- Increased risk of medication dispensary and administration errors due to increased volume of work
- Delays in medication being administered, including critical meds
- Risk of patient harm due to ability to undertake only critical duties and risk of not identifying emerging clinical risk
- Delays in Committal assessments leading to delay in gathering critical clinical information and acting upon leading to patient harm
- Delays in Mental Health assessment , reviews and interventions
- Inability for patients to be inducted/re-induced on Opioid Substitution therapy within custody, leading to potential risk of overdose within prison and on release
- Increased numbers of patients receiving medication for self-administration, including those who would previously have received directly
- Reduced ability for domestic services to clean clinical areas
- Reduced ability of Admin teams to comply with subject access requests, requests from courts
- Delays in communication with Community Teams/GP practice and continuity of care on release
- Potential subsequent negative findings by Prisoner Ombudsman's/ Coroner/Regulators with risk to corporate standing and legal challenge/financial implications, corporate manslaughter etc.
- Increased staff sickness due to workload, compounding risks further

5.0 Key Risks and Proposals to Mitigate

Key risks see above

Mitigations

Business Continuity Arrangements

Corporate and Directorate Risks revised

Partnership working with NIPS and other agencies

Early Alert issued on 9th May 2025 to DOH

Meeting with Director of Prisons 20th May 2025

Meeting with RQIA 22nd May 2025

Inescapable Pressures briefing to SPPG planned for end of May 2025 to provide detail on challenges

Internal business case being progressed with NIAS for a service level agreement to be explored for provision of paramedics for out of hours

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Date: 20 May 2025