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Inequality on the inside

Using hospital data to understand the key health care issues for women in prison

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This work uses data provided by patients and collected by the NHS as part of their care and support. Read more on our website: www.nuffieldtrust.org.uk/about/corporate-policies#informationsecurity-and-data.

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About this report

In October 2021, the Nuffield Trust published *Injustice? Towards a better understanding of health care access challenges for prisoners* (Davies and others, 2021), building on our unique programme of work using hospital data to look at how prisoners in England use hospital services and for what reasons. We found that over the last four years, prisoners have faced ongoing challenges accessing hospital care, and that the use of hospital services is primarily as a result of violence and self-harm, which highlights the challenging conditions across prisons. Although people in prison are deprived of their liberty, their right to health care should be unaffected.

This report draws on admitted patient care data and outpatient data from 2019/20 to look in detail at how women in prison use hospital services. We focus on the key health care issues for women in prison that a range of stakeholders identified and consider how hospital data can inform our understanding of the quality of care women receive while in prison.

Covid-19

In this report we do not look at hospital admissions among women in prison as a result of Covid-19. Limited information about the early impact of Covid-19 on access to services for all prisoners is available in Davies and others (2021). A future piece of research from the Nuffield Trust will address the impact of Covid-19 on prisoners' use of hospital services, including women, in more detail.

Key points and recommendations

Health care for people in prison should be equivalent to the care they would receive if they were in the general population. This means providing the right range and quantity of services to meet people's needs. While women in prison make up only a small percentage of the total prison population, they have distinct health care needs. Given the government's commitment to building 500 new prison places for female prisoners, now is the time for health care issues specific to women to be understood and addressed.

For this research we used routinely collected hospital data to better understand the key health care issues for women in prison. We found that in some areas, such as health care during pregnancy, women in prison experience poor health outcomes. This suggests a need for urgent action. A summary of the key findings is provided below, and this is followed by a series of recommendations based on the findings, which we developed jointly with stakeholders.

Pregnant women in prison are more likely to experience preterm labour than women in the general population.

Babies born premature have a higher mortality rate than those born full term and an increased risk of disability (Tommy's). Of 127 women in prison who gave birth between 2016 and 2019, some 11% went into preterm labour and delivery. This is a significantly higher proportion than in the general population, where 6.5% of births were premature across a comparable time period for women of the same age.

While there have been strides to at least acknowledge and plan for the unique health care needs of pregnant and postnatal women in prison, this highlights that although the number of pregnant women in prison may be small, the risks to these women and their babies are very real.

There are no official data on the number of women in prison who have children. Our work can fill in some of this gap in information. In 2019/20, 212 women had given birth in hospital within the four years before going to prison, 109 within the two years before.

While it is important to support the needs of pregnant women in prison, a much larger group of women have children before they spend time in prison and the needs of these women (and their children) need to be better understood.

This information is essential to ensure that women who have had children before entering prison are able to access the right care and support. For example, the consequences of maternal separation for physical and mental wellbeing can be significant. It is vital that wider work on supporting families (for example through visits) is aligned with health care, recognising this impact.

Access to hospital services is poor and this is a long-term issue.

Access to services is an important part of good-quality care but women in prison continue to face challenges accessing hospital care. This is a long-standing issue that is showing little sign of improvement. In 2019/20 just under 45% of all outpatient appointments for women in prison were missed (n = 3,929). This is likely to be a symptom of wider problems the prison estate faces, in particular around staff availability.

Prisons do not always communicate the reasons for delays in hospital care well to women and uncertainty around when appointments will happen, and fewer options for self-care in the interim, are a significant source of stress.

Hospital data highlight the complex needs of women in prison, particularly around trauma and substance misuse.

Meeting the health care needs of women in prison requires targeted support and recognition of the impact of previous trauma. Our work shows that the experiences women have had before prison, such as domestic abuse, directly impact on their health. We found hospital admissions as a result of brain injury and violence, which may be linked to experiences of domestic abuse

before prison. In 2019/20 there were 28 hospital admissions by 25 women where diaphragmatic hernia (which in adults is often a result of blunt force trauma) was recorded as a diagnosis.

Substance misuse plays a part in a significant proportion of hospital admissions by women in prison.

In 2019/20 just under 30% (356) of inpatient admissions by women in prison had a diagnosis of substance use recorded. In the male prison estate there was a much higher number of admissions where substance use was recorded (2,680), but as a proportion of all admissions by male prisoners, substance use had less of an impact, making up under 20% (19.8%) of admissions. Stakeholders raised concerns that the management of substance misuse may lead to other health care needs being overlooked.

Women's sexual and reproductive health care needs are not talked about openly and symptoms of normal changes to the body, such as the menopause, as well as conditions such as endometriosis, are not well understood or managed.

The lack of priority in terms of women's health can impact on all women, but for women in prison, managing their reproductive health and normal changes to their body linked to the menopause can be particularly hard. Women in prison cannot always access the advice and support they need, and practical things, such as changing bedsheets to manage night sweats, or exercising as a lifestyle measure, may not be possible.

Recommendations

- **Recommendation 1: Ensure women have access to good-quality, understandable and targeted health care information.**

Women in prison need to know basic information about health care processes, such as how to make appointments, and how missed health care appointments can be rebooked. It is essential that this information is presented in a way that is accessible and appropriate to women in prison, particularly considering lower literacy levels than in the general population.

Women with lived experience of prison should be part of any discussions around the sort of information that is needed and crucially how it should be presented.

The way in which this information is made available to women in prisons is important, but the onus should not be purely on the women themselves to seek and find it. Systems need to be in place both to make information available but also to monitor how it is used and adapt it if necessary. While the *Prisons Strategy White Paper* has bold ambitions to embed the use of technology across the prison estate, which could provide a means of improving access to information, this will be meaningless if women cannot (or do not) read it.

- **Recommendation 2: Commit to better data collection to inform planning and address inequality.**

It is important to understand how gender, ethnicity and position in the criminal justice system impact on access to and the use of health care services, particularly given the focus of NHS England and NHS Improvement's 'Core20PLUS5' approach on people in prison as an inclusion health group.

Wider efforts to improve ethnicity coding in national data, such as the work of the NHS Race and Health Observatory, should highlight women in prison as a key example of the need for better-quality data. Women in prison experience significant health care needs related to their mental health and maternity care, and these are areas where there is wider evidence of ethnic health inequalities. It is also of note that offender management statistics data regarding ethnicity have a near-perfect completion rate and therefore data sharing (with appropriate permissions and safeguards in place) may act to improve data quality.

- **Recommendation 3: Better understand and address the needs of those with children as an urgent priority ahead of the new prison places.**

The *Prisons Strategy White Paper* (Ministry of Justice, 2021a) has committed to record data regarding prisoners' family circumstances, which we would support, as separation from children is a core anxiety for women in prison. The important detail is in how this information is then used. While it is widely

acknowledged that families play a vital role in supporting prisoners and reducing reoffending, there is a need to link up health service delivery and the family strategy for everyone's benefit.

- **Recommendation 4: Acknowledge and address the range of reasons why hospital appointments might be missed.**

Access to services is a minimum requirement for care and prisoners have consistently faced challenges accessing hospital care. We know there are a number of reasons why access to services while in prison may be challenging, with staff availability to escort prisoners to appointments being key. There are other reasons for missed appointments, though, which may be more amenable to change and addressing them would have wider benefits in terms of improving care quality for all patients. We recommend bringing together stakeholders (including women in prison or women with lived experience of prison) to reach agreement on key issues and the acceptability of certain solutions.

1 Introduction

There are 12 prisons and young offender institutions in England[1] for women, which altogether hold a population of just over 3,200 (GOV.UK, 2021) – 4% of the total prisoner population. Women in prison are often described as having complex needs, which can include poor mental health, substance misuse as well as experiences of homelessness and violence or abuse (Ministry of Justice, 2021a). More women in prison than men report poor mental health, and self-harm rates are far higher among the former. Of women in prison, 71% report having mental health problems compared to 47% of men (HM Inspectorate of Prisons, 2020). In the year to June 2021 there were 3,808 incidents of self-harm per 1,000 female prisoners compared to 546 per 1,000 prisoners in the male estate (HM Prison and Probation Service and Ministry of Justice, 2021).

Health care services for women in prison

All prisons have some health care services (such as primary care and mental health support) onsite and some also have dedicated health care wings where prisoners can go to receive care and treatment. The exact set-up depends on the characteristics of the prison itself; there is wide variation in the services available across the prison estate.

While in prison, women should be able to access primary care services, and if they need to attend an appointment offsite, at least two escorts will normally need to accompany them. People in prison should also get access to the same public health programmes as the general population. For more information on the health care services that women in prison should receive, see Hutchings and Davies (2021).

1 Wales has no prisons or young offender institutions for women.

Health care inequalities that women in prison experience

People in contact with the justice system are highlighted in NHS England and NHS Improvement's 'Core20PLUS5' approach[2] (NHS, 2021) as a group who experience health inequalities that should be addressed. Health inequalities can include poorer access to services, poorer experiences of care or poorer health outcomes, all of which are true for women in prison.

Women in prison experience similar issues to those seen across the prison estate as a whole in terms of poor access to hospital care (Davies and others, 2020). But also, in 2017/18, 22% of pregnant prisoners missed midwifery appointments and 30% missed obstetric appointments – much higher than the proportions missed in the general population (14% of midwifery appointments and 17% of obstetric appointments respectively) (Davies and others, 2020).

Maternity services are an area of clinical focus in the Core20PLUS5 approach (NHS, 2021) and there is evidence that pregnant women in prison face particular health care risks. The recent service specification for pregnant women in detained settings highlights that all pregnancies in prison must be considered as high risk (NHS England, 2022). Labour is a particular point of risk as prisons are not equipped to support women or new-born babies who require specialist medical care. In 2017/18 just over 1 in 10 births by women in prison took place outside a hospital setting (Davies and others, 2020), meaning they gave birth either in a prison cell or on the way to hospital.

We write this report at a time of continued calls to consider alternatives to imprisonment for women, given the distinct needs of this small part of the prisoner population: advocacy groups have long called for the prioritisation of non-custodial alternatives for women (a recent example being the #StopThe500 campaign; see Women in Prison, 2022), and the role

2 The aim of the Core20PLUS5 approach is to reduce health inequalities at national and system levels. This means focusing resources on the most deprived 20% of the population plus groups of people, such as prisoners, who experience poor access to services, worse health outcomes or negative experiences of care.

of alternatives, such as women's centres, is also highlighted in the *Female Offenders Strategy* (Ministry of Justice, 2018).

Despite this, the government has committed to building 500 new prison places for female prisoners (Ministry of Justice, 2021b) and therefore the need to consider the unique health care needs of women in prison is all the more pressing. In this report we look in detail at how women in prison used hospital services in 2019/20. We have drawn on the expertise of a range of stakeholders, including women with lived experience of prison, to focus our analysis on key health care issues and quality of care for this small but important group. We hope this will inform wider discussions regarding how to reduce health inequalities for women in prison and establish what good-quality health care looks like.

2 What did we do?

Stage 1: Identifying health care issues relevant to women in prison

Literature review

We drew on a literature review of the physical health care needs of prisoners (see Davies and others, 2020; 2021) as a starting point, to consider the existing evidence on health care issues specific to women in prison. Where relevant we refer to insight from the literature review in this report.

We also reviewed existing quality standards for women's health care to guide our analysis. There are some that are prison specific, such as the *Gender Specific Standards to Improve Health and Wellbeing for Women in Prison in England* (Public Health England, 2018) and the Birth Charter for women in prisons (Birth Companions, 2016). But women in prison should receive equivalent health care to health care that women in the general population receive and therefore broader care quality standards are also relevant, such as standards for scheduled, unplanned and specialist gynaecology from the Royal College of Obstetricians & Gynaecologists (2016) and guidance on antenatal care from the National Institute for Health and Care Excellence (NICE) (NICE, 2016). Specific clinical conditions (such as endometriosis and the menopause) are also subject to particular NICE standards.

What do quality standards suggest good-quality health care looks like?

Although there are some specific indicators of quality within secondary care (such as how long it takes to get an appointment following a referral), many of the things that are considered important for good-quality health care are more general – this includes providing clear and accessible information about appointments and procedures and protecting confidentiality (Royal College of Obstetricians & Gynaecologists, 2016). Although the processes in place in prison mean that some of these specific standards may not apply (for

example, the usual practice is for prisoners to not be told the details of their appointments in advance), these wider themes are still relevant and important for ensuring that women in prison are able to access the care they need. Bellass and others (2022) carried out an international scoping review, which provides an overview of quality indicators for prison health care, emphasising that the majority are process rather than outcomes based.

Stakeholder involvement

We held conversations with a range of stakeholders to shape our understanding of the most important health care issues for women in prison and what aspects of care quality we may be able to look at as part of our analysis of hospital data. Stakeholders included women with lived experience of prison, Birth Companions, the Royal College of Midwives, the Royal College of Obstetricians & Gynaecologists, academics researching the experiences of women in prison, the United Kingdom Acquired Brain Injury Forum, the Prison Reform Trust and The Disabilities Trust. We also held a one-off discussion group with six women with lived experience of prison, which the Prison Reform Trust facilitated. Women with lived experience of prison were paid for their involvement following guidelines from the National Institute for Health and Care Research (2018).

Discussions with stakeholders about what good-quality health care for women in prison would look like raised a number of issues, which aligned with themes seen in the literature review. These included making sure health care is accessible, that women in prison receive proper communication and feel listened to, and that they are treated with respect and dignity. It was also noted that perceptions of care quality driven by policy guidance do not necessarily marry up with what patients themselves perceive to be good-quality care. Poor experiences of care before prison may impact on what women's expectations are of health services and how they want to interact with them.

Stage 2: Identifying use of health services by women in prison

Analysis of hospital data

For this report we used Hospital Episode Statistics (HES) data to look at female prisoners' use of hospital services including admitted patient care and outpatient services in England. Although the prison estate covers England and Wales, there are no prisons for women in Wales and therefore Welsh women are all located in England (Jones, 2018).

To identify women we rely on how a patient's sex has been recorded in hospital data. We cannot identify transgender prisoners in our work. Hospital data do not tell us if people have opted to change sex on their medical records. As our work focuses only on patients whose sex is recorded as 'female', we refer to women throughout this report.

The focus of this report is on data from 2019/20, but we also refer to historical data from 2016/17 onwards for certain aspects of the analysis, where appropriate, such as when we look at hospital activity associated with pregnant women in prison. We used postcode as a proxy for prison location and therefore associated hospital activity linked to prisoners. The Nuffield Trust has applied this approach to look at prisoners' use of hospital services in past research (see Davies and others, 2020; 2021). For a full description of the methodology, please refer to Davies and others (2020).

There was an initial descriptive analysis stage to understand how often women in prison used hospital services and the reasons why. We looked at details such as the number of hospital admissions and attendances, key diagnosis information (such as the most common reasons for hospital admissions) and the demographic characteristics of women who accessed secondary care (including age and ethnic group).

We then looked at key health care issues for women in prison, including areas which were pertinent in terms of being common reasons for hospital admissions or attendances, as well as specific health care issues that our stakeholders identified. This sometimes involved looking at secondary or

subsidiary diagnosis information. We also drew on wider literature where appropriate if hospital data alone were not able to provide detail about the health care women received for specific health care issues.

Finally, we looked at access to services as an indicator of care quality – both secondary care services and elements of in-prison health care such as screening programmes.

Stage 3: Validation, drawing out significance and developing recommendations

After the data analysis had been completed, the stakeholder members were brought together for a virtual workshop to discuss the findings and consider practical recommendations that could be made.

At all stages of our discussions with stakeholders we talked about how health care in prison as well as life in prison more broadly impact hospital care. This meant that while we only had access to hospital data and not data about the health care people received in prison, we could touch on these wider issues as part of thinking about what good-quality care looks like and the practical recommendations that we could make based on the findings. The discussions also helped us to understand the wider context of prison health care and provided insight to explain what we were seeing in the data.

3 Use of hospital services in 2019/20 by women in prison

A number of stakeholders who we consulted as part of this work made the point that health care in prison is predominantly focused on managing the most urgent or critical situations. This is important context when thinking about female prisoners' use of hospital services, as the people who make it out of prison to hospital are likely to be those with the most serious current health care needs – the emphasis being on current. Appointments and attendances for other women whose needs are still urgent, may have to be rearranged as resources are limited.

Stakeholders also spoke about how women in prison can often feel like they have to prove or justify why they need health care, and that their experiences and concerns are not taken seriously. It was felt that this was often reflective of wider attitudes to women's health, where women are just expected to 'live with' their symptoms, and access to a diagnosis and appropriate care can take a long time. This lack of agency can affect the ability of women to manage their own health care both within prison and on release.

In 2019/20, there were 1,190 hospital admissions by women in prison, and just under 9,000 outpatient appointments (see Table 1). Whereas in the general population a large proportion of hospital admissions and outpatient attendances are by older people, in prison the pattern of activity by age looks very different as the prison population is much younger. In 2019/20 just 18–21% of hospital admissions or outpatient appointments by women in prison were for those aged 50+, while in the general population 60.3% of inpatient admissions and 54.1% of outpatient appointments for women were for those aged 50+. We will be reporting separately on older prisoners' use of hospital services in a future piece of work but it is important to note here that older age brings unique challenges for women in prison. Whereas

the proportion of people aged 50+ is fairly similar between the men's and women's prison estate (16.6% versus 14.5%) (see Davies and others, 2021), the absolute number of women in prison aged 50+ is far smaller than that for male prisoners (548 versus 12,210). Older prisoners are often quieter and this, in conjunction with their limited numbers, means they can be overlooked. The House of Commons Select Committee inquiry into the ageing prison population (House of Commons Justice Committee, 2020) highlighted a number of challenges facing older people in prison, such as in terms of obtaining social care and having access to screening programmes, but did not comment specifically on the needs of older women in prison. Although the evidence on the health care needs of older female prisoners is limited, our stakeholders raised numerous distinct issues that require attention, such as information and support for the menopause.

Table 1: Admissions to hospital and outpatient appointments by female prisoners, 2019/20

	Admitted patient care	Outpatients
No. of women	719	2,581
No. of admissions or appointments	1,190	8,970
% (no.) of admissions or appointments by women aged 50+	20.8% (247)	18.7% (1,678)

We also wanted to see what hospital data could tell us about access to hospital care for women in prison from different ethnic groups. This is particularly pertinent due to the longstanding health inequalities that minority ethnic groups experience and the compounding impact of gender and contact with the criminal justice system. Agenda and others (2022) talk about the 'double disadvantage' that black, Asian, minoritised and migrant women face within the criminal justice system due to gender inequality and racism.

We already know from our previous work that prisoners' ethnicity is not well recorded in hospital data (see Davies and others, 2021) and this is particularly worrying in relation to women in prison because of their health care needs – mental health and maternity care being key – as there is wider evidence of associated health inequalities linked to ethnicity: people from minority ethnic backgrounds in the general population are reported to face barriers seeking

help for their mental health as well as poorer access to the services that can help them (NHS Race and Health Observatory, 2022).

We have previously reported that women in prison face particular risks during pregnancy and when giving birth (see Davies and others, 2020) but it is unclear what maternity care for women in prison from different ethnic groups looks like. Drawing on work based in the general population, it has been reported that women from a minority ethnic background can feel stereotyped, and a lack of respect and cultural understanding, which impact on their access to and engagement with maternity services (NHS Race and Health Observatory, 2022).

Table 2 shows that 32.5% (n = 387) of admitted patient care data for female prisoners had no meaningful ethnicity information recorded, and over half of outpatient data for women in prison (53.5%, n = 4,794) had missing ethnicity information. Poor recording of ethnic group in national datasets has been highlighted as a factor that hampers efforts to conduct a detailed analysis of ethnic health inequalities (NHS Race and Health Observatory, 2022). Due to the health care needs of women in prison, better-quality data are needed to understand how a woman's ethnicity impacts their access to services in prison, and this should be highlighted as part of wider efforts to improve data recording.

Table 2: Women's ethnicity as recorded in admitted patient care and outpatient activity, 2019/20, and number of women in prison by ethnic group, 30 September 2019

	Admitted patient care – no. of admissions (% of all admissions)	Outpatients – no. of appointments (% of all appointments)	No. of women in prison by ethnic group
Asian or Asian British	21 (1.76%)	158 (1.76%)	154 (4.16%)
Black or Black British	32 (2.69%)	182 (2.03%)	279 (7.53%)
Mixed	25 (2.10%)	90 (1.00%)	177 (4.78%)
Other ethnic group	35 (2.94%)	283 (3.15%)	33 (0.89%)
White	690 (58.0%)	3,463 (38.6%)	3,033 (81.9%)
Unrecorded	156 (13.1%)	1,713 (19.1%)	26 (0.70%)
Not stated	**231 (19.4%)**	**3,081 (34.4%)**	**1 (0.03%)**
Total	1,190	8,970	3,703

Source of numbers of women in prison by ethnic group taken from Ministry of Justice, 2019b, 30 September 2019 data.

4 Key health care issues for women in prison

Women in prison were most commonly admitted to hospital in 2019/20 as a result of either digestive system issues or cases of injury or poisoning (see Table 3). This presents a slightly different pattern to what we have seen in previous years, as there has been a rise in admissions as a result of injury or poisoning. In 2017/18, injury or poisoning was the fourth most common reason for hospital admissions by women in prison (see Davies and others, 2020), accounting for 11% of all admissions), but this had increased to 15% of all admissions by 2019/20.

Table 3: Top five primary diagnoses for female prisoners, aggregated by chapter of the International Classification of Diseases – 10th revision (ICD-10), 2019/20

Primary diagnosis (chapter level)	No. of admissions (no. of women)
Diseases of the digestive system	175 (138)
Injury, poisoning and certain other consequences of external causes	175 (120)
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	159 (132)
Pregnancy, childbirth and the puerperium	118 (79)
Neoplasms (cancer)	92 (43)

Diseases of the digestive system

We looked at the five most common groups of digestive-related diagnoses that were recorded when women in prison were admitted with issues relating to the digestive system. Table 4 shows that dental issues (diseases of the oral cavity, salivary glands and jaws) were the most common primary diagnosis in this area. Of the 48 admissions where dental issues were the primary diagnosis, 24 were as a result of dental caries (tooth decay).

Table 4: Number of admissions split by diseases of the digestive system, 2019/20 (with more than 15 admissions)

Diagnosis group	No. of admissions (no. where this was the primary diagnosis)	No. of people
Diseases of the oral cavity, salivary glands and jaws	51 (48)	45
Diseases of the oesophagus, stomach and duodenum	73 (30)	64
Other diseases of the intestines	79 (27)	63
Non-infective enteritis and colitis	35 (22)	14
Hernia	43 (18)	34

Dental care

As with other aspects of health care for prisoners, dental care for prisoners should be equivalent to dental care that can be accessed in the community (NHS, 2020), but people in prison are disadvantaged from the outset as they are less likely to have accessed dental services in the past and they also have a higher level of need (Public Health England, 2019b). A dental needs assessment in 2010 of the now closed women's prison, HMP Holloway, found that of the 103 women surveyed and examined, 75% had decaying teeth, compared to only 39% in the general population comparison group (Rouxel and others, 2013). Stakeholders consistently highlighted the challenge of accessing dental care in prison.

In prison, demand for dental services is high and waiting lists can be long. A survey of prison dental services in 2017/18 reported that for just under half of practices the average waiting time was six to 12 weeks (Public Health England, 2019b). Of prison dentists, 80% reported making one to three referrals a month for hospital treatment (Public Health England, 2019b). While it is not always easy to access dental care in the community (Association of Dental Groups, 2022), delays are felt more acutely in prison due to the lack of options people have. In prison even accessing pain relief is not straightforward so people may be struggling for a long time in pain, without consistent pain relief or even access to self-care advice.

We looked at what procedures were undertaken when female prisoners were admitted to hospital for dental care and found that it was predominantly for surgery. There were 29 admissions for the surgical removal of teeth and six admissions for the removal of multiple teeth.

Hospital data do not provide evidence of women in prison receiving restorative dental treatment, such as crowns or bridges. Although we do not have access to data on the dental care that people receive in prison, stakeholders highlighted that dental care is a key issue for women in prison but that services are predominantly for urgent care (such as surgery to remove teeth). If female prisoners have used drugs in the past they can be left with multiple missing teeth, which can affect their confidence, feelings of self-worth and ultimately the likelihood of gaining employment after prison. The opportunity for restorative treatment would improve the quality of life of women in prison and on release.

Hernia

Also of note is the number of digestive admissions with a diagnosis of hernia and what this tells us about the potential unmet health care needs of women in prison. In 2017/18, 19 women in prison were admitted to hospital with a diagnosis of diaphragmatic hernia (Davies and others, 2020) and our analysis found that numbers had increased slightly in 2019/20. A diaphragmatic hernia is where a hole in the diaphragm leads to part of the stomach moving up into the chest. It is most commonly identified in children as a birth defect but in adults can happen as a result of trauma or injury (Thiam and others, 2016). In 2019/20 there were 28 hospital admissions by 25 women where diaphragmatic

hernia was recorded as a diagnosis. While these numbers may be small, it is worth reflecting that many women in prison have experienced domestic abuse in the past (Ministry of Justice, 2018) and the presence of a diaphragmatic hernia needs to be ruled out where abuse is disclosed on entry to prison so that treatment can be provided if necessary.

Injury and poisoning

Safer custody statistics from HM Prison and Probation Service and the Ministry of Justice provide important context about levels of violence and self-harm in prison to consider when looking at hospital admissions as a result of injury or poisoning. These data include figures on recorded cases of self-harm in prison as well as assaults on staff and prisoner-on-prisoner assaults. While rates of prisoner-on-prisoner assaults tend to be higher in the male prison estate than the female one (although assault rates on staff are higher in the female estate), rates of self-harm are consistently much higher in the female estate. In the year to June 2021 there were 3,808 incidents per 1,000 female prisoners compared to 546 per 1,000 prisoners in the male estate (HM Prison and Probation Service and Ministry of Justice, 2021).

We looked at hospital admissions where injury or poisoning was noted to see what more we could learn about needs in this area. It is important to note that not all instances of self-harm or violence will require or receive hospital treatment – many will be dealt with directly by prison health care services – and therefore hospital data are likely to reflect the more serious end of cases. Table 5 shows that women were most commonly admitted to hospital as a result of either poisoning, open wounds or the presence of a foreign body.

Table 5: The five most common injury and poisoning diagnoses for female prisoners, 2019/20

Five most common injury and poisoning diagnoses	No. of admissions (no. where this was the primary diagnosis)	No. of people
Poisoning by, adverse effect of and underdosing of non-opioid analgesics, anti-pyretics and anti-rheumatics	30 (22)	25
Open wound of the elbow and forearm	19 (14)	10
Foreign body in the alimentary tract	18 (14)	9
Poisoning by, adverse effect of and underdosing of narcotics and psychodysleptics (hallucinogens)	19 (13)	19
Open wound of the abdomen, lower back, pelvis and external genitals	11 (10)	7

Sexual and reproductive health

Many stakeholders highlighted the importance of considering the sexual health care needs of women in prison as well as their reproductive health. It was felt that these were areas where women overwhelmingly lacked access to information and that this was a missed opportunity.

Sexual health

Gender-specific health care standards for women in prison (Public Health England, 2018) suggest that as part of reception screening, women should be asked about their menstrual cycle, sexual history and contraceptive use and that advice and follow-up should be provided in response to any information disclosed. This may include access to emergency contraceptives or a pregnancy test. Women should also be offered testing for sexually transmitted infections.

Within hospital data we could see a small number of instances where women had required hospital treatment that may have been linked to untreated sexually transmitted infections. There were six hospital admissions where women were admitted to hospital with a diagnosis of pelvic inflammatory disease (PID).[3] PID is an infection of the upper genital tract (uterus, fallopian tubes and ovaries), which can be caused by an untreated sexually transmitted infection such as chlamydia (Public Health England, 2015a).

There were also a number of admissions where the human papillomavirus (HPV) was recorded as a primary or secondary/subsidiary diagnosis, but numbers are too small to report. HPV increases the risk of certain types of cancer, such as cervical cancer (Cancer Research UK, 2021). In 2019/20 there were 13 hospital admissions by 13 women in prison with a diagnosis of cervical cancer, either malignant neoplasm of cervix uteri or carcinoma in situ of cervix uteri.

Reproductive health care needs

We focus here on endometriosis and the menopause, as our stakeholders most commonly raised these gynaecological issues. Stakeholders were concerned that women in prison do not tend to know the signs of either endometriosis or the menopause. It is of note that these are conditions that are poorly understood and treated in the general population. The impact of this is likely to be magnified in a prison setting where women have much less autonomy over their own health and are less able to access information.

Endometriosis

Endometriosis is when endometrial tissue (the tissue that lines the uterus) is found in other places in the body. This tissue breaks down each month but the blood has nowhere to go (Endometriosis UK, 2022). It can be a very painful condition, which can greatly affect a woman's quality of life. It is estimated that endometriosis affects 1 in 10 women in England (Endometriosis UK, 2022), which in the prison population would equate to 320 women. It can take a long time for endometriosis to be diagnosed. We found that there were six hospital admissions by five women in prison in 2019/20 where endometriosis was

3 ICD-10 codes: N70–N74.

recorded as a diagnosis. Yet endometriosis is not referenced in the gender-specific standards to improve health and wellbeing for women in prison (Public Health England, 2018).

The menopause

The menopause is when a woman stops having periods. This is because the ovaries no longer release eggs, which causes the level of oestrogen in the body to fall and periods then stop. The average age of the menopause is 51 years old, but for some women it can be earlier and for others later. The menopause can cause a wide range of symptoms, such as anxiety, low mood, irritability and night sweats and it can affect a woman's bladder, bone health and heart health (see Royal College of Obstetricians & Gynaecologists, 2018; British Menopause Society, 2019).

Gender-specific standards to improve health and wellbeing for women in prison (Public Health England, 2018) state that women should receive support for the menopause if they need it (Standard 7.14). This may include being prescribed hormone replacement therapy, as well as practical support such as access to fresh bedsheets if they are experiencing night sweats. Anecdotal evidence suggests that support for women in prison who are going through the menopause is very poor (Barstow, 2020). Stakeholders discussed women not being aware of the symptoms of the menopause or the possibility that they could be perimenopausal (the time leading up to the menopause).

Within hospital data we could only find minimal evidence of women with a menopause diagnosis having accessed hospital care for any reason. There were a number of admissions where a diagnosis of menopause was flagged, but numbers are too small to report.

The lack of reference to the menopause in hospital data is not unsurprising, for various reasons. First, the menopause is poorly understood and treated in the general population. Second, women in prison may struggle to get an appointment with the prison general practitioner (GP), and if they do get an appointment the GP may attribute the symptoms to something else. Third, the number of women in prison who are over the age of 50 is relatively small (548 out of a population of just under 3,200). And finally, those affected may be more likely to receive care from their GP in prison if the menopause has

been confirmed, meaning we would not necessarily expect to see hospital admissions or appointments linked to the menopause.

It is important that plans for a rising prison population – which will include an increasing number of older prisoners – can provide targeted support to women experiencing the menopause. While there are currently clear challenges around menopause care for all women, regardless of whether they are in prison, the delivery of equivalent care will require a distinct approach in a prison setting. For instance, giving lifestyle advice such as exercising to control weight gain requires women in prison being able to access exercise space. Where appropriate, women in prison may also need access to specialist menopause clinics and therefore, in the future, we may expect to see more use of specialist services as a marker of care equivalence.

Pregnancy and birth

Admissions related to pregnancy and childbirth were the fourth most common reason for women in prison to be admitted to hospital. Our stakeholders saw this as a key health care need due to the unique risks facing pregnant women in prison.

The first official statistics regarding how many pregnant women there are in prison in England and how many of these women give birth each year were released in July 2021, which show that over a nine-month period from July 2020 to March 2021, 31 women gave birth, with two of these births taking place on the way to hospital (Ministry of Justice, 2021c). Many organisations lobbied for these figures to be released (see Ministry of Justice, 2020) to raise awareness of the number of pregnant women in prison and advocate for appropriate services to be in place to meet their distinct health care needs. This is particularly important given the tragic deaths of two new-born babies, one at HMP Bronzefield (see Prisons & Probation Ombudsman, 2021) and the other at HMP Styal (see Prisons & Probation Ombudsman, 2022) in 2019 and 2020 respectively.

Official pregnancy and birth statistics are a good first step to draw attention to the needs of pregnant women in prison as they force an acknowledgement that they exist, but we wanted to learn more about the distinct health care

needs of this small group and where there may be gaps in care. Stakeholders raised concerns about female prisoners' access to maternity services and more specialist care.

We looked at 127 women in prison who had given birth in hospital between 2016/17 and 2019/20. We investigated how they used hospital services in prison before birth, during labour and then after birth. We focused on this specific group, which was a sub-group of all births, to allow time for pre-birth and post-birth activity within the data years available.[4]

Number of hospital admissions by women in prison before birth

As might be expected, admissions before birth were most commonly related to pregnancy (see Table 6). There were 83 hospital admissions before birth by 44 women in prison. Maternal care related to the foetus and amniotic cavity and possible delivery problems included 12 admissions for false labour by 10 women. Admissions with a diagnosis of 'other maternal disorders' included genitourinary tract infections, and 'encounters related to reproduction' included normal pregnancy check-ups.

Table 6: Number of hospital admissions before birth, 2016/17–2019/20 (top three primary diagnoses)

Primary diagnosis	No. of admissions (no. of women)
Maternal care related to the foetus and amniotic cavity and possible delivery problems	34 (24)
Other maternal disorders predominantly related to pregnancy	25 (14)
People encountering health services in circumstances related to reproduction	16 (13)

4 The births occurred between 1 October 2016 and 30 September 2019. We looked at a maximum of six months of activity before and after the births to focus on attendances linked to pregnancy or the postnatal period.

Use of outpatient services

We already know that, in 2017/18, women in prison missed a higher proportion of both midwifery and obstetrics appointments than women in the general population (Davies and others, 2020), and a similar pattern can be seen looking at data from 2019/20. In 2019/20, women in prison missed 31.5% of obstetrics appointments and 21.5% of midwifery appointments, whereas in the general population only 16.8% of obstetrics appointments and 16.0% of midwifery appointments were missed.

Hospital admissions for labour

We looked across all diagnosis information to see what could be learned about labour complications that women in prison experience. There were some similarities between women in prison and women in the general population in that the proportions of women in prison experiencing the most common labour complications were very similar to those in the general population in 2019/20. For instance, perineal laceration during delivery was the most commonly reported complication in the general population (NHS Digital, 2020a), affecting 41% of women, and the same proportion of women in prison experienced it (n = 52 women, 40.9%).

We found, though, that women in prison were more likely to experience preterm labour – meaning birth before 37 weeks of pregnancy – than women in the general population. In our sample of 127 women who gave birth in prison between 2016 and 2019, 11% (n = 14) went into preterm labour and delivery (95% CI, 6.68%, 17.65%). In the general population, across the same time period, for women of the same age, 6.5% of births were premature. So the proportion of premature births in prison was 4.5% higher (0.16%, 11.1%), and this difference was significant. Babies born premature have a higher mortality rate than those born full term and an increased risks of disability (Tommy's, no date).

Postnatal hospital admissions

There were only 8 hospital admissions post birth, by 6 women. Stakeholders were concerned about the lack of evidence of postnatal hospital activity related to mental health treatment.

Women in prison who have children

While it is vital to support the small number of women who give birth while in prison, we should also consider the needs of the much larger group of women who already have children when they enter prison. This is important in the wider context of the impact of prison on family life. Our stakeholders talked about the impact on women of being removed from their children as well as the wider effects on families where mothers (who are often the primary caregiver) are in prison.

Currently, no formal data are collected on whether women in prison have children, although the *Prisons Strategy White Paper* has committed to collecting data on prisoners' 'family circumstances and caring responsibilities' (Ministry of Justice, 2021a, p. 40). This information is important both to ensure that children can be supported but also to identify women in prison who may require specific support due to separation from their children.

We wanted to use hospital data to see how many women in prison had had a baby before prison, to fill in some of the gaps in knowledge in this area. Because we only had access to data from 2016/17 to 2019/20 we are only able to provide a partial picture by looking at births that occurred in those four years. We could also only look at births for women in prison who had accessed secondary care in 2019/20, and our approach only captures hospital births. Our figures therefore represent a minimum estimate of the number of women in prison with dependent children.

We looked at women in prison who used hospital services in 2019/20[5] and found that 212 had had at least one baby in hospital within the four years before being in prison. Of these women, 109 had had a baby within the two years before entering prison, which represents 3.93% of women who used hospital services in 2019/20. The period of conception up to the age of two – the first 1,001 days – is vital for a child's future development and supporting mothers' health and wellbeing is actively beneficial for children (HM Government, 2021).

5 Admitted patient care or outpatient services. Only includes women who gave birth in hospital and if they had subsequent hospital contact while in prison. Includes any births in the general population even if women subsequently moved in and out of prison.

There are six mother and baby units in prisons in England where women can apply to stay if they have a child under 18 months old when they enter prison or give birth in prison. In 2019, 60 women and 57 babies were received into mother and baby units in prison (Ministry of Justice, 2021c). The national capacity of mother and baby units in prison is 64 mothers and 70 babies (Ministry of Justice, 2020). The number of women who enter prison with a baby up to 18-months of age (75) is higher than the number of spaces in mother and baby units – and this is before even thinking about pregnant women in prison who may also require a space. While not all women will be able to go to mother and baby units with their child as a risk assessment has to be made, it is important to understand current need and demand and to project into the future to make sure capacity is sufficient and facilities are appropriate. Women also need to be aware that these facilities exist and be supported to apply to them if they want to.

Brain injury

The Disabilities Trust (2019) found that nearly two thirds of the 174 women it surveyed at HM Prison/Young Offender Institution Drake Hall had a history that suggested they had experienced a brain injury and that this was often the result of domestic abuse.

We spoke to our stakeholders about the health care needs of women in prison with a brain injury. They told us that screening for and the identification of brain injuries were often poor and that, as a result, they would not necessarily expect to see these women present at hospital purely as a result of a head injury, even though they may be experiencing symptoms. We found that there were 13 hospital admissions by 12 women where 'injuries to the head' was recorded as a diagnosis, including a small number of intracranial injuries (traumatic brain injuries). Given the challenges around screening for and the recognition of brain injuries it is likely that these numbers only reflect a small proportion of women in prison who have needs associated with a brain injury.

We also considered other health care needs that may be associated with a head injury, such as epilepsy, and found that there were 73 hospital admissions by 51 women with a diagnosis of epilepsy. While we cannot be sure that all these cases are the result of a head injury, they are likely to be

an explanatory factor in some cases. Previous research has estimated the incidence of epilepsy following a traumatic brain injury to be anything from 2% to 50% (Ding and others, 2016).

Our stakeholders also suggested that the symptoms of brain injuries can often be attributed to other things, such as mental health care needs, and in particular personality disorders. They made the point that if women have experienced domestic abuse in the past and a partner has called their mental health into question, they may not attribute symptoms to a historical head injury. We found that there were 102 hospital admissions by 67 women with a diagnosis of specific personality disorders. If symptoms are misattributed to other things (prisoners are often described as being 'challenging') this may result in women being treated punitively or unfairly.

Mental health

Mental health is often flagged as a key area of health care need for women in prison. HM Inspectorate of Prisons reports that as many as 71% of women in prison have mental health care needs (Prison Reform Trust, 2022).

We looked at hospital admissions where there was a mental health diagnosis.[6] We found that admissions linked to psychoactive substance use and mood (affective) disorders were the most common mental health diagnoses (see Table 7).

6 Mental, behavioural and neurodevelopmental disorders (ICD codes F01–F99).

Table 7: Hospital admissions by women in prison with a diagnosis of mental, behavioural and neurodevelopmental disorders, 2019/20

	No. of admissions	No. of women
Mental and behavioural disorders due to psychoactive substance use	356	269
Mood (affective) disorders	288	207
Anxiety, dissociative, stress-related, somatoform and other non-psychotic mental disorders	191	138
Disorders of adult personality and behaviour	106	70
Schizophrenia, schizotypal, delusional and other non-mood psychotic disorders	68	48

Substance misuse

Stakeholders told us that a lot of staff time is taken up managing the effects of substance misuse. While some felt that care for substance misuse is positive, there was a sense that an emphasis on managing substance misuse leads to other health care needs being overlooked.

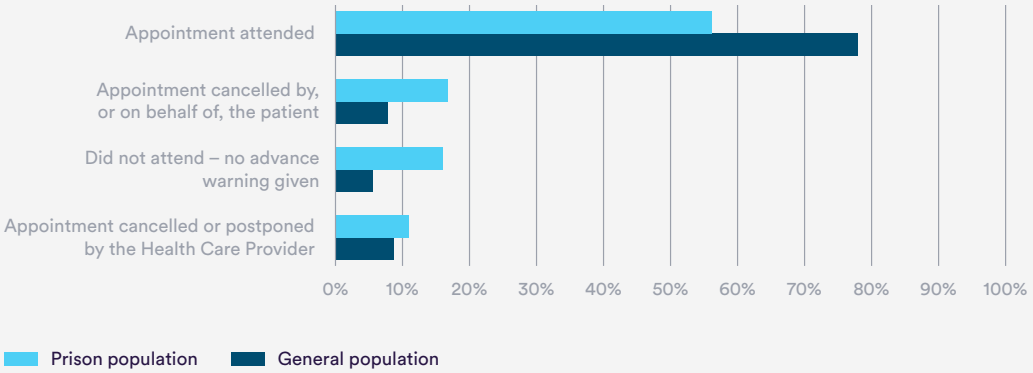
We looked at how many times substance use was recorded for hospital admissions by female prisoners. Table 7 shows that there were 356 hospital admissions where substance use was noted, which represents almost 30% (29.9%) of all admissions by female prisoners in 2019/20. Twenty-eight hospital admissions by women in prison where substance use was flagged had a primary diagnosis of poisoning. In the male prison estate, while there was a much higher number of admissions where substance use was recorded (2,680), as a proportion of all admissions by male prisoners, substance use had less of an impact, making up under 20% (19.8%) of admissions.

5 Access to services for women in prison

Stakeholders were universal in highlighting the importance of access to services as a key marker of good-quality care for women in prison. We have reported in our previous work that prisoners miss a large proportion of outpatient appointments and have discussed the reasons why this can happen, such as staff escorts not being available to take prisoners to hospital (see Davies and others, 2021). In 2019/20, women in prison missed around 45% of all outpatient appointments (43.8%), which equates to just under 4,000 appointments (n = 3,929). We know this is not a short-term issue as we found a similar pattern when we looked at female prisoners' missed appointment rates in 2017/18 (Davies and others, 2020), where just under 40% of outpatient appointments were either missed or cancelled.

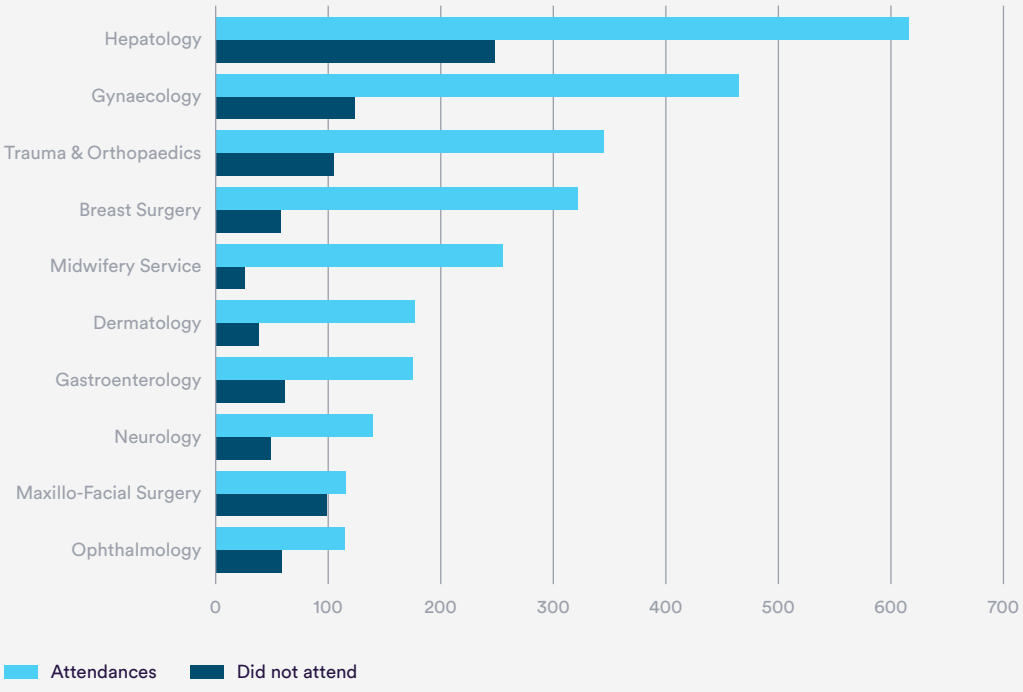
Figure 1 provides details of what hospital data can tell us about why female prisoners' appointments were missed and how this compares to what happened in the general population. In the general population, a much lower percentage of appointments were missed (22.1% compared to 43.8% for women in prison) and the proportion of appointments where women did not attend (with no advance warning) (DNAs) was only 5.6% compared to 16.1% for female prisoners.

Figure 1: Percentage of female prisoner outpatient appointments attended, and not attended, categorised by reason, and compared with the general population, 2019/20



The most common treatment specialities for female prisoners who attended their appointments are shown in Figure 2, alongside 'did not attend' (DNA) rates. Hepatology (liver disease) appointments were most common, followed by gynaecology and then trauma and orthopaedics.

Figure 2: Number of outpatient appointments for female prisoners by treatment specialty and 'did not attend' rates for each, 2019/20



We have previously reported that a lack of staff escorts is a key reason why appointments are missed (Davies and others, 2020) but there are other important factors. Sometimes missed appointments are attributed to patient refusal, but taking this at face value – that someone is just refusing to go to hospital – is too simplistic. One area where this is particularly relevant is gynaecology appointments. Because people in prison are not told when their appointments are going to be, they may have a member of staff just arrive at their door and tell them they need to leave to go to hospital for an intimate procedure. For instance, if a woman has a positive cervical screening result, they may be called for a colposcopy, which is where the cells of the cervix are examined to see if they are abnormal so that a decision can be made about treatment.

We found that 46.6% of gynaecology appointments were not attended in 2019/20. While this will be for a range of reasons, good-quality care in these circumstances is about both enabling access (making sure staff can take people to hospital) and considering how people might reasonably want to prepare (for example, giving them the chance to have a wash or collect a change of clothes).

Stakeholders highlighted that there is significant variation between secondary care providers in the extent to which they recognise the importance of appointments being rebooked promptly. Managing secondary care referrals from prison is complex and secondary care providers do not always have a clear understanding of how prison health care 'works' and the additional logistics involved in getting patients to external appointments.

However, the issue of care quality is not just about the amount of time women are waiting – although long delays are clearly not positive – but also about how delays are communicated. Previous research has highlighted that, for people in prison, missed appointments are a real source of frustration and anxiety, which is compounded by the fact that prisoners are not able to manage their appointments and be clear about any delays (Edge and others, 2020).

6 Impact of screening programmes in prison

People in prison should be included in all the relevant health screening programmes that run in the community (Public Health England, 2019 a; 2021). This means that they should be able to access all the appropriate cancer and non-cancer screening programmes for their age, sex and other risks factors, as well as the NHS Health Check programme. Screening programmes for women should include cervical screening, breast screening, bowel cancer screening and diabetic eye screening.

People in prison are often at a higher risk of conditions identified through screening and may also come from communities with lower access to screening outside of prison. Recent guidance has recognised the need to address inequalities in access to screening within the prison population (Public Health England, 2019a). Many stakeholder conversations highlighted access to screening programmes as an important marker of the quality of care, but also important for identifying health care issues that may have been unaddressed outside of prison.

Some screening tests for prisoners take place in hospital, but in many instances screening is undertaken at the prison itself to avoid the challenges of having to escort people to hospital. Our work uses hospital data so we cannot see how many women are screened in prison but we can see hospital-based screening attendances where they do happen, as well as where women received either inpatient or outpatient treatment that may be linked to a positive screening test. We also drew on inpatient data to provide contextual information about the numbers of women in prison who had a relevant related diagnosis. For the purposes of this report we have focused on cervical screening and hepatitis C, as these are the screening areas where hospital data provide the most detailed information.

Cervical screening (smear tests)

The NHS cervical screening programme (Public Health England, 2015b) is for women aged 25 to 64, and should take place every three to five years depending on the woman's age. It is particularly important to screen women in prison as they have a higher prevalence of cervical cancer (Escobar and Plugge, 2020).

Cervical screening is a test for types of the human papillomavirus (HPV), which if left untreated can cause cervical cancer. If HPV is found during screening and the sample reveals abnormal cells, patients should be sent for a colposcopy. The colposcopy allows a closer look at the cervix to see if cells are abnormal, so that a decision can be made about treatment. We looked at the procedure information that was recorded for women in prison aged 25 to 64 who attended gynaecology outpatient appointments and found that attendances for colposcopy as well as specific treatments for abnormal cells (biopsy or excision) were the most commonly recorded reason. Women may attend outpatients for a colposcopy either as a result of a positive screening test result or if they have possible symptoms of cervical cancer. Two-thirds of all referrals in the UK in 2019/20 were linked to screening (NHS Digital, 2020b). Table 8 shows the most common categories of procedure for female prisoners aged 25 to 64 attending gynaecology outpatient appointments in 2019/20 . These included 180 attendances for colposcopy.

Table 8: Outpatient procedures for women in prison aged 25–64 attending gynaecology appointments, 2019/20

Outpatient procedure	No. of attendances (no. of people)
Other examination of the female genital tract	184 (159)
Biopsy of the cervix uteri	70 (68)
Exploration of the vagina	58 (50)
Assessment	39 (31)
Excision of the cervix uteri	37 (35)

It is difficult to determine whether hospital attendances by women in prison linked to cervical screening are as expected, given that we do not know what screening has taken place inside prisons themselves. Wider evidence suggests that women in prison are less likely to have attended cervical screening in the past than women who are not in prison (Plugge and Fitzpatrick, 2004) so it is important that women are screened in prison and receive any treatment they may need.

Guidance for cervical screening in secure settings (Public Health England, 2021) also notes that cervical screening can potentially be challenging for women in prison if they have experienced trauma or abuse in the past and that women need appropriate information and support to encourage screening attendance.

Hepatitis C

There was a large jump in women prisoners' use of hepatology outpatient services between 2017/18 and 2019/20, which may reflect enhanced testing for hepatitis C in the prison estate as part of a drive to eliminate hepatitis C by 2030 (Harris and others, 2022). In 2017/18, gynaecology, trauma and orthopaedics, and breast surgery were the three most common treatment specialties for female prisoners attending outpatient appointments, and hepatology was fifth (Davies and others, 2020). The number of outpatient hepatology appointments attended increased significantly between 2017/18 and 2019/20, from 226 to 616 (see Table 9). By 2019/20, hepatology was the most common outpatient treatment specialty, representing 11.2% (n = 1,003) of all outpatient appointments booked.

Table 9: Comparing the number of hepatology appointments for female prisoners, 2017/18 – 2019/20

Year	No. of appointments (% of all appointments)	No. of appointments attended (no. of people)	No. of appointments not attended
2017/18	378 (5.94%)	226 (92)	152
2018/19	474 (6.36%)	322 (149)	152
2019/20	1,003 (11.2%)	616 (338)	387

Hepatitis C is a blood-borne virus that damages the liver and can be transmitted by infected blood. There is a much higher prevalence of hepatitis C in the prison population than in the general population – particularly in the women's prison estate. The Hepatitis C Trust (2022) reports that the prevalence of hepatitis C in the women's estate is 15–20%, compared to 0.7% in the general population.

The increase in hepatology-related hospital attendances we saw was from three specific women's prisons. We spoke to stakeholders from NHS England and NHS Improvement and the Hepatitis C Trust who were involved in the hepatitis C elimination campaign to learn more about how hepatitis C is screened and treated, to think about what the data tell us. Over time, treatment for hepatitis C has evolved and much is now conducted as in-reach, meaning prisoners do not have to go to hospital for consultant appointments or scans in these cases.

We also found that there were 59 inpatient admissions by women where viral hepatitis C was a primary, secondary or subsidiary diagnosis.

7 Discussion and recommendations

Our work provides sobering examples of the complex health care needs of women in prison, including the impact of prior trauma. We found a significant amount of need associated with substance misuse as well as hospital admissions as a result of brain injury and violence, which may be linked to experiences of domestic abuse before prison.

Sexual and reproductive health

Several of the health issues our work raises as important for women in prison concern sexual and reproductive health, which are areas where women outside of prison can also struggle to obtain a diagnosis or appropriate treatment.

Health care for women in prison should be equivalent to health care that women in the general population receive, but this is in some ways a problematic starting point. Women's health, particularly reproductive health, is not talked about as openly and freely as other health care issues. This is particularly the case when thinking about the health care needs of older women. Brushing over women's health has an impact on awareness of symptoms and knowing what 'normal' looks like, for both women themselves and health care professionals.

While reproductive health care issues can be challenging for women regardless of where they live, for women in prison the impact is further compounded by the lack of care options available to them, and potentially complex traumatic experiences before prison. But there is a resounding need for women's health to be prioritised in all settings. There were more than 450,000 women on the waiting list for gynaecology care in January 2022, with around 25,000 having waited more than 52 weeks (NHS Waiting List Tracker,

2022). Women have no sense of how long they might have to wait and are expected to put up with pain and discomfort in the meantime. The upcoming *Women's Health Strategy* (Department of Health & Social Care, 2021) provides an opportunity to raise the profile of women's health issues across the population as a whole. It is essential that women in prison are not excluded from this.

Information and communication

Concerns about female prisoners' access to information, and critically how information is made available to them, were a recurrent theme in our discussions with stakeholders. Reasons for delays are not always well communicated, and uncertainty around when appointments will happen, and few options for self-care in the interim, are a significant source of stress. Equally, women in prison need to be aware of what standards of care they are entitled to and have the means and support to challenge if they do not receive care that meets these standards.

While the *Prisons Strategy White Paper* (Ministry of Justice, 2021a) has bold ambitions to embed the use of technology across the prison estate, which could provide a means of improving access to information, this will be meaningless if women cannot (or do not) read it. There are NHS information accessibility standards (NHS England, 2017), but these are designed primarily to meet the needs of patients with a disability, impairment or sensory loss, and fall short of meeting the needs of the wider prisoner population. The Shannon Trust (no date) estimates that more than 50% of prisoners have a literacy level of 11 years old or younger.

Women need to know basic information about health care processes, such as how to make appointments, and how missed health care appointments can be rebooked. The way in which this information is made available to women is particularly important. Women in prison should be a part of any discussions about what information they need and the best ways to receive it.

Aspirations in the *Prisons Strategy White Paper* to improve access to information should also include the involvement of prisons in public health campaigns and provide prisoners with a step towards information

to support their own self-care. Information accessibility also needs to be auditable. Providing access to information is positive but the onus should not be on the women themselves to seek it out. This should be a priority in the commissioning/support process.

Pregnant women in prison and women with children

While there have been noticeable strides over recent years to at least acknowledge and plan for the unique health care needs of pregnant and postnatal women in prison, we found that pregnant women in prison continue to be at risk of poor outcomes as they miss many more midwifery and obstetrics appointments than women in the general population. Without targeted efforts to deal with the systemic issues causing missed health care appointments, the risks to women and their babies remain.

It is important to support the needs of pregnant women in prison, but our work highlights that a much larger group of women have children before they go to prison and the needs of these women (and their children) need to be better understood. It is clear from our discussions with stakeholders that separation from children can be a core anxiety. We found that 212 women had had at least one baby within the four years before being in prison, 109 within the two years . The period of conception up to the age of two – the first 1,001 days – is vital for a child's future development and supporting mothers' health and wellbeing is actively beneficial for children (HM Government, 2021).

The *Prisons Strategy White Paper* (Ministry of Justice, 2021a) has committed to recording data on prisoners' family circumstances, which we would support. The important detail though is in how this information is then used. While it is widely acknowledged that families play a vital role in supporting prisoners and reducing reoffending, there is a need to link up health service delivery and the family strategy for everyone's benefit.

Access to services as a measure of the quality of care

While our work provides various examples of challenges to care quality – access to services being key – our stakeholder discussions made it clear that perceptions of care quality driven by policy guidance do not necessarily marry up with what patients themselves perceive to be good-quality care. This again links back to the importance of access to information in an appropriate format. Women need to be aware of what standards of care they are entitled to and have the means and support to challenge if they do not receive care that meets these standards. Access to services is a minimum requirement for care and prisoners have consistently faced challenges accessing hospital care. Given the high percentage of people in prison on short sentences, the consequences of poor access – in the short, medium and long term – may only be felt once people have left prison, thereby increasing the burden on NHS services.

There are a number of reasons why access to services while in prison may be challenging. There are wider system challenges around staff availability to escort prisoners to hospital but there are also other reasons for missed appointments, which may be more amenable to change and would also have the associated benefits of improving care quality for all patients.

We know there are particular challenges around gynaecology appointments, which may involve intimate procedures. Stakeholders highlighted that refusal to attend can be the result of a lack of opportunity to prepare (such as taking a bath and changing clothes) as well as fears about intimate procedures due to previous trauma.

It is important to bring together stakeholders (including women in prison or women with lived experience of prison) to reach agreement on the reasons why women may not want to attend appointments and the acceptability of certain solutions. The *Prisons Strategy White Paper* mentions the use of technology to inform prisoners about upcoming appointments and remind them of the need to attend, but the value of this is again reliant on how this information is communicated to people in prison.

The impact of the Covid-19 pandemic

Our data did not cover the Covid-19 pandemic, but in our discussions with stakeholders we thought about what the impact of the pandemic might be on some of the issues raised in this report. In terms of the ongoing challenges around access to services, the pandemic sped up the roll-out of remote consultations across the prison estate (Edge and others, 2021) and future data years may show an impact of this in terms of missed appointment rates, as well as an increasing proportion of remote consultations when compared to current levels.

Stakeholders also talked about the less tangible impacts of the pandemic on access to services. For instance, there were concerns that spending more time in cells meant a loss of informal support from peers as well as staff, which female prisoners may have relied on before the pandemic if they needed help to make appointments or deal with specific health care issues.

Looking ahead

The *Prisons Strategy White Paper* (Ministry of Justice, 2021a) has laid out an ambitious plan for the prison estate for the next 10 years, which acknowledges that women in contact with the criminal justice system need care and support that reflects their specific needs. Despite the call for more community-based custodial and support options for women, there are plans to increase the number of spaces for women in prison. We make the following targeted recommendations so that the increasing number of women who will be held in prison receive the health care and support they need.

- **Recommendation 1 – for prison health care**: Ensure women have access to good-quality, understandable and targeted health care information.

- **Recommendation 2 – for NHS England and the Ministry of Justice**: Commit to better data collection to inform planning and address inequality. This includes NHS England improving the recording of ethnicity coding in routinely collected data and the Ministry of Justice meeting its commitment to collect data on women in prison with dependants to inform planning.

- **Recommendation 3 – for the Ministry of Justice**: Better understand and address the needs of those with children as an urgent priority ahead of the new prison places.

- **Recommendation 4 – for the national partnership members** (This includes Ministry of Justice, Her Majesty's Prison and Probation Service, (former) Public Health England, the Department of Health & Social Care, and NHS England: Acknowledge and address the root causes of missed appointments, which may be more complex than staff availability. This requires partnership working as health care often sits at the interface between the prison environment and health care.

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