Designing a Prison System for an Ageing Population

RECOOP response to the Independent Review of the Prison System in England and Wales

Final submission | August 2026

Prepared from RECOOP's frontline practice, lived-experience evidence, independent evaluations and national research.

Executive summary

RECOOP welcomes the Independent Review's focus on the long-term resilience, performance and effectiveness of prisons. Our central submission is that the ageing prison population is not a specialist issue at the margins of prison policy. It is a foreseeable structural change which exposes weaknesses in the design, operation, commissioning and culture of the current prison system.

RECOOP's specialist expertise is in the needs and experiences of older people in prison. This response uses that expertise as a lens through which to examine the wider prison system. Older prisoners often experience the consequences of inaccessible design, fragmented services, rigid regimes and discontinuity most acutely, but the underlying weaknesses are not unique to age. Designing a prison system capable of responding well to ageing, frailty and complexity would improve accessibility, decency, rehabilitation and resilience for a much wider prison population.

England and Wales is operating an estate and regime substantially designed around a younger, able-bodied population while holding increasing numbers of people living with frailty, disability, dementia, multimorbidity and the consequences of long sentences. At 31 March 2026, 35,767 prisoners were aged 40 or over, around 41% of the prison population; 16,370 were aged 50 or over. Government projections indicate that the 50+ population will rise from 16,163 in September 2025 to around 18,600 by September 2029. The Chief Medical Officer (CMO) has also highlighted that age-related illness, dependency and frailty can arise earlier in prison than in the general population.[1-3]

RECOOP's evidence shows that the consequences are experienced in ordinary daily prison life: whether someone can get out of bed safely, collect a meal, stand in a medication queue, reach healthcare, use a shower, understand signage, attend a family visit, take part in meaningful activity, or prepare for release. These apparently small operational issues can accumulate into isolation, deconditioning, greater dependency, deteriorating mental and physical health, and increased demand on prison, health and social care services.

The Review should therefore treat older prisoners as a test of whether the future prison system can respond to complexity. An age-responsive prison is not a specialist wing or a single service. It is the combination of estate, allocation, regime, workforce, healthcare, social care, meaningful activity,

structured peer support and continuity beyond the gate working around the functional needs of the person.

Since the first draft of this submission, further direct prisoner and frontline evidence has reinforced the same picture. In a RECOOP consultation with 63 older prisoners at one establishment, 82.5% reported a long-term illness, disability or infirmity, yet only six reported having a local authority Care Plan. Eighty-eight per cent said staying fit was important, but only 24% felt they got enough exercise, and 36.5% did not know where they would live on release.[27] This is not presented as nationally representative data. Its value is that it shows how the wider system issues described in national research are experienced by older people themselves.

We also recommend that the Review move beyond simply adapting conventional prisons. Government should create a commissioned continuum of custody, secure care, specialist forensic provision and age-responsive post-custody accommodation for people whose current risk and complex health or social care needs require different levels of support. That continuum must extend beyond the prison gate through suitable Approved Premises, CAS2, CAS3 and supported or mainstream community provision where appropriate. Secure care should be tested as one component of the continuum, supported by a single accountable commissioning pathway with authority to bring together HMPPS, NHS and local-authority resources around the individual.

Our priority recommendations

1. Design new and refurbished prisons for changing function across the life course, not only for a fixed quota of wheelchair-accessible cells. Accessibility must include the whole journey through the prison, sensory and cognitive accessibility, adaptable accommodation, locate-low/locate-flat arrangements, appropriate bunk allocation, accessible activity and visits spaces, and the ability to maintain independence.
2. Introduce a consistent older-person and frailty pathway across the estate, including systematic screening and periodic review of frailty, cognition, mobility, falls risk, sensory loss, nutrition, continence, mental wellbeing and social care needs, with clear triggers for reassessment after illness, hospitalisation, transfer or recall.
3. Create a single accountable commissioning pathway for prisoners with complex health, social care and forensic needs. The lead commissioner should have authority to coordinate HMPPS, NHS and local-authority responsibilities and assemble pooled or aligned funding around an agreed pathway, so that suitable placements and care packages can be secured before transfer or release rather than negotiated at the point of crisis.
4. Audit and future-proof the post-custody accommodation estate for an ageing population. HMPPS should assess the accessibility and age-readiness of Approved Premises, CAS2 and CAS3 provision, including genuinely step-free and wheelchair-accessible bedrooms and bathrooms, suitability for mobility equipment, access to essential services and the ability to receive commissioned health and social care support. A bed should not be counted as a successful accommodation outcome if the individual cannot safely and practically live in it.
5. Treat structured peer support as part of the prison's preventative infrastructure. Informal help between prisoners should never be mistaken for a safe system of care. Where prisoners depend on peers for essential daily living or mobility, support should be trained, bounded, supervised, safeguarded, accountable and linked to professional services.
6. Broaden the concept of rehabilitation and purposeful activity for an ageing population. Meaningful activity that maintains physical function, cognition, identity, social connection, contribution and hope should sit alongside work and education, not beneath them.
7. Design resettlement preparation to follow the person rather than depend on transfer to a particular resettlement prison. Older long-sentenced people, including people convicted of

sexual offences, need earlier and more intensive preparation for unfamiliar communities, digital life, accommodation, healthcare and licence requirements.

8. Use supported resettlement day release and commissioned community navigation for prisoners with additional transition needs. Where age, long-term institutionalisation, mobility, cognition or social isolation make unsupported release less effective, appropriately trained voluntary and community-sector partners should be able to accompany people into the community before release, help them practise essential journeys and services, identify barriers while there is still time to resolve them, and continue time-limited support after release while independence is rebuilt.
9. Build continuity across transfer, recall and release into the prison operating model. Health, social care, medication, equipment and support arrangements should travel with the individual. Short periods of recall should not repeatedly dismantle care and resettlement plans.
10. Develop regional options for prisoners whose frailty, disability or end-of-life needs can no longer be managed appropriately in conventional accommodation, while retaining proportionate security and dynamic risk assessment.
11. Make age-responsive capability part of workforce development. Staff working on residential units should receive proportionate training in ageing, frailty, dementia, cognitive change, sensory loss and reasonable adjustment, with clear escalation routes when changes in behaviour or function may indicate deteriorating health or care needs.
12. Require forward modelling of the age and functional profile of the sentenced population over the Review's five-, ten- and fifteen-year horizon, including the likely age in custody of people serving long and indeterminate sentences, so that estate, workforce, health and social care investment is based on future need rather than today's age profile.
13. Protect family and significant relationships as part of prison design and placement. Visiting arrangements should be accessible to older and disabled visitors as well as prisoners, and decisions about regional specialist provision should explicitly weigh the benefits of concentration against distance from healthy support networks.
14. Make the response to ageing in custody explicitly gender-responsive. Older women should be visible within both older-prisoner and women's strategies, with sex-disaggregated data, attention to menopause, trauma, mental health and relationships, and co-designed testing of appropriate peer-led wellbeing approaches.
15. Protect access to time-critical medication during restricted regimes. Where medication cannot safely be held in-possession, prison operating arrangements must ensure clinically appropriate administration at the required time, including during lockdowns, with clear escalation routes and periodic review of whether greater self-management is safe.
16. Make risk and placement genuinely dynamic across long sentences. Periodic reviews should explicitly consider material changes in age, frailty, cognition, physical capability and opportunity to offend or abscond, alongside offence-specific and safeguarding risks, so that people are held in the lowest security and most appropriate setting consistent with public protection.
17. Commission and evaluate a regional continuum of secure and specialist care provision, including a secure care pilot and better routes into existing forensic provision. Eligibility should be based on current risk, legal status and functional need rather than age alone, with evaluation covering public protection, care quality, prison places released, hospital use, bed watches, staffing, family contact, whole-system cost and progression or release outcomes.

1. About RECOOP and our evidence

RECOOP is a specialist charity working with older people in prison and people with complex health, social care, wellbeing and resettlement needs. Our evidence comes from sustained frontline

delivery across prisons, direct engagement with prisoners, operational case studies, service data, research undertaken with academic partners and independent evaluations.

This response deliberately distinguishes between national evidence, independent evaluation, RECOOP primary research, operational intelligence and individual lived experience. A case study is not presented as evidence of national prevalence. Its value is to show how a system issue is experienced in practice and, where possible, to triangulate that experience with wider research.

- Finding Meaning Behind Bars (2025), by Marion Vannier, Helen Gair and Vlad-George Zaha, University of Manchester and RECOOP: research focused specifically on meaningful activity for older prisoners.
- Independent THREADS evaluation by SERIO, University of Plymouth (2023): mixed-method evaluation of a peer-led, person-centred mental wellbeing intervention.
- RECOOP Buddy Support Service Evaluation, interim findings (2026), led by Professor Helen Codd: questionnaires using recognised wellbeing and loneliness measures, with National Research Committee approval for further qualitative work.
- RECOOP operational and lived-experience material, including Buddy, resettlement, health, dementia/frailty and end-of-life case studies.
- RECOOP survey and intersectionality work examining how age, disability, health, social care, family relationships and resettlement barriers combine.
- Historic RECOOP/Clinks work on the needs and experiences of older people in prison, retained alongside the fuller working evidence that underpinned the final publication.
- Direct older-prisoner consultation evidence, including a 63-response questionnaire exercise covering health, activity and resettlement, and additional recent Buddy/peer feedback on healthcare access, wellbeing and continuity at release.
- Recent frontline operational evidence on mattresses, supportive seating, wheelchair availability and maintenance, social care referral difficulties and the practical impact of regime restrictions on medication access.

2. The strategic case: ageing is a prison-system issue

The prison population is not only large; it is increasingly complex. At 31 March 2026, around two in five prisoners were aged 40 or over. The 50+ population accounted for almost one in five. The number of people serving Extended Determinate Sentences reached 9,697 by June 2026, while the unreleased life-sentenced population stood at 7,617. Government projections expect the life-sentence population to continue growing.[2,4,5]

Age in prison is not equivalent to chronological age in the community. The CMO reports earlier onset of age-related illness, dependency and frailty, and notes that more than 40% of men over 50 admitted to hospital in an emergency showed signs of frailty. The same report recognises that the estate was generally designed for a young male population and that employment and activity are often oriented towards younger prisoners.[3]

The policy implication is straightforward: the system should plan for functional need and frailty, not merely count prisoners over a particular age threshold. Someone may enter prison independently mobile and later experience stroke, cancer treatment, Parkinson's disease, dementia, arthritis or progressive deconditioning. Estate design, allocation, staffing and care arrangements need to accommodate that journey.

3. Estate design: accessibility is the whole prison journey

The Review explicitly asks what changes are required to the design, configuration and condition of the estate over the next five to fifteen years. RECOOP's experience is that accessibility is too often reduced to the availability of a small number of adapted cells. The relevant question is whether a person can participate in ordinary prison life as their function changes.

Our earlier work identified older prisoners housed on higher landings and top bunks, insufficient storage for mobility aids, stairs that made meal and medication collection difficult, and lifts or stairlifts that could not be used without staff or peer assistance. In some settings, older people with mobility difficulties were reported to face a practical choice between collecting medication and collecting lunch because there was insufficient movement time to do both. The same work identified better practice where older people were located on ground-floor accommodation close to healthcare.[6]

RECOOP's operational experience adds further detail: activity can exist but be inaccessible because it is too far from the residential block; wheelchairs may not fit through older cell doorways; a person may technically have access to visits but be unable to reach the visits hall; and delays over grab rails, equipment or adaptations can create dependency that might have been avoided.

Recent operational evidence shows how basic equipment and design failures continue to create avoidable dependency. A RECOOP manager reported a 73-year-old first-time prisoner using two worn mattresses with a quilt between them because no suitable mattress was available. At another establishment, supportive Crib 7-rated chairs could not pass through cell doorways. Wheelchairs across several prisons have been found with missing footplates, damaged fabric or twisted wheels, while local repair and replacement routes can be unclear or slow. These examples are modest in cost compared with the consequences, but they directly affect pain, sleep, mobility, dignity, evacuation, access to visits and independence.[28]

This is consistent with earlier RECOOP/Clinks evidence in which prisoners described thin, hard mattresses, delays in mobility aids, inaccessible showers, inappropriate top-bunk allocation and areas that could not be reached by wheelchair.[6] The persistence of the same practical problems strengthens the case for designing predictable needs into the estate rather than relying on repeated individual workarounds.

Design principles for future prisons

- Design for the journey, not just the cell: reasonable distances to healthcare, visits, activity, exercise and outside space; places to rest; reliable lifts where vertical movement is unavoidable.
- Design for changing function: adaptable cells, wider doorways, accessible showers and toilets, storage for mobility aids, appropriate bed and bunk allocation, and consistent locate-low/locate-flat practice.
- Design for cognition and sensory loss: clear wayfinding, larger legible fonts, strong contrast, recognisable landmarks and colour coding, appropriate lighting, hearing support and quieter spaces.
- Design for independence: environments that allow people to do things for themselves for as long as possible, reducing avoidable reliance on peers, officers and paid care.
- Design for meaningful occupation: accessible workshops, practical 'men in sheds'-style spaces, crafts, raised beds, gardens and outdoor areas close enough to residential units to be genuinely usable.

- Design for connection: family visits, social spaces and communal activity must be reachable by people with limited stamina or mobility.

A key principle for the Review is that distance itself can be an accessibility barrier. A service that exists on paper is not meaningfully available if the person cannot physically or cognitively reach and use it.

4. Health, social care and the problem of fragmented ownership

Older prisoners sit at the intersection of prison operations, NHS healthcare and local-authority social care. The legal and commissioning responsibilities may be defined, but RECOOP's operational experience is that delivery is not consistently joined up around the individual.

The Care Act framework places responsibility on the local authority in whose area the prison is located to assess and meet eligible social care needs. Previous HM Inspectorate of Prisons work nevertheless identified inconsistent provision and recommended stronger cross-departmental coordination. RECOOP continues to be contacted by prison leaders seeking help to navigate social care referrals where local arrangements are not functioning as they should.[7]

RECOOP's recent direct consultation evidence illustrates the gap between need and formal social care. Of 63 older prisoners consulted at one establishment, 82.5% reported a long-term illness, disability or infirmity, while only six reported having a local authority Care Plan. Thirty-five per cent reported hearing difficulties, 31% mobility problems and 31% eyesight problems.[27] These figures are establishment-specific, but they provide a useful lived-experience test of whether formal assessment and care planning are keeping pace with need.

The policy landscape has recently been clarified by HMPPS's June 2026 framework on access to health and social care, which places mandatory duties on prisons and probation to enable timely, safe and equitable access while recognising that clinical governance rests with health services. That clarification is welcome, but it reinforces our central point: the quality and safety of care still depend on operational access, information flow and partnership working under the prison roof.[29]

The CMO's 2025/26 report reinforces the underlying problem. It identifies gaps in provision, poor data flows and transition points into, between and out of prison as significant risks. It also notes that current reception screening does not include standardised questions on frailty or cognition and is not systematically repeated, despite earlier Department of Health guidance recommending health and social care assessment from age 60 at least every six months.[3]

A consistent older-person pathway

RECOOP recommends a consistent pathway that combines health, function and social care rather than waiting for crisis. It should include frailty, cognition/dementia, mobility, falls, sensory impairment, continence, nutrition, medication, mental wellbeing, daily-living ability and social care need. Review should be periodic and triggered by significant events such as hospital admission, stroke, cancer treatment, transfer, recall or a marked change in function.

Existing clinical practice provides building blocks. The CMO points to frailty assessment and Comprehensive Geriatric Assessment approaches already used in health services and to local prison examples. The issue is not an absence of tools; it is the absence of consistent application and operational ownership across the estate.[3]

5. Access to secondary healthcare is an operational capacity issue

Prison healthcare cannot be judged solely by what is commissioned inside the gate. Access to external diagnostics and treatment depends on the prison's ability to transport and supervise people safely.

Nuffield Trust analysis found that prisoners had 24% fewer inpatient admissions and outpatient attendances than comparable people in the wider population, and that 40% of outpatient appointments were not attended in 2017/18, double the general-population proportion. Staff and escort availability were identified as important contributors. Nuffield's later work on older people specifically highlights mobility barriers, broken lifts, inaccessible spaces and missed outpatient appointments.[8,9]

Recent peer evidence collected for this submission gives a human example of the same problem. One respondent was aware of a cancelled healthcare appointment that had left a prisoner in pain and still waiting ten weeks later.[33] This is a single reported example, not prevalence evidence, but it illustrates why delay matters to the person rather than simply to an appointment-performance measure.

For prisons holding a predictably older and less healthy population, escort demand is not an exceptional event; it is part of the operating requirement. Staffing models and in-reach health provision should reflect the morbidity profile of the population. A cancelled appointment is not operationally neutral where it delays diagnosis or treatment for someone with serious disease.

The CMO also shows how a very small number of medically complex prisoners can generate disproportionate external healthcare demand. The Review should consider how better prevention, in-reach diagnostics and treatment, telemedicine where clinically appropriate, and appropriate regional provision could reduce avoidable operational pressure without restricting access to necessary care.[3]

Medication, autonomy and regime resilience

Medication is a distinct example of how prison operations and healthcare intersect. Many prisoners cannot safely hold all of their own medicines because of overdose, diversion or trading risks. Where that is the case, the institution controls when the person can access medication. For older people taking medication for multiple long-term conditions, that loss of control can itself create significant anxiety, particularly during restricted regimes when movement is stopped and peer supporters may also be locked behind their doors.

RECOOP staff report repeated conversations with men who know that medication is due, press their cell bell during a lockdown, and then wait without knowing when healthcare will reach them. For somebody with Parkinson's disease, this is not simply a matter of convenience. Parkinson's medication is clinically time-critical and specialist guidance states that it should be taken within 30 minutes of the prescribed time because delays can materially affect movement, speech, swallowing and daily function.[30]

The prison principle should therefore be clear: where the state removes an individual's ability to self-administer medication, it assumes a corresponding responsibility to make the operating model resilient enough to deliver it safely and on time. In-possession decisions should remain individual and risk-based, but should be reviewed as circumstances change, with secure storage and greater self-management used where clinically and operationally safe. Restricted regimes must include an explicit medication-continuity plan rather than making access contingent on ordinary unlock arrangements.

This also reinforces the workforce argument later in this submission. Wing staff do not need to make clinical decisions, but they do need to understand that some medicines are time-critical, recognise deterioration and have a route to escalate when normal arrangements fail.

6. Maintaining independence is prevention

A recurring theme across RECOOP's evidence is that small interventions can determine whether somebody remains independent or becomes progressively more dependent. A handrail, appropriate chair, mobility aid, accessible shower, supported walk, medication prompt or help to maintain routine can prevent deterioration that later requires substantially more staff or statutory care.

The 2026 Buddy evaluation illustrates the level of need among service users: most respondents were living with multiple significant health conditions; depression and anxiety were common; and Buddies were supporting meals, cell cleanliness, healthcare access, medication, activities, listening and advocacy. Ninety per cent of service users agreed that their Buddy helped with daily life, and 90% reported that without their Buddy they would need more officer support.[10]

The Lancashire Buddy investment case records 67 trained Buddies delivering 2,520 hours of structured support each week across five prisons at March 2026, supporting 264 people. Forty people had regained sufficient independence to come off support plans during the year. RECOOP presents the calculated £3.21 million annualised healthcare-assistant replacement value as an indication of scale, not a cashable saving.[11]

The policy lesson is wider than Buddy provision: maintaining independence should be treated as preventative prison infrastructure. It protects dignity and can also protect scarce officer, healthcare and social care capacity.

7. Informal peer care is not a safe care model

Prisoners have always helped one another. That can be humane and positive. It is not, however, a sufficient response where a vulnerable person depends on another prisoner for essential daily living, mobility, food, communication or access to services.

RECOOP's operational experience is that prison officers do not routinely provide wheelchair assistance and that this is generally not regarded as part of the officer role. We have not identified a published national instruction or Prison Officers' Association policy establishing a blanket prohibition, so we do not present it as one. In practice, however, prisoners with significant mobility needs can become reliant on peers to move around an establishment.

In one case identified during a RECOOP Board visit, deteriorating mobility and the absence of suitable wheelchair provision contributed to an older prisoner going for an extended period without family visits because he could not get to the visits hall. RECOOP purchased a wheelchair to address the immediate need. The important question is not who bought the wheelchair; it is who was responsible for ensuring that the person could continue to participate in ordinary prison life.

Where informal support is relied upon without assessment, training, supervision or safeguarding, the prison has little assurance about boundaries, coercion, debt, manipulation, exploitation or psychological dependency. RECOOP has operational concerns in this area, but does not claim prevalence figures without supporting data.

The principle should be clear: peer support should supplement professional responsibility, not become the mechanism by which the system quietly transfers responsibility to prisoners. Structured schemes should include selection, risk assessment, training, safeguarding, supervision, documentation, escalation routes and clear links to healthcare and social care. The independent

THREADS evaluation demonstrates the importance of exactly these structures in a peer-led intervention.[12]

8. Workforce capability, culture and compassion

The Review rightly includes workforce culture as well as capacity and capability. Age-responsive prisons require staff who understand frailty, dementia, disability, sensory loss, social care and reasonable adjustment, and who recognise maintaining independence as part of effective custodial practice.

Age-responsive practice cannot be delegated to healthcare and social care. For an older person in custody, the residential wing is their community and the landing is their immediate neighbourhood. The people living and working there form the day-to-day support network around the individual. Wing staff and peers may see a person repeatedly between formal clinical contacts and can therefore be among the first to notice changes in mobility, cognition, appetite, mood, self-care, continence, social engagement or behaviour.

That makes staff training fundamental. Prison officers are not expected to become clinicians, but they do need sufficient knowledge and confidence to recognise when apparent non-compliance, irritability, withdrawal, forgetfulness or changed behaviour may reflect dementia, delirium, frailty, illness, sensory loss or deteriorating mental health, and to know how and where to escalate concerns. RECOOP recommends a core ageing, frailty and dementia-awareness component within prison staff development, proportionate to role, with enhanced training in establishments holding substantial older or complex-needs populations.

The most recent Buddy/peer feedback shows why this matters. One respondent described a man returning from hospital who had not eaten for four days before healthcare was informed. In that account, healthcare responded once alerted, but the delay occurred because the need had not reached them.[33] That is precisely the gap between clinical responsibility and the everyday residential environment that whole-prison training and clear escalation routes need to close.

The Buddy evaluation identifies operational barriers including unlock, staffing and differing levels of staff understanding of the role. The THREADS evaluation similarly found that staff buy-in and clear ownership within HMPPS were important to delivery, while restricted regimes could limit impact.[10,12] These findings reinforce that training alone is insufficient unless leadership expectations and operating practice enable staff to apply it.

RECOOP's wider frontline experience suggests that barriers cannot always be explained by resource pressure alone. In some establishments, attitudes towards older or disabled prisoners and towards peer-led support can themselves become implementation barriers. We do not generalise this across the workforce; there are many examples of committed and compassionate staff. But a future operating model should make age-responsive practice an expected capability, supported and modelled by leadership, rather than dependent on individual goodwill.

Compassion should not be dismissed as a soft value. For a frail or cognitively impaired prisoner, whether staff notice deterioration, take time to explain, enable an adjustment or support access can determine whether the person eats, attends healthcare, leaves their cell or remains connected to family. Healthcare owns clinical care and local authorities retain statutory social care responsibilities, but maintaining wellbeing and independence under the prison roof is necessarily a whole-prison responsibility.

9. Meaningful activity: rehabilitation must be relevant to the person

RECOOP supports the principle that prisons should prepare people to lead law-abiding and contributing lives. But rehabilitation cannot mean exactly the same thing for every prisoner. A model dominated by conventional work and education can exclude people who are retired, frail, chronically ill or serving very long sentences.

Finding Meaning Behind Bars argues for a distinction between purposeful and meaningful activity for older prisoners. It identifies overlapping vulnerabilities including physical decline, mental health difficulties and social isolation, and calls for activity that supports autonomy, identity, social connection, cognitive stimulation and contribution.[13]

The current HMPPS National Regime Model gives this argument an important operational route. Regime plans must include Foundation, Tier 1 and Tier 2 activity, and prisons are measured on actual delivery against planned delivery through the Purposeful Activity measure in the Prison Performance Tool. HMPPS has also reported that Tier 2 recording feeds the Regime Dashboard and that Tier 1 and Tier 2 activity recorded on NOMIS forms part of the refreshed purposeful-activity measure.[18,19]

This is an opportunity rather than a criticism of the framework. HMPPS has created an architecture capable of recognising activity beyond conventional work and education. The next step is to ensure that Tier 2 is consistently available, recorded and valued as an outcome-bearing part of the regime, particularly for prisoners who are marginalised from or unable to access conventional provision.

For an older prisoner, meaningful rehabilitation may include maintaining mobility and cognition, mentoring others, practical crafts, gardening, social participation, creative activity, family connection, preparing for release and retaining the skills needed for everyday living. This is not a lower expectation. It is a relevant expectation.

RECOOP recommends that HMPPS develop a meaningful-activity outcome or KPI within the regime framework for cohorts for whom conventional participation measures are insufficient. Measurement should look beyond hours occupied to whether activity maintains function, social connection, confidence, contribution, cognitive stimulation and independence.

Physical design matters here too. RECOOP has delivered services that some older men could not reach because activity spaces were too distant from their accommodation. New prisons should therefore place accessible, age-appropriate activity closer to residential areas and include outdoor and practical spaces such as raised beds, gardens and workshops.

Recent prisoner feedback brings this gap into sharp focus. In the 63-person RECOOP consultation, 88% agreed that staying fit was important to them, yet only 24% felt they got enough exercise. Eighty-nine per cent said they did not take part in activity specifically for older prisoners; 17 respondents said there were no suitable activities and 19 cited health or mobility as a barrier.[27]

The same consultation also shows why meaningful activity should start with identity and lifetime experience. One participant described practising bonsai for 30 years and teaching others in community groups; another asked for cooking, basic DIY and first-aid classes. These are not marginal recreational preferences. They are examples of skills, contribution, cognitive stimulation and practical independence that can be recognised within Tier 2 provision.[27]

International experience also shows why England and Wales should look further ahead. US Bureau of Justice Statistics data found a 400% increase in state prisoners aged 55 or over between 1993 and 2013, driven in part by longer lengths of stay and people ageing into older cohorts while serving

sentences.[20] This is not a forecast for England and Wales, but it demonstrates how rapidly the age profile of a prison population can change when long sentences accumulate.

The Review should therefore commission forward modelling of the existing sentenced population: not only how many prisoners will be over 50, but how many people currently serving long and indeterminate sentences are likely to be aged 50+, 60+, 70+ and 80+ in five, ten and fifteen years. That information should inform future estate design, workforce capability, health and social care capacity and meaningful-activity planning.

10. Dementia, frailty and end of life

Dementia and frailty expose the limitations of a regime that interprets need primarily through behaviour and compliance. RECOOP case material includes people whose cognitive impairment contributed to confusion, withdrawal and exclusion from activities, and examples where relatively modest person-centred adjustments enabled continued participation and independence.

The CMO recommends greater attention to frailty and cognition, while recent research has strengthened the evidence base on dementia and mild cognitive impairment among older prisoners. The practical implication is that cognitive decline must be recognised early and not simply interpreted as non-compliance, irritability or lack of motivation.[3,14]

Palliative and end-of-life care is a smaller but growing requirement. Hospice UK's Dying Behind Bars identified challenges in delivering consistent end-of-life care and the value of hospice partnerships. RECOOP has experience of Buddy and staff training linked to hospice expertise and of supporting people undergoing terminal cancer treatment.[15]

The Review should consider whether conventional prison accommodation remains the right setting for every person whose physical dependency becomes profound. Regional secure health or care-style provision may allow some people to be managed more humanely and efficiently, subject to individual security, legal and public-protection requirements. Age should never be treated as synonymous with low risk; risk should, however, be assessed dynamically rather than assumed to remain unchanged as circumstances and physical capability alter.

RECOOP's Buddy training illustrates what a properly developed peer role can require. The programme has been adapted to align with national Care Certificate standards and, in response to experience from Buddies themselves, includes additional prison-specific modules on end-of-life care and bereavement. These recognise that a peer may support someone through serious illness for months or years, experience that person's death, and then continue living in the same environment while carrying grief, loss and potential vicarious trauma.

This matters because peer supporters are not simply recipients of a prison job or volunteers filling spare time. Properly selected, trained, supervised and supported, they form a valuable complementary part of the whole-prison workforce. The benefit flows in both directions: the person receiving support can retain independence and connection, while the peer develops purpose, responsibility, skills, identity and contribution.

The Lancashire evidence makes the preventative value tangible: 40 people regained sufficient independence to come off support plans during 2025/26.[11] The lesson is not that unpaid prisoners should replace statutory care. It is that a well-governed peer workforce can work upstream, alongside professional services, to prevent avoidable dependency and make better use of scarce paid capacity.

A specific recommendation: create a commissioned continuum of secure and specialist care

RECOOP now believes the Review should go further than asking whether conventional prisons can be adapted. For a small but growing group with profound frailty, dementia, complex social care, serious physical illness or end-of-life needs, the more fundamental question is whether a conventional prison is the right environment at all, and whether current commissioning arrangements allow an appropriate alternative to be secured when one exists.

The answer should not be a single new model. Government needs a commissioned continuum that can match current risk, functional ability and care need to the least restrictive safe and suitable setting. That continuum could include specialist prison units, a regional secure care model, existing forensic health or care provision, age-responsive Approved Premises, CAS2 and CAS3 accommodation, and appropriately supported community provision where legal and public-protection requirements permit. Accommodation and support should be commissioned as one pathway rather than treating the bed, care package and resettlement support as separate problems.

This is not a new proposition. RECOOP and Clinks previously recommended regional secure care home pilots, and the Prison Reform Trust's 2024 consultation with 121 older people in 39 prisons similarly recommended that the Ministry of Justice pilot secure social care in the community. Academic and parliamentary evidence has also continued to identify the absence of an intermediate secure care option for people whose care needs cannot be met well in prison but whose risk profile may prevent ordinary residential care.[6,31,32]

RECOOP is also receiving current operational intelligence from forensic care providers who report vacant specialist beds but difficulty receiving appropriate referrals from prisons because responsibility for assembling and funding the required package is unclear. We do not present this as national utilisation data. It is nevertheless important frontline evidence of a potential system failure: suitable capacity can exist in one part of the system while a person remains in prison because no single commissioner can bring the health, social care and justice funding together to make the placement happen.

We recommend a time-limited regional pilot within a wider commissioned pathway, with a tightly defined eligibility framework based on current risk, functional need and legal status rather than age alone. The secure care component could be located within or adjacent to the secure estate, or operate through an appropriate community-based secure or supervised legal framework. It should provide 24-hour health and social care capability, dementia-friendly design, palliative care links, meaningful activity, family access and properly trained peer support where appropriate.

The business case should be evaluated at whole-system level. Conventional custody for a person with high dependency can require repeated hospital escorts, bed watches, officer abstraction, external care placements and substantial adaptation while still delivering a poor living environment. The evaluation should therefore measure quality of care and public protection alongside cost per place, prison capacity released, hospital use, bed-watch and escort demand, incidents, staffing, family contact, functional outcomes and progression or release.

We do not claim in advance that secure or forensic care will always be cheaper, or that every vacancy is suitable for a prisoner leaving custody. The point is that fragmented departmental budgets can conceal whole-system cost. The Review should test whether better use of existing specialist capacity and a purpose-designed secure care option can deliver more proportionate use of scarce prison places without weakening public protection.

Secure care should not become an age-based route out of prison or a mechanism for diluting legitimate public-protection concerns. It should be one part of a graduated pathway in which security and care intensity are matched to the person's current needs and risks, with transparent oversight and public confidence built into the design.

11. Family, significant relationships and social connection

Family and significant relationships are an important part of safety, wellbeing, rehabilitation and successful resettlement. HM Inspectorate of Prisons' 2026 thematic review found that prisons too often fail to get the basics of family contact right, including booking visits, travel and financial support, and that family provision is too often treated as a 'nice to have' rather than an essential part of the prisoner's journey. The review also emphasised the contribution that family and friends can make to mental and physical wellbeing, hope, safety and preparation for release.[21]

For older prisoners, the barriers can be compounded by age on both sides of the prison gate. A spouse, partner, parent, sibling or lifelong friend may themselves be older, disabled, living with poor health or no longer able to undertake long and difficult journeys. The relevant question is therefore not only whether an older prisoner can physically reach the visits hall, but whether the people who matter to them can reach the prison, navigate the visitor journey and participate in a visit. Accessibility should be considered from both sides of the visits table.

This matters particularly where specialist or regional provision is being considered. Concentrating expertise can improve health, social care, regime and end-of-life provision, but it may also increase distance from home. Placement decisions should therefore weigh the benefits of specialist provision against the potential loss of regular contact with significant relationships, with accessible face-to-face visiting protected wherever possible and digital contact used to supplement rather than replace it.

The nature of family relationships also requires nuance. For some older prisoners, including some people convicted of sexual offences, family ties may have fractured or contact may be inappropriate. For others, a small number of supportive relationships may be one of the strongest remaining protective factors. The system should focus on healthy and supportive relationships rather than assume either that family contact is universally available or that it is unimportant.

RECOOP has less systematic case-study evidence on families than on health, social care and peer support, so we do not make prevalence claims from our own practice. However, the national evidence is sufficiently strong to conclude that future prison design, placement and resettlement planning should treat meaningful social connection as part of the operating model rather than an optional adjunct.

12. Recall, churn and the differential impact on older people

Recall is now a major source of churn through custody. Between January and March 2026 there were 13,193 licence recalls, a 31% increase on the same quarter in 2025, compared with 12,977 releases from sentences during the quarter. These are different measures and should not be treated as a direct one-for-one comparison, but they demonstrate the scale of movement back into custody.[4]

Fixed-term recall policy has also changed rapidly. Changes from September 2025 expanded 28-day fixed-term recall for eligible cases, and further changes from 31 March 2026 introduced 56-day arrangements for other eligible recalled prisoners. The Review itself explicitly identifies recall as a factor affecting future estate demand.[1,4]

RECOOP's concern is the differential effect of short recall periods on people with complex age-related needs. A return to a reception or local prison may disrupt medication, equipment, social care, mobility support, peer support and resettlement arrangements, only for those systems to need rebuilding again on re-release.

Our operational evidence includes a recalled prisoner whose previous support arrangements were not reinstated, followed by deterioration in nutrition, continence and medication management. This should be treated as a continuity-of-care warning, not merely a service failure.

For older people, a short recall can therefore carry consequences disproportionate to its duration. Care and resettlement information should travel with the person, and recall should trigger rapid reinstatement and review rather than a fresh start from zero.

Recent peer feedback gathered for this Call for Evidence describes the problem in simple terms: there is perceived to be 'no link between services and men being released', adding to worry and anxiety before release and having a major mental-health impact.[33] This is practitioner/peer observation rather than prevalence data, but it closely aligns with the transition failures identified elsewhere in our evidence.

13. Long sentences, sexual offending and release into unfamiliar communities

Longer sentences and offence mix matter to ageing. At June 2026, around seven in ten prisoners serving an immediate custodial sentence had been convicted of violence against the person, sexual or drug offences; 22% had been convicted of sexual offences. Extended Determinate Sentences, which may be imposed for specified sexual, violent or terrorist offences, had risen to 9,697, around 11% of the total prison population.[4]

RECOOP's frontline experience is that some older men convicted of sexual offences do not progress to a resettlement prison before release because there is insufficient capacity or headroom in the estate. We have not identified national data that quantify this phenomenon, so we present it as operational intelligence rather than a national prevalence claim.

The consequences can nevertheless be significant. Some men leave long periods of highly structured custody for unfamiliar towns or cities, unable or unsuitable to return to former communities, with fractured family relationships, limited digital capability and substantial anxiety about life outside. RECOOP practitioners have heard accounts suggesting that inadequate preparation, institutionalisation and fear can contribute to behaviour that places licence compliance at risk. This requires further research; it should not be interpreted as evidence that recall is generally deliberate.

The system-design point is that resettlement preparation must follow the person. Access to age-appropriate preparation should not depend on reaching a particular prison. For older long-sentenced people, preparation should start earlier and include practical daily living, digital skills, accommodation, healthcare continuity, social connection, licence understanding and psychologically supported transition.

Direct prisoner feedback also demonstrates the uncertainty behind this argument. In the 63-person consultation, 36.5% did not know where they would live on release and the same proportion had concerns about accommodation or location. Forty-two per cent said they had had no contact with their probation officer. One participant summarised the problem as: 'I have anxiety because it is not dealt with until final weeks.'[27] This is precisely why age-responsive resettlement must begin

earlier and be designed around the functional and emotional transition, not merely the administrative release date.

14. Dynamic risk, ageing and proportionate placement

RECOOP recommends that the Review explicitly connect ageing and frailty with the principle of dynamic risk management. The current HMPPS security categorisation framework already requires people to be held in the lowest security category appropriate to the risks they present.[34] Our concern is not that age should mechanically reduce security category, but that material changes in physical capability, cognition, health and opportunity over a long sentence should be actively considered in risk, security, placement and progression decisions rather than the index offence dominating indefinitely.

The population-level evidence supports asking this question. The Justice Committee has previously recorded that older prisoners are less likely to reoffend than younger groups, while more recent Ministry of Justice data continue to show adult proven reoffending falling with increasing age after the 35-39 group.[35,36] Historical MoJ data supplied to the Committee also showed people over 60 were more likely to complete licence conditions successfully than offenders overall. HM Inspectorate of Prisons has long described older prisoners as a generally compliant population whose needs can be overlooked precisely because they create fewer day-to-day management problems.[35,37]

This evidence must be handled carefully for people convicted of sexual offences. Age is associated with lower sexual recidivism on average, and modern actuarial approaches explicitly take age at release into account, but risk does not disappear uniformly with age. Offence history, victim profile, current sexual interests, cognition, access to potential victims, health and other dynamic and static factors remain relevant.[38,39] A frail older person should therefore neither be assumed safe because of age nor assumed to carry an unchanged level of practical risk because of the seriousness of an historic index offence.

We recommend a mandatory age-and-function prompt within relevant periodic risk and placement reviews for long-sentenced prisoners, asking whether changes in frailty, cognition, mobility and physical capability materially alter escape risk, opportunity, supervision need or the environment required to manage risk safely. Where they do, HMPPS and the Parole Board should be able to consider the most proportionate lawful setting and supervision model.

This is distinct from compassionate release. Early Release on Compassionate Grounds remains an exceptional mechanism and public protection remains the priority; recent parliamentary data show that only a handful of people were released on ill-health grounds in 2023 and 2024.[40] The Review should nevertheless examine whether current pathways, including compassionate release, parole, recategorisation and secure care alternatives, work coherently for people whose health and functional circumstances have changed fundamentally during very long periods in custody.

15. Transitional living environments inside prison

The future estate should include more opportunities for people approaching release to practise ordinary living skills in environments closer to those they will encounter outside. This should not be limited to a very small group of enhanced prisoners.

Small-group or supported-living units could include shared kitchens, laundry, cleaning, budgeting, meal preparation and management of an ordinary living space, with appropriate risk controls. For someone who has spent decades in custody, this is rehabilitation in a very practical sense.

Such environments could also improve assessment of functional need. It is difficult to judge whether someone can prepare food, remember domestic sequences, manage a living space or recognise when they need help in an institutional environment where many ordinary tasks are done for them. Observation in a more normalised setting could inform better transition planning and social care assessment, while recognising that legal Care Act responsibility and community reassessment still apply after release.

16. Older women: avoiding a cohort hidden between two policy agendas

The ageing prison population is not exclusively male. RECOOP has direct operational experience of supporting older women, including approximately 15 years of group-based provision at HMP Eastwood Park and preventative menopause support delivered in three women's prisons in Surrey. These services reinforced that older women can have a different combination of needs and life experiences from older men, with wellbeing, mental health, trauma, relationships and gender-specific health needs often particularly important.

National evidence supports a gender-responsive approach. The National Women's Prisons Health and Social Care Review concluded that women in prison have disproportionately greater health and social care needs than both men in prison and women in the general population, alongside high levels of poor mental health, trauma and adverse life experience.[22] Research focused specifically on older women remains limited. A recent England and Wales study identified unmet needs across health screening, health services, emotional wellbeing, social and family connections, professional coordination and data and research; the authors concluded that older women's needs remain under-researched and are often unmet.[23]

Menopause is an important part of this picture but should not become the whole older-women agenda. A 2025 systematic review found that menopause in prison remains poorly understood, with barriers to symptom management, gaps in awareness and treatment knowledge, and a need for further research, policy development and education.[24] Existing gender-specific standards have also recognised that women in prison should have access to the same standard of menopause care as women in the community and that the prison environment itself can make symptoms harder to manage.[25]

Geography can further compound these issues. The Farmer Review for Women identified distance, travel cost and the limited number of women's prisons as significant barriers to family contact, reporting that women were held on average around 100 miles from home compared with around 50 miles for men at the time of that review.[26] For an older woman whose partner, parent or other support network is also ageing, the interaction between gender, age and distance can become particularly significant.

RECOOP therefore recommends that the emerging response to older people in prison is explicitly gender-responsive as well as age-responsive. Older women should not become a small cohort hidden between two larger policy agendas - ageing in prison and women's imprisonment - neither of which alone captures the intersection of their needs. Future data and research on ageing in custody should routinely be disaggregated by sex and should include older women's voices.

There is also a case for testing proven principles from peer-led wellbeing models within the female estate. RECOOP does not claim that THREADS has been evaluated with women where it has not. Its independently evaluated principles - trusted peer relationships, person-centred support, early intervention, wellbeing and clear supervision - nevertheless merit consideration and testing in a female-estate context, particularly given the high levels of mental distress and self-harm nationally.

Any adaptation should be co-designed with women and evaluated rather than simply transferred from the male estate.

17. Continuity beyond the gate

The Review will make recommendations about prisons, but the effectiveness of a prison operating model cannot be judged only at the gate. The CMO identifies transition into, between and out of prison as a significant health risk point.[3]

RECOOP's operational experience includes inconsistent application of social care duties, prison leaders seeking help to secure local-authority engagement, and cases where people are moved or released without relevant prison-based social care staff or receiving services being informed in time. We also encounter practical problems around medication and repeat prescriptions after release.

Recent Buddy/peer feedback adds a further practical dimension: delays in linking services before release are experienced as a source of worry in their own right, while discontinuity in medication and healthcare can quickly become destabilising for someone with multiple conditions.[33] For older people, continuity should therefore be tested before release, not assumed from a referral having been sent.

These are not arguments for the Review to redesign community services. They are arguments for prisons to design continuity as part of custody. A prison that builds independence and stability but releases a person without the information, equipment, medication, care arrangements or receiving contacts needed to sustain it has not completed the rehabilitative task.

For older people, the first days and weeks after release can involve a sudden change in environment, routine and responsibility. Where accommodation is unfamiliar and support is delayed, vulnerability and anxiety increase. The future prison system should therefore treat handover as an operational outcome, with named ownership and confirmation that essential arrangements have been received and activated.

The accommodation pathway is a critical part of that continuity. HMPPS describes Approved Premises as providing enhanced supervision and rehabilitative support for high-risk and complex people leaving prison, while CAS2 and CAS3 provide other tiers of temporary accommodation. Yet current independent inspection evidence shows that parts of the Approved Premises estate have significant physical limitations. In 2026, HM Inspectorate of Probation found one Approved Premises with only one designated accessibility room that was not fully wheelchair compliant and recommended that HMPPS review the long-term suitability of the building, taking account of space and accessibility. At another, inspectors required HMPPS to ensure that accessible rooms met the needs of wheelchair users.[44-46]

This matters because an available bed is not necessarily suitable accommodation. For an older or disabled prison leaver, the relevant test is whether the person can safely enter and move around the accommodation, sleep, wash, use the toilet, manage medication and daily living, store and use mobility equipment, reach essential services and receive any required health or social care support. RECOOP recommends a national accessibility and age-readiness audit across Approved Premises, CAS2 and CAS3, including the number and geographical distribution of genuinely step-free and wheelchair-accessible placements and their ability to support people with frailty, sensory impairment and commissioned care needs.

Suitable accommodation must also be accompanied by practical transition support. For some long-sentenced older people, particularly those released to unfamiliar areas with limited family or social

networks, signposting alone is insufficient. The transition may require supported orientation: learning local transport, locating and registering with healthcare, finding shops and essential services, practising routes to probation and other appointments, understanding digital or payment systems, and rebuilding confidence in ordinary community living. This support should begin before release and reduce progressively as independence develops.

RECOOP has previously delivered this kind of support in open and Category D prisons by accompanying prisoners on resettlement day release into local towns. Used well, supported resettlement day release can do more than familiarise someone with an area. It can act as a real-world resettlement assessment, exposing barriers before release: an inaccessible proposed placement, an unmanageable bus journey, difficulty navigating healthcare or shops, or cognitive and anxiety-related needs that were less visible inside prison. HMPPS policy already frames Release on Temporary Licence as a mechanism to prepare people for resettlement in the community, and commissioned rehabilitative services are already delivered by specialist voluntary and community-sector organisations.[47-49]

RECOOP therefore recommends that prisons and probation are able to commission supported community orientation before and after release, including through resettlement day release where appropriate. Probation should retain its public-protection and case-management role; specialist partners can provide the practical, age-informed rehabilitation that helps the risk-management plan work. For people with identified needs, responsibility for this support should be explicit in the release plan rather than assumed to fall informally to the individual, an Approved Premises team or a family network that may not exist.

18. Commissioning: fragmented responsibility requires joint accountability

The needs described in this submission cannot be solved by HMPPS alone. NHS England, local authorities, hospital services and other partners all have responsibilities. The Review's Terms of Reference explicitly recognises dependencies on other government departments and partner agencies.[1]

RECOOP's concern is that separate commissioning lines can produce gaps at the interfaces. Social care may be a local-authority responsibility; healthcare may be commissioned separately; the prison controls access and movement; hospital attendance depends on escort capacity; and a specialist placement may require health, social care, accommodation and risk-management funding to be agreed simultaneously. The prisoner experiences these as one need, while the system can experience them as several organisations' responsibilities.

This is particularly visible when someone may be ready to leave conventional custody but has complex forensic and care needs. RECOOP is currently hearing from forensic care providers that specialist beds can remain vacant while people with complex needs remain in prison, not necessarily because suitable provision does not exist, but because no single commissioner is able to assemble the funding and authorisation required to make the placement happen. This is operational intelligence rather than national vacancy data, but it illustrates how a coordination failure can manifest as a prison-capacity problem.

There are already models for joint commissioning

Government does not need to invent the principle from scratch. The Offender Personality Disorder pathway is jointly commissioned by NHS England and HMPPS. Its current resource envelope is around £72 million, with approximately £58 million from NHS England and £14 million from HMPPS.

Each region has an NHS commissioner and an HMPPS commissioner who jointly undertake needs assessment, service specification, procurement, contracting, performance management and quality assurance.[41]

NHS-led Provider Collaboratives provide another relevant precedent in adult secure services. They are designed around responsibility for a defined population, pathway and budget, bringing providers together to manage specialist secure care more coherently.[42] These models demonstrate that health and justice can jointly own a complex cohort when Government chooses to create a clear pathway around it.

There are also established legal mechanisms for pooled health and local-authority budgets. Section 75 of the NHS Act 2006 allows integrated commissioning arrangements between NHS bodies and local authorities. The Department of Health and Social Care's 2024 summary of responses to its review of Section 75 found strong support for better integration, but recurring barriers included separate funding streams, unclear commissioning arrangements, short-term funding, different organisational structures and weak governance. Sixty-four per cent of survey respondents supported widening the range of organisations that could enter Section 75 arrangements beyond NHS bodies and local authorities, with justice services among the suggested additions.[43]

The lesson for this Review is that the problem is not simply the absence of a legal mechanism. It is the absence of a consistently applied commissioning pathway for prisoners whose needs cut across justice, health, social care and forensic provision.

A single accountable route into the system

RECOOP recommends a national framework with a single accountable lead commissioner for prisoners with complex health, social care and forensic needs. The lead should have authority to convene the relevant agencies, coordinate assessments, agree the setting that can safely manage current risk and need, and assemble pooled or aligned funding before transfer or release. This does not require one department permanently to own every budget line. It does require one route through which a decision can actually be made and funded.

The forthcoming national strategy for older people in prison creates an opportunity to establish this pathway. The Independent Review should complement that work by recommending that HMPPS, NHS England and local government develop the commissioning architecture together, with clear national accountability and regional delivery.

At regional level, planning should bring together projected frailty and morbidity, social care demand, adult secure and forensic capacity, the accessibility and age-readiness of Approved Premises and CAS2/CAS3 provision, external hospital demand, palliative care, preventative health and social prescribing, peer-support capacity, estate accessibility, workforce requirements and transition arrangements. Spending decisions should reflect the total system cost of unmanaged deterioration, delayed movement and unsuitable accommodation, not only the budget line of the organisation asked to fund the next intervention.

This matters directly to the Review's prison-capacity question. Government should ask not only how many new prison places are required, but how much current and future demand is generated because people cannot move into more appropriate provision. Capacity can exist in one part of the system while people remain unnecessarily and expensively trapped in another because no single commissioner has the authority to assemble the package required to move them safely.

19. Social prescribing and preventative health

Prisons should make greater use of preventative and social-prescribing approaches appropriate to the population. For older people this can include physical activity, falls prevention, nutrition, social connection, cognitive stimulation, purposeful roles, gardening, peer support and condition-specific health education.

The opportunity is not simply to create a larger menu of activities. A prison-based social-prescribing model needs people who can help translate professional advice into daily behaviour. Trained peer supporters, healthcare orderlies and other peer roles can provide that connective tissue between healthcare, the regime and the individual: encouraging someone to attend, walking alongside them, noticing when confidence or function changes, helping them understand an instruction and feeding concerns back through appropriate routes.

Their particular value is proximity and shared frame of reference. A clinician may recommend exercise, improved nutrition, social engagement or condition self-management; a trusted peer is present when motivation falls, when someone is frightened of joining a group, when they struggle to understand what has been asked of them, or when an operational barrier prevents access. This is not a substitute for clinical expertise. It is a way of making preventative advice more likely to translate into everyday practice.

A peer respondent captured the relational value simply: giving empathy can make the people they support feel 'valued, safer, heard, understood'.[33] That trust is not incidental. It is often what enables someone to disclose a problem early enough for the formal system to respond.

The benefit to the peer supporter should also be recognised. RECOOP's Buddy and THREADS evidence shows the potential for peer roles to create purpose, responsibility, skills, confidence and contribution. Properly supported peer activity can therefore deliver meaningful Tier 2 activity at the same time as strengthening health, wellbeing and social connection across the wing.[10-12]

RECOOP's own HELP and activity work indicates the potential for practical, group-based health interventions, while the CMO calls for stronger prevention and peer-health approaches. These interventions should be integrated with healthcare and regime planning rather than treated as discretionary activities that disappear first when staffing is constrained.[3,13]

The test should be whether the intervention maintains function, confidence, connection and self-management and reduces avoidable dependency. Where it does, the value should be understood across the system: improved wellbeing for the individual, a meaningful role for the peer, and potentially more efficient use of healthcare, social care and operational staff.

20. What the Review should ask of the prison system

Across the evidence, one question recurs: who owns the whole person? Older prisoners with complex needs may simultaneously interact with prison operations, healthcare, social care, estates, activities, probation, hospitals and voluntary organisations. The individual experiences the cumulative effect when one part fails, but no single organisation necessarily owns the overall outcome.

The future system should therefore be designed around a small number of principles:

- Function before category: assess what the person can do and what is changing, not only their chronological age.
- Prevention before crisis: maintain independence and identify deterioration early.

- Accessibility before nominal availability: a service only exists for the individual if they can reach, understand and use it.
- Structured peer support before unmanaged dependency: recognise the value of peers while protecting vulnerable people and retaining statutory responsibility.
- Continuity before hand-off: care, information and responsibility must survive transfer, recall and release.
- Meaning before occupancy: time in prison should preserve identity, contribution and capability, not merely contain people safely.
- Joint accountability before fragmented commissioning: the system should measure outcomes around the person, not only activity within separate organisations.

21. Mapping to the Call for Evidence

Review question	RECOOP contribution	Relevant sections
Q1-3 Outcomes, risks, opportunities	Ageing/complexity as a structural risk; prevention, accessible design and continuity as opportunities.	2, 6, 14, 20
Q4-6 Capacity and estate	Ageing, recall and long sentences affect demand and configuration; future estate must be adaptable and accessible.	2, 3, 10, 12-15
Q9-10 Workforce	Frailty/dementia capability, operational capacity, leadership and culture; partnership workforce including peers.	5-8, 14
Q11-12 Safety and decency	Mobility, food, hygiene, healthcare, family contact, safeguarding and dignity as practical tests of decency.	3-8, 10-11
Q13-14 Rehabilitation/reoffending	Meaningful activity, practical independence, resettlement, transition and recall prevention.	9, 12-15, 17, 19
Q15-16 Women	Direct RECOOP experience with older women; gender-responsive health, trauma, menopause, relationships and geographical barriers; research gaps and potential for evaluated peer-wellbeing approaches.	16, 11, 17 and references

Review question	RECOOP contribution	Relevant sections
Q17-18 Different cohorts	Older and disabled prisoners are the central specialist contribution of this response.	Throughout, especially 2-10 and 14
Q19 Technology	Digital inclusion and accessibility should form part of release readiness and prison communication.	13, 15, 17
Q20 Best practice	Structured Buddy support, THREADS, meaningful activity, hospice partnerships and geriatric/frailty approaches.	6-10, 19
Q22 Additional evidence	RECOOP lived experience, independent evaluations, operational case studies and older-prisoner research.	1 and references

This evidence paper is intentionally broader than a series of isolated answers because the issues affecting an ageing and increasingly complex prison population cut across the Review's themes. The online portal applies a 4,000-character limit to each answer. RECOOP will therefore use this paper as the fuller evidence base underpinning concise responses to the relevant questions, or submit it directly to the Review Secretariat where appropriate.

- Questions 2 and 3, key risks and opportunities: Sections 2, 4, 5, 8, 10, 14, 17 and 18 address demographic change, complexity, workforce capability, fragmented accountability, prevention and opportunities for system redesign.
- Questions 4 to 6, capacity and the prison estate: Sections 2, 3, 10, 14 and 15 address future demand, accessible design, adaptable accommodation, secure and specialist care, dynamic placement and transitional living environments.
- Questions 9 and 10, prison leadership and workforce: Section 8 addresses staff capability, culture and mandatory awareness of ageing, frailty and cognitive decline; Sections 6 and 7 address the safe use of trained and supervised peer support.
- Questions 11 and 12, safety and decency: Sections 3 to 8 and 10 address accessibility, healthcare, medication, social care, independence, informal care, dementia, frailty, end-of-life care and the everyday conditions that determine dignity and safety.
- Questions 13 and 14, rehabilitation and reducing reoffending: Sections 9, 13, 15, 17 and 19 address meaningful activity, long-sentence resettlement, supported resettlement day release, community navigation, continuity and social prescribing.
- Questions 15 and 16, women's prisons: Section 16 considers the distinct needs and experiences of older women and the risk that they remain hidden between ageing and women-specific policy agendas.
- Questions 17 and 18, different cohorts: The paper as a whole uses older prisoners as a lens on complexity, with Sections 2, 3, 4, 8, 10, 14 and 16 most directly addressing age, disability, frailty, cognition, environment and equitable access.
- Question 20, best practice: Sections 6, 7, 9, 10, 15, 17 and 19 provide examples from RECOOP practice and independently evaluated peer-support and resettlement models, alongside wider evidence.

- Question 22, additional evidence: The references and evidence sources at the end of this paper identify the national research, independent evaluations, RECOOP research, direct prisoner voice and operational intelligence on which the submission draws.

22. Conclusion

Much of what older prisoners and practitioners have been saying for years remains recognisable today. Earlier RECOOP/Clinks work recorded inaccessible accommodation, difficulty collecting meals and medication, inadequate age-appropriate activity, social care concerns and anxiety about release. More recent research and the CMO's report describe many of the same structural issues.[3,6,13]

The challenge is therefore no longer principally to prove that older prisoners have different needs. Government now has substantial evidence of that, and a national older-people-in-prison strategy is being developed. The challenge for this Review is to ensure that the prison system beneath that strategy is capable of delivering it.

For an older person living in custody, the prison wing is not simply the place in which services are delivered. For months, years or sometimes decades, it is their community. The people living and working there are the people most likely to notice deterioration, maintain connection, encourage independence and respond when something changes. An age-responsive prison therefore cannot outsource ageing to healthcare or social care. It must equip the whole community around the person - professional and peer - to play its appropriate part.

Older prisoners make visible weaknesses that matter beyond age: fragmented accountability, inaccessible design, regimes that accelerate dependency, preventable health deterioration, poor continuity, narrow definitions of rehabilitation and reliance on informal support to bridge gaps. Addressing those weaknesses would improve decency and outcomes for older people, but it would also create a prison system better able to manage complexity across the population.

That wider benefit is important. Dementia-friendly signage also helps people with learning difficulties, cognitive impairment or limited literacy. Accessible layouts benefit temporary as well as permanent disability. Flexible meaningful activity helps people unable to engage in conventional work for many reasons. Better continuity benefits everyone moving between establishments and the community. Staff who understand cognitive change are better equipped to distinguish vulnerability from deliberate non-compliance. Structured peer support can strengthen safer and more connected prison communities.

Designing around complexity does not mean creating a specialist prison for every specialist cohort. It means designing a mainstream prison system sufficiently flexible, accessible and responsive to accommodate human difference. Older prisoners are the lens through which this submission examines that challenge, not the limit of its relevance.

The same principle should apply to security, placement and commissioning. Public protection is non-negotiable, but proportionality requires the system to respond when the person changes. A prison system designed for the future should be able to move people between levels of security, care and independence as risk and function evolve. That requires both appropriate provision and a commissioning route capable of funding the move. Secure care should be tested as one component of a wider continuum that also makes better use of existing forensic and specialist capacity where this can safely meet the person's needs.

Partnership alone is not enough if nobody has authority to make the decision. For the most complex cases, RECOOP believes Government should create a single accountable commissioning pathway

that can bring justice, health and social care funding together around the individual. Without that, prison capacity can be consumed by people whose needs could potentially be managed more appropriately elsewhere, while specialist capacity in another part of the system remains unused.

The strategic choice is whether future investment continues to retrofit responses after people deteriorate, or designs prevention, accessibility, meaningful activity, trained and supported communities, and continuity into the prison operating model from the outset. RECOOP strongly recommends the latter. Get the system right for people ageing with complexity, and the benefits will extend far beyond the older cohort.

References and evidence sources

[1] Ministry of Justice (2026), Independent Review of the Prison System in England and Wales: Call for Evidence and Terms of Reference. Published July 2026.

[2] Ministry of Justice (2026), Justice in Numbers / Offender Management Statistics: prison population by age, 31 March 2026.

[3] Chief Medical Officer for England (2025; updated 2026), The health of people in prison, on probation and in the secure NHS estate in England, especially chapters on older people and palliative/end-of-life care.

[4] Ministry of Justice (2026), Offender management statistics quarterly: January to March 2026; prison population at 30 June 2026.

[5] Ministry of Justice (2025), Prison Population Projections 2025 to 2030.

[6] RECOOP/Clinks (2021), fuller working/skeleton evidence underpinning work on the needs and experiences of older people in prison.

[7] HM Inspectorate of Prisons / Care Quality Commission (2018), Social care in prisons in England and Wales, and government action plan.

[8] Nuffield Trust (2020), Locked out? Prisoners' use of hospital care.

[9] Nuffield Trust, What does it mean to be an older person in prison? Evidence on healthcare access, mobility and missed appointments.

[10] Codd, H. (2026), RECOOP Buddy Support Service Evaluation - NW Prisons: Summary of Interim Findings.

[11] RECOOP (2026), Lancashire Buddy Support Service: Local Commissioner Investment Case 2025/26.

[12] SERIO, University of Plymouth (2023), Independent evaluation of the THREADS programme, including additional evaluator-collected interview quotations supplied to RECOOP.

[13] Vannier, M., Gair, H. and Zaha, V-G. (2025), Finding Meaning Behind Bars: Activities for Older Prisoners in England and Wales, University of Manchester and RECOOP.

[14] Forsyth, K. et al. (2025), Prevalence of dementia and mild cognitive impairment among the older prisoner population in England and Wales: a cross-sectional study, BMJ Open.

[15] Hospice UK (2021), Dying Behind Bars: How can we better support people in prison at the end of life?

[16] RECOOP (2026), Intersectionality report and underlying 2025 survey material on older prisoners' overlapping needs and release concerns.

[17] RECOOP operational case studies and service-user evidence: Buddy, dementia/frailty, end-of-life, resettlement, health and social prescribing. Individual examples are anonymised and used illustratively.

[18] HMPPS / Ministry of Justice (2025), National Regime Model Policy Framework, issued 10 December 2025: regime plans must include Foundation, Tier 1 and Tier 2 activity and actual delivery is measured against planned delivery through the Purposeful Activity measure in the Prison Performance Tool.

[19] HMPPS (2024), Submission to the Prison Service Pay Review Body 2024/25: Tier 2 activity recording feeds the Regime Dashboard and the refreshed purposeful-activity measure reports Tier 1 and Tier 2 activity recorded via NOMIS.

[20] US Bureau of Justice Statistics (2016), Aging of the State Prison Population, 1993-2013: the number of state prisoners aged 55+ increased 400% over the period, with longer lengths of stay and ageing-in contributing to the change.

[21] HM Inspectorate of Prisons (2026), Safety, well-being and hope: The untapped potential of family contact in prisons.

[22] HMPPS, NHS England and Ministry of Justice (2023), The National Women's Prisons Health and Social Care Review.

[23] Robinson et al. (2024/25), Older women in the criminal justice system: a brief report from a nominal group. The study identifies health screening, unmet health need, emotional wellbeing, social/family connections, professional coordination and limited data/research as key themes.

[24] Lockwood, K. and Wood, T. (2025), Menopause and the prison: A systematic review exploring the experiences and support needs of women in prison in relation to the menopause.

[25] Public Health England / NHS England / HMPPS, Gender Specific Standards to Improve Health and Wellbeing for Women in Prison in England (historic standards; used here as evidence of recognised menopause-related needs and environmental barriers).

[26] Farmer, M. (2019), The Importance of Strengthening Female Offenders' Family and other Relationships to Prevent Reoffending and Reduce Intergenerational Crime.

[27] RECOOP (2026), direct consultation with 63 older prisoners at one establishment: questionnaire and consultancy findings on health, activity and resettlement. Establishment anonymised for this submission.

[28] RECOOP (2026), frontline operational evidence supplied by a prison service manager following discussion with the relevant local authority: mattresses, supportive seating, wheelchair provision and maintenance. Establishments and individuals anonymised.

[29] HMPPS / Ministry of Justice (2026), HMPPS responsibility for access to health and social care policy framework, issued 1 June 2026.

[30] Parkinson's UK (2025), Time critical medication: guidance and recommendations for timely Parkinson's medication. Used here to evidence the clinical importance of timing; prison delivery arrangements remain governed by prison healthcare medicines policies.

[31] Prison Reform Trust (2024), Growing old and dying inside: improving provision for older people in prison, recommending a pilot of secure social care in the community.

[32] RECOOP / Clinks and parliamentary/academic evidence on secure care alternatives for older people with complex needs, including Understanding the Needs and Experiences of Older People in Prison (2021) and subsequent evidence to the Justice Committee.

[33] RECOOP (2026), Buddy/peer Call for Evidence feedback form: observations on healthcare access, wellbeing and continuity at release. Individual and establishment anonymised.

[34] HMPPS / Ministry of Justice (2025), Security Categorisation Policy Framework, updated 28 April 2025.

[35] House of Commons Justice Committee (2020), Ageing prison population: evidence on risk, reoffending and the older prisoner cohort.

[36] Ministry of Justice (2026), Proven reoffending statistics: January to March 2024 cohort. Adult proven reoffending falls with increasing age after the 35-39 age group.

[37] HM Inspectorate of Prisons, thematic evidence on older prisoners, including the longstanding finding that older prisoners are generally a compliant population whose needs can be overlooked.

[38] Hanson, R.K. (2002) and subsequent age-adjustment research on sexual recidivism, including evidence that sexual recidivism generally declines with age but varies by offender type and individual risk factors.

[39] Helmus/Hanson and subsequent Static-99R research on age at release and sexual recidivism risk; age is one empirically relevant factor within, not a substitute for, individual risk assessment.

[40] UK Parliament / Ministry of Justice (2025), written answer on Early Release on Compassionate Grounds: 7 ill-health releases in 2023 and 6 in 2024 across determinate and indeterminate sentences.

[41] NHS England and HMPPS (2023), The Offender Personality Disorder Pathway: a joint strategy for 2023 to 2028. The pathway has a resource envelope of around £72 million and is jointly commissioned regionally by NHS England and HMPPS.

[42] NHS England, NHS-led Provider Collaboratives and Adult Secure Services: commissioning arrangements in which collaboratives take responsibility for defined populations, pathways and budgets across specialist mental health services.

[43] Department of Health and Social Care (2024), Section 75 call for evidence: summary of responses. Respondents identified separate funding streams, unclear commissioning, short-term funding and governance as barriers to integration; 64% supported widening eligible organisations beyond NHS bodies and local authorities, with justice services among those suggested.

[44] HM Inspectorate of Probation (2026), Approved Premises inspection programme and standards. Approved Premises provide temporary community placements for high-risk and complex people on probation, with roles in public protection, rehabilitation and resettlement.

[45] HM Inspectorate of Probation (2026), An inspection of Pennywell House Approved Premises. Inspectors found significant physical constraints, including only one designated accessibility room which was not fully wheelchair compliant, and recommended that HMPPS review the long-term suitability of the premises taking account of space and accessibility.

[46] HM Inspectorate of Probation (2026), An inspection of Victoria House Approved Premises. Inspectors recommended that HMPPS ensure accessible rooms meet the needs of wheelchair users.

[47] Ministry of Justice / HMPPS, Release on Temporary Licence Policy Framework. ROTL is intended to facilitate rehabilitation and preparation for resettlement in the community.

[48] Ministry of Justice (2026), Commissioned Rehabilitative Services Evaluation. The evaluation calls for tailored, needs-led support, greater face-to-face delivery, improved accommodation provision and stronger collaboration between probation and other justice partners.

[49] HMPPS (2026), Community Performance Annual update to March 2026 and HMPPS Annual Report 2024/25. Specialist rehabilitative services, including accommodation and personal wellbeing support, are delivered under contract by voluntary, community and specialist organisations; HMPPS operates a three-tier Community Accommodation Service comprising Approved Premises (CAS1), CAS2 and CAS3.